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RESEARCH ARTICLE

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The Presence 5 for Racial Justice Framework for anti-racist communication with Black patients

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Abstract

Objective: To identify communication practices that clinicians can use to address racism faced by Black patients, build trusting relationships, and empower Black individuals in clinical care.

Data Sources: Qualitative data ($N = 112$ participants, August 2020–March 2021) collected in partnership with clinics primarily serving Black patients in Leeds, AL; Memphis, TN; Oakland, CA; and Rochester, NY.

Study Design: This multi-phased project was informed by human-centered design thinking and community-based participatory research principles. We mapped emergent communication and trust-building strategies to domains from the Presence 5 framework for fostering meaningful connection in clinical care.

Allergy and Asthma Research at Stanford University

Data Collection Methods: Interviews and focus group discussions explored anti-racist communication and patient–clinician trust ($n = 36$ Black patients; $n = 40$ nonmedical professionals; and $n = 24$ clinicians of various races and ethnicities). The Presence 5 Virtual National Community Advisory Board guided analysis interpretation.

Principal Findings: The emergent Presence 5 for Racial Justice (P5RJ) practices include: (1) *Prepare with intention* by reflecting on identity, bias, and power dynamics; and creating structures to address bias and structural determinants of health; (2) *Listen intently and completely* without interruption and listen deeply for the potential impact of anti-Black racism on patient health and interactions with health care; (3) *Agree on what matters most* by having explicit conversations about patient goals, treatment comfort and consent, and referral planning; (4) *Connect with the patient's story*, acknowledging socioeconomic factors influencing patient health and focusing on positive efforts; (5) *Explore emotional cues* by noticing and naming patient emotions, and considering how experiences with racism might influence emotions.

Conclusion: P5RJ provides a framework with actionable communication practices to address pervasive racism experienced by Black patients. Effective implementation necessitates clinician self-reflection, personal commitment, and institutional support that offers time and resources to elicit a patient's story and to address patient needs.

KEYWORDS

African American, Black, communication, community-based participatory research, design thinking, human-centered design, patient care, qualitative

What is known on this topic

- Effective communication that mitigates pervasive racism is central to the delivery of high-quality and equitable care for Black patients.
- In the clinical setting, Black patients frequently face overt racism, as well as unconscious biases that negatively impact care.
- Anti-racism is a core aspect of Professionalism from the Accreditation Council for Graduate Medical Education (ACGME), which calls for discussion-based frameworks to support clinicians in anti-racist communication and trust-building.

What this study adds

- The Presence 5 for Racial Justice (P5RJ) framework incorporates human-centered design and community-based participatory research strategies, and input from patients, clinicians, previous literature, and nonmedical professionals.
- P5RJ focuses on clinician self-reflection and awareness of personal biases, interpersonal communication practices focused on empathy, and institutional anti-racist practices promoting team-based care and additional time with Black patients.
- Listening was at the core of Black patients' requests, including active listening in one-on-one encounters, as well as listening for cues about the impact of anti-Black racism on patient health.

1 | INTRODUCTION

In 2021, the US Centers for Disease Control formally recognized racism as a fundamental threat to health,[1] a legacy of 400 years of systemic racism through enslavement, redlining,[2] and police brutality against Black Americans.[3] In the clinical setting, Black patients frequently face overt racism, as well as unconscious biases that negatively impact care.[4] Clinicians interacting with Black patients interrupt more often, display and elicit fewer emotions, and receive lower ratings of patient satisfaction and trust.[5,6] Although interrupting more frequently and displaying fewer emotions may seem like subtle communication practices to some observers, these clinician behaviors can profoundly impact patients and contribute to health care inequities, compounding the negative effects of "anti-Black racism"—which is racism specifically directed at Black individuals.

Transformation of clinical practices is a crucial step to promoting justice and disrupting embedded racism in the health care setting.[7] Anti-racism is mentioned in the Accreditation Council for Graduate Medical Education (ACGME) core competency of Professionalism.[8] This competency calls for discussion-based frameworks to support clinicians in anti-racist communication, which has been defined as communication that actively promotes racial justice and health equity by healing, organizing, and empowering historically marginalized patients.[9]

Effective communication that mitigates pervasive racism is central to the delivery of high-quality and equitable care for Black patients. A 2021 qualitative systematic review involving participants identifying as Black or from other historically marginalized groups reported perceived condescension, limited empathy, assumptions of low socioeconomic status, and assumptions of poor behavior from clinicians.[10] These negative experiences were often enacted in one-on-one patient–clinician communication.[10] Conversely, there is evidence that anti-racist communication can build patient trust through positive clinician affect, including affirmations and expressions of encouragement.[11] Patient trust in clinicians, in turn, has been documented among low-income Black women to correspond with patient activation to access preventive health care,[12] a predictor of long-term health. Effective communication supports high quality of care for all patients,[13] but research is limited on specific anti-racist communication and trust-building strategies for clinicians to use in supporting Black patients.

Black voices have been systematically excluded from research and innovation in medicine. Community-based participatory research (CBPR) is one proposed framework to advance health equity and incorporate Black patient input in interventions.[14] In best-case scenarios, CBPR creates opportunities for stakeholders to participate meaningfully in research projects, engaging communities in bidirectional learning and knowledge creation. CBPR has recently been further enhanced with human-centered design ("design thinking") strategies,[14,15] which emphasize rapid iteration of products to support scale and impact.[16]

The Presence 5 framework was previously developed to support clinical encounters and foster meaningful connections between clinicians and patients. It was developed using health services research and design thinking approaches[17] that involved a systematic literature review,[18] interviews with clinicians[19] and individuals in "analogous" non-clinician roles,[20] and a national expert Delphi panel.[21] In the current study, we sought to leverage the Presence 5 framework in order to synthesize specific communication practices that promote health equity and justice for Black patients, and present them within a framework that can be integrated into routine clinical encounters.

1.1 | Objective

Our objective was to identify communication practices that clinicians can use to address racism faced by Black patients, build trusting relationships, and empower Black individuals in clinical care. In this paper, we synthesize literature and qualitative discussions with clinicians, Black patients, and nonmedical professionals. We present the development of a novel framework, Presence 5 for Racial Justice (P5RJ), comprising practices that clinicians can use to navigate and address racism faced by Black patients.

2 | METHODS

Figure 1 illustrates the development of the P5RJ framework. During development, we adapted the approach used to develop the original Presence 5 framework, and shifted the focus from expert panel synthesis to synthesis of experiences and insights described by Black patients (interviews), clinicians serving Black patients (focus groups), and nonmedical professionals working in predominantly Black communities (interviews with analogous professionals).

