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Culturally Responsive Communication: Its Conceptualization and Transferability

Abstract

When folks ask me what I love most about teaching, I share how I value being able to determine what is important for learners to know. In essence, I get to determine what counts as knowledge and whose knowledge is worth knowing. There is incredible power in this. I recognize the value in showcasing wide-ranging perspectives, world views, social positions and lived experiences. Doing so necessarily dismantles the dominant culture of whiteness, maleness, heterosexual-ness and able-body-ness as the only way to view and experience the world. I do this by intentionally centering the voices and realities of historically overlooked and marginalized communities – most notably Black cisgender and transgender women – including indigenous, non-gender conforming, and neurodivergent voices. I treat all knowledge as expertise – valuing its sacredness – while not romanticizing such perspectives but instead critiquing, interrogating, and problematizing them as the process all knowledge generation undergoes.

As I immersed myself in the geopolitical and sociocultural thought of my Black foremothers and alongside contemporary Black woman scholars and thought leaders, I found myself starting to question the ways culture interacts with (and shapes) health outcomes. Oftentimes, culture is presented as a linear and unidirectional pathway to explain how health beliefs and behaviors are developed, and therefore, can be changed. In the context of health, why is culture predominantly described as a personal trait of the patient? Don't clinicians "have culture" and doesn't this culture pervade the clinical encounter? These are the types of wonderings I explored as I designed a national research-informed training effort called the Two in One Model to build the capacity of primary care practitioners (PCPs) to eliminate HIV and COVID-19 vaccine stigma. In this paper, I conceptualize the value and transferability of culturally responsive communication as four tenets of culture rooted in a Black feminist epistemology and explored in the Two in One Model training as a structural competency for clinicians.

In the context of health, why is culture predominantly described as a personal trait of the patient? Don't clinicians "have culture"? And, isn't there value in expanding our ecological perspective[1] on culture to include its dogmatic forms, such as core assumptions about social identities? Historically, old/er white cis men would answer these questions and claim these types of knowledge while "subjugat[ing]" the knowledge that is believed Black women can produce, challenge, or inspire. It is within this Black feminist epistemology that my work sits.[2] I knew there needed to be a specific competency that primary care practitioners (PCPs)could learn to address these wonderings– and thus the call for culturally responsive communication (CRC) emerged. While I previously defined CRC as a re-imagining of how DEIJ values within healthcare settings get translated in patient-clinician encounters ,[3] I have also teased out how it differs from other models of cross-cultural communication.[4] I argue in this paper that there are four tenets of culture that clinicians must address. My articulation of CRC has been explored in-depth in 3 of the 9 lectures of the Two in One Model PCP training series.

When discussing the relationship between culture and health, the unit of analysis primarily focuses on patient behavior.[5] It is important to depart from a sole focus on the clinician's understanding of the culture of the patient, or what gets described as cultural 'competence'.[6-8] It is widely believed that a patient's language, communication, and social norms are cultural in nature. This explains the existence of the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care.[9] But what does it mean for a clinician to follow these standards? The decisions that clinicians observe of patients are largely indicative of the structural inequities they navigate. This idea is not new. Metzel and Hansen[10] introduced the concept of structural competency to explain that what we have been calling *cultural* very well may be the choices, which patients make based on the choices they have. As an example, a patient may not be "non-adherent" with a treatment plan but instead preoccupied with daily survival. A Black feminist epistemology identifies a need for accountability, which includes patients engaged in truth-telling about their lived experience as the impact of social conditions and clinicians weighing this as clinically relevant. [2]

There has been an ethnocentric shift away from cultural "competence" to cultural safety[11] as a way to emphasize the lifelong learning involved in understanding the dynamic ways that culture influences health. In doing so, there is no longer an othering of patients that centers the dominant culture. Instead, the concept of the culture of the clinician must be introduced for its measurable impact within the PCP-patient relationship. When clinicians reflect on their deeply-held health beliefs, it removes the hierarchical values placed on which beliefs are "right" and instead calls for recognizing that a range of beliefs exists. Interrogating clinician culture also questions the concepts of power and expertise, as this served as a topical focus of the Two in One Model PCP training series. Historically, the PCP-patient relationship has a paternalistic emphasis on the clinician having sole authority in the decision making process.[12] Living in one's body offers an experiential knowing that must be valued as expertise. This is what a Black feminist epistemology refers to as, "lived experience as a criterion of meaning."[2] Undoubtedly, having a medical license should come with a sense of power. And, CRC calls for a sharing of that power.

In addition to patient and clinician culture, it is important to address the culture of medicine. There are altruistic underpinnings of why individuals select a career in medicine. An ethic of caring is core to a Black feminist epistemology and the other benevolent ideals are written about extensively. [2,13] Black women experience threats to humanity that lend itself to the ongoing practice of empathy and healing. As I conceptualize a culture of medicine, I prefer to explore how medical attitudes can be at odds with – and undermine – the shared traditions of compassionate and empathetic care. In other words, "the culture of medicine is not only defined by what doctors do, say, feel, and think, but also by what they do *not* do, say, feel, or think.[14] These unnamed beliefs may not be solely tied to clinicians but instead reminiscent of institutional values. For instance, if a patient shares their preference to rely on prayer before resorting to therapeutics, this patient will likely be deemed as refusing treatment rather than as not subscribing wholly to Westernized medicine. Clinicians are within a system that includes prevailing notions of what is "right" and counts as "evidence."[15] Accepting these shared beliefs becomes the dominant narrative that often goes unquestioned, until now. These are the types of critiques offered in the Two in One Model PCP training series.

We need to expand the traditional biomedical approach to the practice of medicine from a focus on anatomical functioning to also account for a host of psychosocial factors that affect one's experience of their body and health outcomes. [16] And of all the factors shaping the culture of medicine, I would be remiss if I did not name how U.S. medicine exists within a capitalistic healthcare system that operates within a business model. The implications of increasing drug prices and copays are especially important to note among states that refuse to expand Medicaid[17] These considerations are critical for routinizing a set of screening questions, as advocated by the Two in One Model, as this will invariably affect visit time and billable hours, additional lab testing, and use of vaccine vials per visit.

The culture of patients, clinicians, and institutions seem instinctual since they have been accepted over time. The same holds true for the culture of racism. As Benjamin writes in her *Imagination: A Manifesto*, "racism… make[s] hierarchies, exploitation and violence seem natural and inevitable – but all emerged from the human imagination". [18] Racism was constructed, so antiracism can be, too. When it comes to minoritized patients, there are assumptions that exist *discursively* for why they face the health outcomes they do. [19] While many of the explanations for scientific racism have been discredited, the cultural narratives remain intact and prejudice how minoritized patient populations are characterized in research, [20] in medical charts, [21] and in health policies. [22-23] This coded language – 'at-risk', 'difficult'– further marginalizes patient populations, contributing to how they are viewed in pathologizing ways. The American Medical Association attempts to address discursive inequities in their language guide that augments the Black feminist epistemological call for dialogue. [24,2] The language we used to discuss racialized disparities must be reframed in medical education.

Conclusion

The implications of CRC are far-reaching when it comes to clinical practice changes in whether, and how, the HIV, PrEP and COVID vaccine screening guidelines are routinized in the primary care setting. Likewise, research using a CRC lens on HIV, PrEP and the COVID vaccine will include a more nuanced understanding of the role and function of culture in eliminating disparities and its stigma.

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