Our team conducted six steps of research activity to inform P5RJ: two informed by design thinking; three informed by CBPR; and an ongoing iterative analysis/synthesis (see Table 1). Design thinking activities included (1) targeted literature review to identify evidence-based practices that promote racial justice and health equity for Black patients, and (2) design thinking interviews with analogous professionals[28] (i.e., primarily self-identified Black professionals who were non-clinicians). Activities informed by CBPR included the following: (3) focus group discussion "Presence 5 for Racial Justice Circles" with clinicians at partner primary care clinics primarily serving Black patients; (4) interviews with self-identified Black patients; and (5) feedback/validation discussions with the P5RJ National Virtual Community Advisory Board composed of clinicians and self-identified Black patients. Our multi-phased research process, and synthesis of results, was guided by the P5RJ National Virtual Community Advisory Board with clinician and patient representatives from partner clinics (Roots, Oakland, California; Culver Medical, Rochester, New York; University of Alabama Birmingham, Leeds, Alabama; Church Health, Memphis, Tennessee). Iterative analysis and synthesis activities revolved around (6) research team synthesis of practices. Qualitative data collection (steps 2–4) took place between August 2020 and March 2021. Throughout data collection, we mapped emergent communication practices to the Presence 5 framework domains for fostering meaningful connection in clinical care: *Prepare with intention*; *Listen intently and completely*; *Agree on what matters most*; *Connect with the patient's story*; and *Explore emotional cues*.[21]

Synthesis steps broadly included the following: (1) systematic documentation of practices/strategies from each data source, mapped to the original Presence 5 framework; (2) triangulation of practices that surfaced in multiple data sources; and (3) iterative discussion about emerging P5RJ domains and practices with interdisciplinary research team and Community Advisory Board members. With each

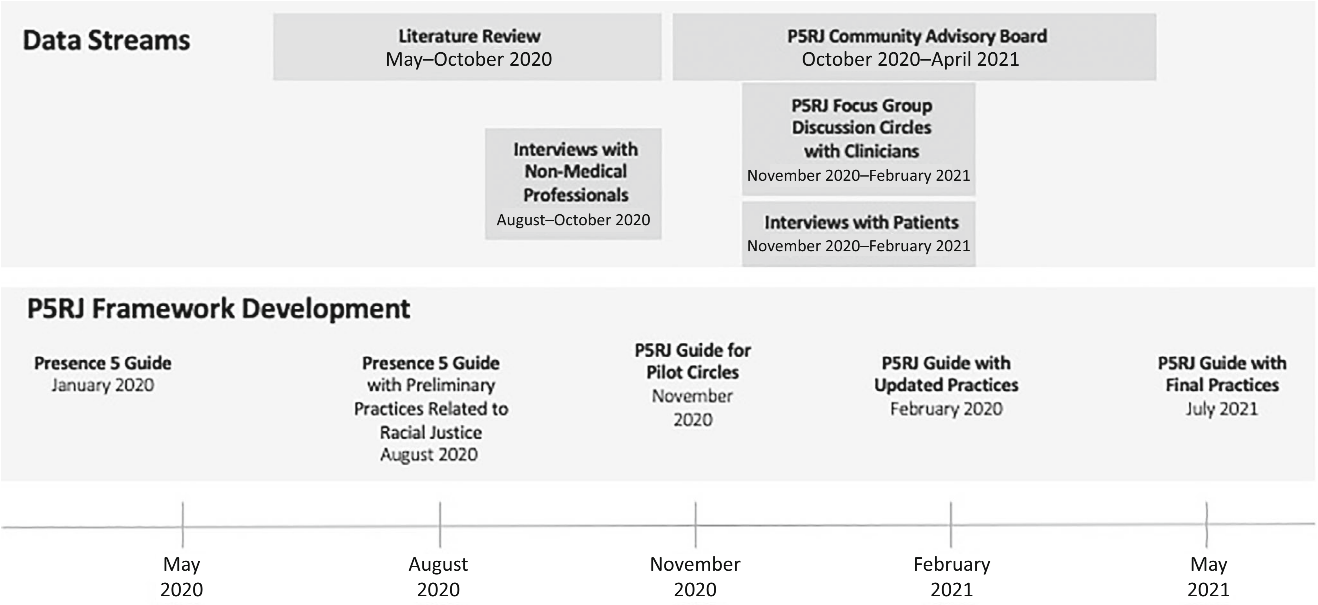

FIGURE 1 Development of the Presence 5 for Racial Justice (P5RJ) Framework: Data streams and iterative synthesis over time

data stream (interviews and focus groups), potential practices were coded in Dedoose (i.e., a qualitative coding software), and these excerpts were mapped non-exclusively to Presence 5 domains (i.e., one P5RJ practice could map to multiple domains). In consensus discussion over multiple weeks, excerpts were determined to be one of the following: (a) duplicative with existing practices; (b) adding nuance to practices, which were then adapted (e.g., preparing a welcoming clinic environment with inclusive signage, adapted from clinician focus groups); (c) novel, to be added to current practices (e.g., the Black community is diverse and not monolithic, added from interviews with nonmedical professionals); or (d) outside of scope (e.g., pertaining to clinician communication with non-Black patients who express racist beliefs). We met with the Community Advisory Board throughout the P5RJ framework design process to guide research activities and interpretation of findings.

3 | RESULTS

3.1 | Participants

Qualitative research steps involved 112 participants: 40 nonmedical professionals (interviews), 24 clinicians (discussion circles), 36 patients (interviews), and 12 clinician and patient Advisory Board members (Table 2).

An overview of the Presence 5 for Racial Justice Framework is presented in Table 3, and domains and specific practices are described below. Briefly, *prepare with intention* includes reflecting on individual biases, cultivating awareness of system biases and diagnoses that disproportionately impact Black patients, and fostering welcoming environments; *listen intently and completely* emphasizes nonverbal communication strategies of engagement and avoiding interruptions; *agreeing on what matters most* focuses on explicit conversation to identify and incorporate patient priorities for care, overseeing equitable treatment in specialty referrals, and extending clinician–patient partnership beyond the visit; *connect with the patient's story* relies on empathy and acknowledgment of social and environmental factors influencing patient health, and attending to racism's impacts on Black patient health; and *explore emotional cues* counsels clinicians to notice and name patient emotions while engaging in trauma-informed care. Table 4 presents evidence and exemplar quotes for practice recommendations for each P5RJ domain. An in-depth P5RJ Reflection and Discussion Guide can be found in Data S1.

3.2 | Prepare with intention

Prepare with deep reflection for anti-racist communication. Consider how your identity and biases (implicit/explicit) could influence clinic encounters. Familiarize yourself with the person you are about to meet, keeping an open mind about the values and perspectives they might bring to the visit.

The practice of *Preparing* begins before patients are present, emphasizing elements that are reflexive and clinician-internal, as well as the process of implementing systems to support anti-racist care at the clinic level. Previous literature emphasizes the importance of (a) staying informed to improve patient health outcomes and confidence,[29–32] (b) recognizing the impact of racism, which can change understanding of organ systems and disease,[33] and (c) reflecting and conversing with colleagues, which can reduce bias and racism,[34,35] and increase confidence for addressing bias[36] (see Table 4).

TABLE 1 Research activities incorporated into the creation of Presence 5 for Racial Justice

Formative/Human Centered Design ("Design Thinking")	
1. Literature Review: Leveraged the existing Presence 5 systematic review to conduct a secondary review of communication interventions to support Black patients.	In summer 2020, we extracted themes from *n* = 30 articles from PubMed using the following broad search terms: health equity, structural inequality, racism, health care, health outcomes, patient–clinician race-concordance/race-discordance, racism conversations, clinician communication racism, trauma-informed care, cultural sensitivity, and cultural centeredness. Articles were identified based on relevance to primary care and/or safety-net clinical settings. Articles detailing health outcomes, specific strategies for clinicians, and/or health models were also included. We utilized this initial literature review to adapt Presence 5 to the new Presence 5 for Racial Justice.
2. Design Thinking Interviews with Analogous Professionals: Interviewed non-clinicians about their experience supporting Black individuals in the workplace.	Using design thinking approaches previously employed in Presence 5 research,[20] in fall 2020, we conducted interviews with n = 40 professionals to obtain nonmedical "analogous" information on workplace experiences with anti-racist communication (Stanford IRB #43314).[22] Interview topics included racial justice, experience with anti-Black racism, and needs for anti-racist work environments. We oversampled Black participants (*n* = 24, 62%) to ensure first-hand representation of the experience of Black professionals. To leverage diverse settings and experiences of participants, we intentionally recruited across industries: management, legal, education, science, social service, personal care, and arts.[23] We used inductive analysis and consensus approaches to identify and code themes, mapping emergent themes to established categories of internalized, interpersonal, and institutional racism.[24]
Community-based participatory research	
3. Clinician P5RJ Circle focus groups: Conducted virtual peer-discussion "Presence 5 for Racial Justice Circles" in which clinicians from clinics serving primarily Black patients discussed personal best practices and strategies for (a) connecting with Black patients, (b) identifying their own implicit biases, and (c) considering any social determinants of health that might influence their patients' ability to heal.	Primary care clinicians (n = 24 total) from four partner clinics (Roots Community Health Center in Oakland, CA; Culver Medical in Rochester, NY; UAB Primary Care Clinic in Leeds, AL; and Church Health in Memphis, TN) participated in two moderated virtual P5RJ Circles per clinic (8 circles total) in small groups (*n* = 4–6 clinicians). P5RJ Circles included: (1) reflection on individual racial biases; (2) presentation of evidence on the history and state of care for Black patients in the United States; (3) presentation of strategies clinicians could use to forge connections with Black patients during clinical encounters; (4) reflection and discussion about these strategies and other emergent practices; and (5) creation of individual goals and action plans for adopting specific practices. We recorded these facilitated conversations to capture proposed practices originating from clinicians. In the second circle, we also followed up on clinician goals shared during the first circle, explored any barriers encountered in practicing these goals, and asked if knowledge of P5RJ practices increased clinician attention to equitable care or impacted encounters with Black patients.
4. National Virtual Community Advisory Board: Partnered with clinics serving predominantly Black patients to build a community advisory board.	Our efforts were guided by an Advisory Board that included Black patients, and clinicians and other clinical care team members (medical assistants, nurses, and health navigators) who served Black patients (*n* = 12). We engaged with Advisory Board members in a series of monthly, hour-long virtual Advisory Board meetings (*n* = 6 meetings) between October 2020 and March 2021. Average attendance was n=8 participants, with a range of n=7–9 participants. Meetings covered topics including Black patients' experiences with medicine, patient interview recruitment strategies, review of and response to preliminary analyses of interviews and content from P5RJ Circles, and emergent concerns (e.g., COVID care and vaccination in Black communities). To ensure multiple avenues for participation, we invited Advisory Board members to less formal virtual "coffee chats," which were also monthly, hour-long conversations (average attendance: n=3 participants, range: n=2–4 participants).
5. Patient Lived-Experience Interviews: Engaged Black patients in semi-structured, qualitative interviews to identify clinician practices that build trust and facilitate engagement between Black patients and their clinicians.	We recruited Black patients from our partner clinics via snowball sampling to discuss patient-preferred clinician practices that foster trust and facilitate engagement between Black patients and their clinicians (*n* = 36; Culver Medical = 13, UAB Primary Care Clinic = 7, Church Health = 15, Roots = 1). Interview topics included health care engagement, preferred clinician practices, experiences with racism in medicine, and COVID-19 care. We intentionally built participant reflection check-in points between each section to give participants as much control over the interview as possible, reflecting culturally-sensitive research approaches.[25] This choice was informed by reviews of best practices for interviewing Black populations,[25] due to the potentially triggering nature of discussions. Recorded video/telephone interviews (average 30 minutes, range 30–90 minutes) were conducted by team members. All interviewers participated in a qualitative interview training conducted by JC. 39% of the interviews with Black patients were racially concordant. We analyzed interview transcripts using Dedoose,[26] with original Presence 5 practices as a deductive framework and emergent inductive themes surfaced by research team interviewers and coders.

(Continues)

TABLE 1 (Continued)

Analysis/Synthesis	
6. Synthesis	Our specific approach to synthesizing clinician practices/strategies for anti-racist communication and trust-building across data sources included the following steps, which were at times iterative and non-linear, in line with design thinking principles: (1) systematically documented practices/strategies from each data source, using Dedoose to code excerpts and Excel to annotate excerpts for corresponding Presence 5 practices and specific recommended actions; (2) discussed and integrated practices emerging from various data sources with our interdisciplinary research team in research meetings and with Advisory Board members; (3) conducted multiple small-group conversations around the emerging P5RJ practices within our research team to ensure input from all research team members; (4) returned to data (transcripts and research notes) when we did not come to consensus or had additional questions, per constant comparative qualitative methods[27]; and (5) prioritized patient voices above other data sources by going back to patient interview transcripts and reviewing patient Advisory Board member feedback when questions occurred or conflicting viewpoints surfaced in the data.

Patients requested that clinicians explore deeper knowing and awareness of themselves in order to overcome internal bias and support Black patients. Patients asked clinicians to be mindful of each interaction and learn about diseases that disproportionately impact Black patients (e.g., sickle cell anemia): “Paying attention, researching if we have something that they don't know” (Patient36). Clinicians acknowledged challenges to *Preparing* related to clinic pace and implicit biases: “the pace required [to keep up in our clinic] makes it hard to slow down and really prepare” (Circle1C).

Clinicians *Preparing with intention* reported taking reflective actions long before reaching clinic. To foster a welcoming clinic environment, clinicians reported creating signage for specific groups, including Black patients; in one clinic “the title of the poster said, ‘We see color’… the message is that we do see color, and we want to know your experience because it can help enrich us and the care you get” (Circle2C). To address bias in real time, clinicians expressed desire for protocols (e.g., written expectations of staff and patient behavior).

Other clinic- and system-level practices included supporting clinical teams to stay informed on current and historical events related to racial justice, and maintaining accurate and up-to-date documentation of external resources to address social determinants of health. In one clinic, executive leadership discussed current events that might impact Black patients for 3–5 min during morning huddles, encouraging staff and clinicians to reflect on current events and consider whether there was a role for clinic action in response (Circle1D).

3.3 | Listen intently and completely

Sit down, lean forward, do not interrupt. Position yourself to listen for your patient's unique experiences.

Listening was at the core of patient requests. The practice of *Listening* included attentive and patient-focused listening in one-on-one encounters, as well as careful listening for cues about the potential impact of anti-Black racism on patient health. Practices included nonverbal communication and specific strategies to enhance focus and engagement during conversation. Previous studies have found that taking time to listen without bias can improve quality of care,[39] and asking questions to personalize care based on the unique experiences and needs of individual patients can facilitate trusting partnerships.[41]

Nonverbal elements of *Listening* were highly important. Sitting down, leaning forward, making eye contact, and facing the patient contributed to perceptions of excellent care:

> [Clinicians] just coming in being warm and asking us…‘What's going on?’ and being a little more compassionate. Then sitting down eye level. I mean, when you have a physician that comes in and sits down, it kind of creates a more friendly environment. Because they're kind of getting on your level. (Patient 9)

Practices to support *Listening* included giving patients time and space to tell their complete health and health care story, listening for their unique experience as a Black patient, and asking questions to personalize care. One patient expressed the strong positive impact of a clinician taking time to listen:

> [My doctor] actually sat there and wanted to know what happened, what my story was. And where most doctors are rushy, rushy, rushy, he sat there with me, and he listened … (Patient 28)

Patients reported clinician disengagement, entrenched hierarchy, and rushed pacing as potential barriers to *Listening*; clinicians verified the need for additional time.

3.4 | Agree on what matters most

Find out what your patient cares about. Incorporate your patient's priorities and concerns into the visit and develop a plan together that addresses your patient's goals. Be mindful of your biases about what a patient should care about.

TABLE 2 Participant demographics

Participant demographics	Number ($n = 112$)	%
Self-identified race and ethnicity		
Asian	5	4%
Black or African American	70	63%
Latinx/Hispanic	5	4%
Native American	1	1%
White	18	16%
Multiple selections[a]	8	7%
Missing	5	4%
Age		
18–29	22	20%
30–39	27	24%
40–49	21	19%
50–59	11	10%
60+	23	21%
Missing	8	7%
Gender		
Woman	67	60%
Man	39	35%
Non-binary	1	1%
Missing	5	4%

[a] Participants were asked to self-disclose all racial and ethnic identities that applied. NB: We intentionally over-recruited individuals who self-identified as Black and/or African American for all aspects of our work to better represent the lived experience of Black patients.

The practice of *Agreeing* includes avoiding biased assumptions by explicitly asking Black patients about their priorities for their care, as well as extending joint responsibility outside of clinic visits. Previous literature emphasizes the need to earn Black patients' trust in the health care system,[5,42,60] and evidence suggests that effective strategies include sharing information,[45] involving patients in care plan conversations,[46] and identifying patients' health goals.[41]

Practices to support *Agreeing on what matters most* included relying on explicit conversation to identify patient goals, as opposed to making assumptions based on potentially biased expectations, and having patients share back their understanding of care. One patient reported on a tool for *Agreement*: “They always give me a sheet to put whatever issues that I may be having” (Patient27). Another patient emphasized the importance of having her clinician attend to emerging concerns:

> I love her [my clinician], because if I say, ‘Well, okay, like just the other day before I came, I had this pain somewhere,’ and she'll go, ‘Okay, so after we get done doing this, I'm going to check on that pain.’ And I'm like, ‘Great, thanks.’ She just says, ‘If it's something out of the way, we'll make an appointment for that pain, and I want to see you come back in a couple weeks so we can check out that.’ (Patient 35)

Agreeing also encompassed overseeing the quality of referral care to ensure equitable treatment and building trust with affirmation and reaffirmation that the clinician–patient partnership extends beyond the visit. Clinicians reported a variety of strategies for ensuring high-quality referral care for Black patients, including sending personal notes as a warm handoff to specialists.

3.5 | Connect with the patient's story

Acknowledge social and environmental factors influencing your patient's health and focus on positive efforts and events to encourage patient agency. Address any negative past experiences with health care, particularly those due to impacts of bias or anti-Black racism.

The practice of *Connecting with the patient's story* relies on empathy and intentional use of positive, non-stigmatizing language to reduce internal clinician biases related to race and address impacts of any previous negative experiences with health care. Previous literature has described the value of acknowledging patient–clinician similarities[50,61] and addressing Black patients' past experiences with health care.[51,52]

Practices to support *Connection* with Black patients included empathizing to understand sociocultural reasons for health beliefs and patient experiences with racism. *Connection* could also be supported using humble inquiry, a process of learning about patient life circumstances without making generalized assumptions.

Connecting was also fostered in some cases by explicitly naming the impact of racism and medical mistreatment on Black patients. However, not all patients reported preferring to discuss racism directly. One patient underscored the importance of clinicians explicitly recognizing the history of mistrust between Black patients and medicine.

> She [my clinician] was sitting down eye-to-eye, and she's like, ‘I really want you to trust me on this. Please, trust me.’ It was almost as if she was saying like, ‘I know, in the African American community, y'all have a hard time trusting physicians.’… I see her now and I love her. (Patient9)

3.6 | Explore emotional cues

Notice and name patient emotions, including those conveyed by facial expressions and body language, to become a trusted partner. Tune into signs that a patient has experienced racial trauma.

The practice of *Exploring emotional cues* includes attending to and clarifying patient verbal and nonverbal emotional cues, making space for patients to share emotions, and providing follow-up support through open lines of communication and counseling resources where available. *Exploring emotional cues* also includes resisting assumption of patient anger to avoid perpetuating the

TABLE 3 Presence 5 for Racial Justice Practices

Prepare with Intention—Prepare by reflecting on identity, bias, and power dynamics. Reflect on how your identity and biases (implicit/explicit) could influence clinic encounters.

The practice of Preparing begins before patients are present, emphasizing elements that are reflexive and internal. Clinics can also foster welcoming environments by creating systems to support anti-racist care at the clinic. Remain aware of system biases and diagnoses that disproportionately impact Black patients.

- Reflect on your identity and the biases and power dynamics that might result from that identity.
- Take a deep breath before walking in, considering the values and perspectives your patient brings.
- Have a plan and clinical protocol to create a welcoming environment and address bias when you recognize it.
- Remain well-informed on historical and current events related to social and racial injustice.
- Prepare to address structural determinants of health by knowing what resources are available.

Listen Intently and Completely—Listen without interruption and listen deeply for the potential impact of anti-Black racism on patient health. Sit down, lean forward, do not interrupt. Position yourself to listen for your patient's unique experiences.

Listening is at the core of Black patient requests. Focus on non-verbal communication strategies of engagement and avoiding interruption.

- Sit down, lean forward, face your patient.
- Ask open-ended questions to personalize care based on the unique experiences and needs of the individual.
- Avoid assumptions about all Black patients.

Agree on what matters most—Have explicit conversations about patient goals, treatment comfort and consent, and referral planning. Explore what your patient cares about. Incorporate your patient's priorities and concerns into the visit and develop a plan together that addresses your patient's goals. Be mindful of your own biases about what patients **should** care about.

The practice of Agreeing on what matters most includes avoiding biased assumptions by explicitly asking Black patients about priorities for care, as well as extending joint responsibility outside of clinic visits.

- Avoid biases about priorities by explicitly asking your patient to identify their goals.
- Include your patient's perspective in care planning by offering all treatment options with transparency and asking for their opinion and permission throughout the visit; given current and historic disparities and lack of trust in the health care system, ensure your patient agrees with and understands their care plan.
- When patients deliberate about care options, discuss concerns without judgment and provide educational resources. When patients are uncomfortable sharing concerns, reassure confidentiality and normalize experience.
- Check in with your patient before making referrals or involving on-site interdisciplinary staff.
- Reaffirm that your partnership extends beyond the visit.

Connect with the Patient's Story—Acknowledge social and environmental factors influencing your patient's health with support from humble inquiry approaches. Focus on positive efforts and events to encourage patient agency.

The practice of Connecting with the patient's story relies on empathy and intentional use of positive, non-stigmatizing language, as well as addressing impacts of any previous negative experiences with health care.

- Consider sociocultural and structural reasons for your patient's health beliefs and actions. Use humble inquiry to learn about your patient's life and circumstances without making assumptions
- As you listen to your patient's story, empathize with experiences of anti-Black racism.
- Use positive language to emphasize partnership. Avoid stereotyping language (e.g., “noncompliant”). Pay attention to how your patient may have experienced anti-Black racism, stigma, and discrimination in their life and their interactions with the health care system. Empathize and acknowledge negative experiences.

Explore Emotional Cues—Notice and name patient emotions, including those conveyed by facial expressions and body language, to become a trusted partner. Tune into signs that a patient has experienced racial trauma.

The practice of Exploring emotional cues includes attending to and clarifying patient verbal and non-verbal emotional cues, making space for patients to share feelings. Resist assumption of patient anger to avoid reinforcing stereotypes.

- Recognize racial trauma and practice trauma-informed care throughout the visit.
- Make space for patients to share their feelings with non-judgmental inquires: “This seems to be really affecting you. What are you feeling right now?” Avoid assumptions. surrounding emotion type and source. Validate emotions.
- Even when unable to directly address concerns, check-in, listen, offer support, and connect patients with other resources available in your clinic setting.
- Explore strengths-oriented coping mechanisms (e.g., ask, “What behaviors have helped you deal with painful feelings? What have you learned from spiritual practices, family, friends etc.?”).

stereotype of Black individuals being labeled as angry. Evidence to support this practice emphasized the importance of attending to emotion on both sides of the patient–clinician relationship. Previous studies have found that clinicians block discussion of emotional issues more often with Black patients.[54] However, attempting to identify patient emotional cues is associated with improved satisfaction, adherence, and learning.[44,55] Additionally, attending to the emotional and physical impact of racism and generational trauma is needed[59] and may be facilitated through trauma-informed care practices.[56,58]

Although some patients and clinicians actively did not want to discuss racism, other patients reported appreciating space to share their feelings about racial trauma and current events involving or impacting Black individuals:

TABLE 4 Presence 5 for Racial Justice (P5RJ) literature review evidence and practices with exemplar quotes

Prepare with intention
Evidence
Stay informed. Being informed about structural inequities and the concerns of marginalized individuals towards the health care system can improve patient health outcomes and enhance patient confidence (Ford-Gilboe '18; Browne '18; Purkey & MacKenzie '19; Vyas '20).[29–32]
Recognize racism, which can change how we learn about an organ system or a disease (Ufomata '20).[33]
Sustained self-reflection practice and conversations about biases and racism among colleagues can begin to reduce bias and racism in clinical settings (Bailey '17; Tsai '18).[34,35]
Discussions of hypothetical scenarios related to bias and identifying non-threatening strategies leads to increased confidence in addressing instances of bias (DallaPiazza '18).[36]
Recognize the historically inaccurate use of race in clinical calculators, which wrongly estimate Black patients' disease severity, propagate race-based medicine, and lead clinicians to interpret racial disparities as immutable facts rather than injustices that require intervention. Race-based calculators worsen Black patient health outcomes and decrease access to treatments (Vyas '20).[37]
Be aware that race is a social construct that has been used as a proxy for pathology in medical education, propagating institutionalized racism (Nieblas-Bedolla '20).[38] For diagnosis use objective measures that do not include race as a factor.
Be aware of your own biases, considering broad differential diagnoses for every patient, and making treatment recommendations based on efficacy instead of convenience to reduce disparities, increasing symptom remission and decreasing chronic impairment (Medlock '17).[39]
Practices and exemplar quotes
Consider the impact of your identity and power as a clinician on interactions with Black patients. "It's just asking questions and not being told, 'Oh it's because I've done this for years, I know what I'm talking about.' It is just asking questions and just like understanding you are a doctor and you are going to have other patients, that it's going to be a busy day, but just making sure that you are not rushing that patient and that they are comfortable to ask you questions, even if it's 'What is this?' or 'I do not know', like, obviously I come to you because I'm trusting you to tell me what's wrong. And this is what is going on with me. This is my body. Obviously, everybody's body is not the same so I'm telling you about my dire needs and just because you gave this person this medicine does not mean it is going to work on this person. So just being mindful of that too, like all bodies do not react the same. Asking questions and just being patient." (Patient 36)
Overcome internal bias to support Black patients. "Right. And I think it's just is gonna take… It's just up to the individual physician. And it's more of a heart condition. I can tell you something all day long, but if your heart does not change, you are not gonna change. So to me, it's a heart condition [to say] that, 'You know what, it does not matter what color you are, when you come in my door, everybody deserves to be treated the same, and it does not matter how much money you have, or you do not.' Jesus was not a respecter of person." (Patient 16)
Create a welcoming environment: in one free clinic "the title of the poster said, 'We see color'… the message is that we do see color, and we want to know your experience because it can help enrich us and the care you get." (Circle 2C)
Address bias when you recognize it in yourself and others; make a commitment to effort and willingness to learn. "But I'm actually usually impressed with how much people are willing to say that they are promising to bring… That they'll say like, 'Yes, I will speak honestly and do my best to be respectful, but I know that not all of the ways I articulate my ideas are necessarily going to comport with language that people want, so I'm going to do my best, I'm going to listen, but…' That they are still really gonna put in an honest effort and try not to be intimidated because of language or something." (Professional 23)
Stay well-informed. "Recently our clinical leadership… We've seen a lot of issues around Black Lives Matter that have been brought up. Since coronavirus [started our executive director has] done a three to five minute essentially morning homily five days a week. Very often that's focused on like Black Lives Matter and actually giving us some things to meditate on or simply willing to take action… [Our clinic] is involved in more than just a token level … So I think we have got a long way to go, but compared with other organizations… we have made a conscious effort and hopefully it's trickling down to at least be on the minds of the individuals. All the staff members, but as providers when we see patients to try to put our prejudices aside that we all have and try to meet that patient one on one, see what they need." (Circle 1D)
Know available resources. "Yeah, I was gonna say I really like the second example about having resources. I think that's one of the things I struggle with is you know I truly feel like I'm open to talking with my patients about social and environmental factors. The problem I feel ends up being when I really cannot do anything about it. And I know that patients do appreciate just having the conversation, just knowing that you are, you know you as a doctor, are interested or, you know, concerned in that in that area. But just knowing that I have resources or like I know where to go for questions and things like that. It's been very helpful. I think." (Circle 1C)
Listen Intently and Completely
Evidence
When meeting with Black patients, physicians are significantly more likely to have shorter visits, speak faster, and verbally dominate the conversation (Martin '13).[5] When asked to rate clinicians on communication skills like "My clinician listened carefully to me," Black patients rated lower than White patients (unpublished VA data, FY2020).
Ask questions to personalize care based on the unique experiences and needs of the individual (e.g., "How does your medical condition affect your life or your family's lives?") to allow patients the space to share the social context surrounding their health concerns and to facilitate a trusting partnership with your patients (Batista '18; Drake '17).[40,41]

(Continues)

TABLE 4 (Continued)

Practices and exemplar quotes
Give patients time to tell their story. "In September, I actually died. I mean, I physically died and I was gone for 30 days. They had me on life support and I came back. And over that period of time, me and him [my clinician] had not had an opportunity to sit down and talk since September, because sometimes I see a nurse practitioner when I go in. And [when I finally went to see my doctor] he actually sat there and wanted to know what happened, what my story was, and where most doctors are rushy, rushy, rushy, he sat there with me, and he listened, and we went back and forth with this conversation about what had happened and how it affected me, and I thought that was over and beyond what you expect from your doctor because usually you get maybe five minutes or at the most 10. And I think, we probably spent about 30 min in there talking." (Patient 28)
Sit down at eye level. "I guess my thing is just come in and just sit down, kind of sit at eye level, not come in and stand like they are looking down. Just kind of sit down eye level and just really talk, like 'How did this happen? What's going on?', just basically to, I will not say icebreakers, but just kind of kind of feel us [patients] out, what's going on. Asking basic questions like, 'What's her asthma treatment?', because if that question was asked, I would have let them know, like obviously we would have answered the question [about] what her asthma treatment [is] because we are on top of it. You know what I'm saying. So asking questions because you could ask basic questions that will automatically tell you where the patient is. If the patient cannot tell you what they are taking, then they may not be compliant. You know what I mean. So just being very, just coming in being warm and asking us, just kind of fielding questions, like what's going on, and being a little more compassionate. Then sitting down eye level. I mean, when you have a physician that comes in and sits down, it kind of creates a more friendly environment. Because they are kind of getting on your level. You know what I'm saying, and not just coming in standing, like, 'Hey, what's going on?' like this paternalistic, 'What's going on', or 'What're y'all doing?' Like you are automatically wrong and they are right." (Patient 31)
Be cognizant of how your non-verbal cues may impact your patient. "So many times, in medicine, we are often discussing how our patients are coming to us and not us coming to our patients. Looking at body language or facial expressions, we will pick up if they have any questions and we also can go more in depth of why we are recommending certain things. It is fascinating to know that patients are always reading us when we are in the room too. That's something we need to be aware of to break through that barrier causing that disparity." (Circle 1D) "If someone says something that's even like outrageous to you, do not show it. Do not wide-eye them like… Because some people have some… They feel how they feel, you know what I mean? And that's just to be respected, I guess." (Patient 19)
Position yourself for listening and avoid assumptions. "I had a doctor that was sitting in, standing in for another, a doctor. He was one of them doctors that would come in, and look at you, and just walk away. He did not explain nothing, why he was… If he was writing you a prescription, he would not tell you why. He would just damn near walk away. He did not sit down and talk to you. I do not like a doctor like that. If you want to examine me, tell me what's going on. Do not just assume I'm supposed to automatically know what's wrong, and you just walk away and, 'Take this and take that,' and do not explain to me why I'm taking this." (Patient 33)
Agree on what matters most
Evidence
Black patients report lower patient–physician communication quality and satisfaction; less information-giving, partnership building, participatory decision making, and positive talk; more negative talk; shorter visits; verbally dominant physicians; and worse outcomes on non-verbal communication, respect, and support (Chen '18; Martin '13; Roter '03).[5,42,43]
Clinicians have been shown to vary in question-asking, diagnostic decision making, symptom management, treatment considerations, referral to specialty care, and interpersonal behavior based on a patient's racial identity; thus, implementing standardized protocols for patient interaction and treatment decisions can reduce variations in treatment and outcomes based on implicit biases (Hall '15; Medlock '17).[39,44]
Information sharing (e.g., giving patients more information about test results and details about the pros and cons of various treatment options) enhances patient trust and adherence (Peek '12).[45]
Encourage patients to describe their perspective, health goals, and treatment plan in their own words; and ask for patient opinions, permission, and reassurance throughout the visit to improve patient trust and engagement, health outcomes, positive communication, and reduce disparities (Cuevas '16; Martin '13; Drake '17; Oliver '14).[5,41,46,47]
Include your patients in clinical decision making (e.g., "What do you think caused your problem?" or "What treatment do you think you should receive?") to reduce the likelihood of clinicians making decisions based on preconceptions of specific groups (Kleinman '03; Medlock '17).[39,48]
Establish a partnership with your patients using person-focused care. This is associated with patients maintaining connection and addressing health needs with their primary care clinician for a longer period of time (Batista '18).[40]
Practices and Exemplar Quotes
Create tools and standardized protocols to reduce variation and identify patient goals. "They always give me a sheet to put whatever issues that I may be having. So when I do go to the back, they already have the questions ready of what's going on with me. 'Can you check what's going on with this? Can you check this and what's going on with it? Oh, your blood pressure's good,' stuff like that. And just to give you a head start when you first go in, they always give you a… I'm gonna call it 'not feeling good sheet.' … [It's about] what's going on with you. They always check if we do not give them problems and they just seem prepared. They are always ready." (Patient 27)
Attend to patients' emerging concerns. "I love her [my doctor], because if I say, 'Well, okay, like just the other day before I came, I had this pain somewhere,' and she'll go, 'Okay, So after we get done doing this, I'm going to check on that pain.' And I'm like, 'Great, thanks'. She just says, 'If it's something out of the way, we'll make an appointment for that pain, and I want to see you come back in a couple weeks so we can check out that'."(Patient 35)
Affirm partnership beyond the visit. "She checks up on me, she actually she makes sure…I do not know if that's my primary with it, but I see her more. But she's not technically my primary but I just call her my primary anyways. But yeah…she actually reach out. That's what she does, she reaches out to me [sending an email or a text or call]. Yeah. The best. … it's just like you know how you communicate with your family or your friends that you

TABLE 4 (Continued)

are close to? Instead of just being told, they actually converse with you instead of just telling you what to do or telling you what they need you to do.” (Patient 4)
Facilitate referrals. “…We have to empower our patients to just understand… you might get lucky and get [a surgeon who is] nice [but] I cannot guarantee that to you, unfortunately. But I'll help you find someone else [if needed], but it's tricky.” (Circle 1A)
Ensure high-quality referral. “So I can think about some missed opportunities in the past for patients where I probably could have explored racial injustices more. For instance, when I mentioned referral to like an OB GYN, and they asked me, ‘Is that a White doctor or Black doctor?’ You know, it's kind of exploring. ‘Do you have a preference? Is there something that's happened previously that you'd like to talk about?’ I think I've had some opportunities where I could have explored more and given patients an opportunity to talk about it if they wanted to, that I missed. And so that's something I can think about for the future.” (Circle 2B)
Use partnership and patients sharing back their understanding of care to extend joint responsibility. “Well, they ask me a lot of questions and make sure they get the right understanding, and they share information with me like, I need to exercise more or I need to go to therapy and why I need to go to therapy or I need to stop eating this, change my lifestyle. And he'll be like, ‘I know it's hard ‘cause I do not wanna go home and exercise, too.’ So yeah, he helps me out a lot.” (Patient 24)
Connect with the Patient's Story
Evidence
Black patients who have had more experiences with discrimination within the health care system have been shown to trust the health care system less compared to White patients (Martin '13).[5]
Clinician affective behaviors are lower on average for Black patients than those from other racial groups. Clinicians' positive tone is associated with higher trust among Black patients (Martin '13).[5]
Eliminating language that demonstrates preconceptions about groups that have been historically marginalized (i.e., “noncompliant”, “vulnerable”) can lead to improved documentation, history taking, and understanding of patients of color through the context of health disparities and historically discriminatory policies (Tsai '18; Goddu '18).[35,49]
When a patient and clinician are racially discordant, acknowledging similarities with patients leads to improved treatment decisions and patient health outcomes (Saha '08).[50]
Acknowledging a Black patient's past experience with health care and perspective can initiate dialogue concerning a care plan (Brooks '16)[51] and identify barriers ‘beyond the disease’ (Moffett '19).[52]
Promote self-efficacy in the patient by emphasizing previous successes, identifying successful role models, expressing confidence in the patient, and educating the patient on what to expect physically during the planned change (Chick ‘14).[53]
Practices and exemplar quotes
Use humble inquiry to ask questions instead of assuming. “I guess something I've learned recently, you know, unfortunately in painful ways with some of my patients, is that I make assumptions about the people that they lose in their life, you know, some of these. Some patients will discuss that they have lost a cousin or an aunt or somebody like that and I sort of assume that it's a secondary family member, and [I] have been struck by a couple of these instances where these were people that were raising them or were there were their parent or godmother… In one instance, it was a cousin that was almost like a sibling… so I try now to say, you know, ‘What was that person to you?’” (Circle 1C)
Ask about patients' negative health care experiences; summarize back in your own words. “I remember I recently had a patient, maybe three or four weeks ago, that we were being consulted on…who is in the hospital with an ortho surgery to her shoulder, who she'd been telling us about some past experiences, not having good pain control after surgery. And I kind of reformulated to her and said ‘What I'm hearing from you is that sometimes people with my skin color do not hear the amount of pain that somebody your skin color has after surgery’ and she basically started crying…in the moment.” (Circle 1C)
Empathize with patient experiences of anti-Black racism. “My endocrinologist, they found the nodule on my thyroid, and it came out it was cancerous and I had to get the left side of my thyroid removed. But when I was going through the process, I was needing an endocrinologist for the first time. I love [my doctor] and she's a White female. Before we got into the process, she got my ultrasound, and we were talking, and she's like, ‘They look suspicious. I talked with a colleague, and we think we need to do a fine needle aspiration.’ And I do not know, maybe I just had a look on my face, but she was sitting down eye-to-eye, and she's like, ‘I really want you to trust me on this. Please, trust me.’ It was almost as if she was saying like, ‘I know, in the African American community, y'all have a hard time trusting physicians.’ She did not say that, but by her saying that, I was like, ‘Okay’. She's like, ‘Please, trust me. I'm going to take care of you,’ and she did, she did. I see her now and I love her. I mean, I'll see her tomorrow. She looks over everything. I can email her. When I was going through the process, I emailed her, she would email me back very, just, she's on top of it. How can I say this? Listening and not disregarding your concerns, that's the biggest thing clinicians can do in the African American community. If an African American patient has an issue - I do not care how trivial a physician thinks it may be - they need to listen, because that patient feels like they are being heard. It's huge.” (Patient 9)
Acknowledge any negative experiences in other appointments. “It took for me to keep complaining, complaining, complaining about all these different providers, and so there was this one provider that actually stepped up, and she actually sat down for 30 minutes, she's not even a woman of color, and I told her, I said, ‘You know what, the type of work that I do, I've been hearing all these different stories about how women of color are treated. Just people of color, period.’ When it comes to the medical field, when it comes to even workplaces, all these different things, they are not treated fairly, and they have all these different disparities, all these things, and so she had even agreed. She said, ‘I do not know what it is’. She said, ‘I'm not gonna say that that provider was racist that was seeing you here, but I will say that they did not make you a priority and that they did not get you the support and help that you needed, and I'm gonna make sure that I help you and get you all the things that you need and make sure that you feel comfortable within this clinic’. And that made me feel better because I was like, I am pregnant, and I do not even know if I could trust you guys even

(Continues)

TABLE 4 (Continued)

doing care for me because I do not know if me and my child are safe because it was just too many different times that I was having to be an advocate for myself…" (Patient 17)
Discuss previous health care system experiences. "I think there's probably a reason she has not sought any care in the last 15 years although she's had reasons to. And I think that's something that we need to get into in the future, but knowing how to get into that and how to introduce that conversation, I do not know that I feel comfortable with that yet. And that's something I'm still learning." (Circle 2B)
Explore emotional cues
Evidence
Clinicians block discussion of emotional issues more with Black patients and provide Black patients fewer passive responses that permit emotional talk (Park '20).[54]
Clinician attempts to elicit and identify patient emotional cues are associated with greater patient satisfaction, appointment adherence, and learning of conveyed information, even when the clinician is mistaken (Hall '11; Weng '11).[44,55]
Trauma-informed care (TIC) allows clinicians to avert persistent psychological traumatic stress responses from traumatic experiences by realizing the impact of trauma exposure, identifying the impact of trauma on patients, families, and staff, and applying acquired trauma-related knowledge into practices and policies, without re-traumatizing patients from their health care experiences (Bruce '18).[56]
When providing clinical care, it is critical to consider cultural identity and explore strengths-oriented coping mechanisms. Focus on inherent strengths and previous experiences of resiliency of the individual and their community (Liu '20).[57]
Enhancing trust and comfort between patients and clinicians is essential in providing high-quality trauma-informed care through patient–clinician relationships as it is a notable method for allowing survivors to feel empowered to discuss their traumatic experiences (Reeves '15).[58]
Given that significantly more Black and Hispanic/Latinx children have experienced at least one ACE compared to White and Asian children, it is important to identify the impact of racism and generational trauma on patients' lives and health (Sacks '14).[59]
Exemplar quotes
Discuss racism more openly and provide your patient the opportunity to share how they are feeling: "This summer is when I started discussing race more with my patients and asking them how they felt about what is going on in the world. It's hard as a white person coming to it and not asking or expecting to be educated or forgiven - I think that's where I worry about coming from. But just opening that up and not ignoring it is something I started doing. Saying 'This is a really stressful situation with everything that is going on in the world, especially with racial injustice, how has that been affecting you?' and opening it up. Some patients would take the opportunity; I did not do with every patient, but with some I felt we had the rapport to do it."(Circle 1B)
Make space for feelings with non-judgmental inquiries: "She became tearful during early on in the interview and her daughter who was with her at the visit had actually pulled me aside and told me about some personal issues that have gone on in the family that have led to the depression and anxiety that she was dealing with currently. And so that was another layer of the thing of how much is the daughter okay with me, indicating that I know that she told me and it was kind of a complex visit in that sense. But I did say, 'You know, you seem upset, you know. Is that right? Tell me, tell me what's going on. Let us talk more about that'. So I did try to kind of name that but I think her emotion was not just depression or anxiety. It was a guilt and a lot of other things that were playing and we did delve into that some. And I think the most important and effective thing that we accomplished at that visit besides an SSRI and x, y, and z was getting her open to counseling, so that they could dig through some of what all what was kind of between us, because … I was not equipped not being a counselor to really get into all of that in a safe and healthy way." (Circle 2B)
Even when unable to directly address concerns, check-in, listen, and offer support: "This reminds me of this visit where it was … a two month old well-child check and see, you know, just like going through the usual questions and mom just looked so like distraught. So then I just sort of paused and was like, 'Is, is everything okay?' because she just looks so distraught and she broke down crying because I guess earlier that day, like a few hours before she had brought her kid in for the well child check,… I guess her partner who she had been living with and then she had the baby and two other kids [with]…the police I guess came to arrest her partner, and she wasn't exactly sure why, but there was all this chaos. So she somehow ended up like outside and watched them essentially beat up her partner and then she was trying to get back in the house because her kids were in there, but they were telling her she could not go back in until after they had like taken him to the police car and left and she was just so completely distraught and… she came, she came to the visit right after all of that it happened. So she had no idea where her partner was, like what he was even accused of, and, I guess, to make matters worse it's like, somewhere in there when the police - because the police were still at the house - when they had left, I guess, the door was unlocked. So then someone else came in and like stole a bunch of stuff and like then when I saw her like a few days later, it was like the story had gotten worse. But so yeah I did not ask a single question about the child. I just gave them the vaccines." (Circle 1C)
Offer your patient other resources available in your clinic setting: "If I perceive something is bothering the patient but they are not in a position to share that with me, saying, 'If this is hard for you to talk about with me, we have other people available'." (Circle 2A)

> It would be nice to, even if it's brief, [for a clinician to ask] 'Where's your mind at?' just as a release as far as like a mental state. I think that would be helpful to African Americans, because sometimes we have to hold in how we feel because we don't want to seem like we want sympathy, or for people to empathize. Sometimes we just want to vent because we're just like, we're exhausted about like secondhand pain. Like, although it didn't happen to us, it did happen to someone of our color, just because of our color… it's painful. (Patient 36)

More than one clinician recounted *Exploring emotions* with positive results in terms of medication, referral planning, and connecting:

> I did say, you know, 'You seem upset, you know, is that right? Tell me, tell me what's going on, let's talk more about that.' So I did try to kind of name that but I think her emotion was not just depression or anxiety. It was a guilt and a lot of other things that were playing and we did delve into that some and I think the most important and effective thing that we accomplished at that visit …was getting her open to counseling, so that they could dig through. (Circle 2B)

Patients recommended several system-level strategies that could support emotional health and well-being, including ubiquitous mental health screening and increased access to local mental health staff. To reduce barriers to seeking outside counseling, one patient recommended having "staff on duty where [patients] can talk to them if they have any kind of problems or anything on their mind" (Patient18).

4 | DISCUSSION

Presence 5 for Racial Justice (P5RJ) highlights opportunities for clinicians to provide high-quality care to Black patients, while also addressing patient experiences with racism through anti-racist communication practices that support trusting relationships and empower Black individuals in clinical care. Our goal was not necessarily to identify new communication practices—although we were open to that possibility—but to synthesize valuable practices from evidence-based literature and different stakeholder perspectives to present actionable recommendations for how clinicians can engage in anti-racist communication with Black patients.

In addition to building on Presence 5, we report here the synthesis of multiple data streams, some of which have individually been reported elsewhere. For example, our team's independent analysis of interviews about supporting nonmedical Black professionals surfaced themes of trust-building, dialogue and humble inquiry, and allyship and shared humanity as foundational to supporting Black workers and promoting workplace anti-racism efforts. We have previously used design thinking "analogous inspiration" interviews to provide novel views that can be applied to medicine.[28] The work reported herein shifts emphasis from these related but distinct conceptual themes to specific actions and practices, aided by data triangulation across multiple sources.

Cornerstones of P5RJ focus on internal clinician self-reflection, interpersonal clinician communication practices, and clinic-level institutional anti-racism. Attentive listening was key to the Black patients we interviewed. Awareness and acknowledgement of racism's impact on previous care for patients, as well as the health care system overall, was also paramount. This project highlights a number of opportunities for clinicians, clinics, and health care systems to advance one-on-one interactions, training, team-based care, and individual- and system-level action. To better organize these emergent opportunities, we categorize recommendations based on Dr. Camara Jones's levels of racism (internalized, interpersonal, institutional),[24] focusing on interpersonal anti-racist practices to address internal clinician bias and patient–clinician communication, and institutional anti-racist practices to address clinic-level or structural issues.

4.1 | Recommendations for interpersonal practices

Clinicians should take time to consider their biases, in moments of general reflection and before seeing individual patients (e.g., Practice 1: *Prepare with intention*). Independent work may also be required by those in health care to address internal biases toward Black patients.[62] In addition to the prompts of the P5RJ worksheet (see Data S1), in-depth and formal reflection may be one independent way to examine and challenge personal biases.

The quality of interactions between clinicians and patients influences important outcomes, including patient trust, treatment adherence, and clinical symptoms,[63–65] while also impacting clinician well-being and burnout.[66] Clinical care that includes listening with empathy and allowing patients to be heard can also provide important insights for patient care not reflected in the electronic medical record (EMR).[67] In order to foster respect and meaningful connections that support Black patient care and clinician well-being, clinicians can listen closely for patients' experiences with racism and should stay abreast of current events that may impact Black patients (e.g., Practice 2: *Listen intently and completely*). Many clinicians shared concerns about knowing what to say when communicating about racism, particularly about events that may impact Black patients. If patients are open to discussing current events, broaching the topic of a challenging current event can take the broad structure of grief counseling: "I heard about X and felt Y. How are you?"[68] Another approach might be to say: "I don't know how you feel, but I am here to help in any way I can."[69]

4.2 | Recommendations for institutional practices

Clinics can take action by ensuring that all staff are trained in anti-racist practices and are aware of and attentive to equity (e.g., Practice 3: *Agree on what matters most*). Medical schools are increasingly including anti-bias curricula as part of standard training.[41,70,71] However, existing frameworks guiding the standard curricula, such as cultural competency, may offer catch-all approaches that neglect nuances of a patient's individual identity. Even among clinicians and medical educators who have teaching and leadership roles focused on health equity, self-accountability and allyship statements are underutilized tools for communicating with Black patients.[72] P5RJ may offer a framework for teaching these practices in medical education and clinic settings.[22]

Clinics could also network with specialty clinicians to address patient population needs and/or explore team-based care to improve support and access for Black patients (e.g., Practice 3: *Agree on what matters most*). For example, a 2019 meta-analysis showed that diabetes-focused, team-based care that augmented primary care with a nurse and/or pharmacist reduced blood glucose and diastolic blood pressure among low-income Black patients.[73] In terms of psychosocial health, team-based care can also facilitate warm hand-offs to mental health specialists (e.g., licensed social workers) who may be better equipped to address mental health needs and navigate barriers to care related to social or environmental circumstances (e.g., Practice 5: *Explore emotional cues*).[74,75]

Other aspects of this project point to opportunities to address structural factors that hinder excellent care for Black patients. Notably, there was a recurrent theme that brief visits do not ensure sufficient time for Black patients to share their story (e.g., Practice 2: *Listen completely and intently*) and address the whole person (e.g., Practice 4: *Connect with the patient's story*). In some circumstances, a clinician may be able to lengthen a visit for specific patients,[76] but this type of transformation will likely need to come at a system level, perhaps addressing reimbursement policies for complex patients to extend visits (e.g., US Level 4 vs. Level 3 primary care visit reimbursement).[77] Another systems approach to increase time for listening and connecting involves prioritizing continuity of care with clinicians and team members. Indeed one study of culturally and linguistically concordant care coordinators showed major improvements in diabetes outcomes for Black patients in Texas.[78] Within a networked system, ancillary clinicians could support patient connection with primary care clinicians.

4.3 | Limitations and strengths

This work has several limitations. First, in attempting to provide excellent care recommendations applicable to all Black patients, we have largely ignored the variation inherent in the Black experience. For instance, our choice to use the term "Black," while intended to provide room for all individuals of the African diaspora, may create the impression of a uniform racial/ethnic identity, when in reality, we talked to individuals with unique racial identities, including African Caribbean, African American, and multiracial individuals. Too often, historically marginalized populations are lumped together; in the era of precision health care, it is highly important to understand patients individually for individualized treatment.[79] Second, discussions with clinicians surfaced a number of barriers that pose challenges to implementing P5RJ practices. Lack of time, fear and discomfort, and not knowing what to say were major concerns for non-Black clinicians. We have suggested strategies related to longer visits and self-compassion for mistakes and are developing further resources that emphasize specific language clinicians can use to support P5RJ practices. Finally, there may be risks in choosing Presence 5 as a starting point for this project. This lens could have limited the emergence of novel practices; thus, these practices may not be comprehensive. Also, P5RJ practices, when deployed at the point of clinician–patient contact, are insufficient to achieve the needed impact of health equity for Black patients. Upstream interventions outside the scope of this work are needed, including substantial policy change to ensure access to care.

While this project is by no means the first attempt to foster communication that promotes health equity and high-quality care for Black patients, the strength of P5RJ stems from our data triangulation and integration of varied viewpoints. Our design thinking- and community-based participatory research-informed approaches prioritize Black individuals' lived experience through interviews with analogous professionals and patients, and the national virtual Community Advisory Board.

5 | CONCLUSION

Effective communication that mitigates pervasive racism is central to the delivery of high-quality and equitable care for Black patients. P5RJ provides a framework for individual clinicians to invest in anti-racist care and offers accessible and concrete strategies to address racism experienced by patients and promote health equity. There is well-documented need for interpersonal communication practices that support clinicians in developing healing human connections with patients during the clinic visit. P5RJ practices may help to address this need and serve as a step toward equal and eventually equitable care for Black patients.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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