Presence 5 for Racial Justice: Preparing for Anti-Racist Communication in Pediatrics

Introduction

Racial inequities in medicine impact the health and lives of Black children and their families; research is needed to identify how clinicians can promote health equity and foster meaningful connection with Black pediatric patients and caregivers. Our goal is to promote racial justice for Black pediatric patients and families by adapting the Presence 5 for Racial Justice framework to pediatric needs. The objectives of this summer study were to identify preparatory communication practices that pediatric clinicians can use to address racism, build trusting relationships, and empower Black patients and caregivers in clinical care. Using a targeted literature review, P5RJ framework’s Prepare domain was refined. The following gaps were targeted: 1) Pediatric-specific examples of anti-Black interpersonal racism 2) Racial Socialization, 3) Earned Medical Mistrust, and 4) Frameworks for Reflection: Positionality, Reflexivity, and Intersectionality. Synthesizing P5RJ’s previous work with the conducted targeted literature review, resulted in two subdomains: 1) Addressing interpersonal Anti-Black racism and 2) Preparing accessible materials and resources. Studies like this are needed to strengthen feasibility, sustainability, and potential for long-term effectiveness of anti-racist curricula that support clinicians in delivery of equitable care for Black pediatric patients that also empowers caregivers and families.

Literature Review

The Presence 5 framework evolved from a line of research starting in 2017, through a piece that aimed at understanding Clinical Presence.¹ This study was the first to use human-centered design principles and methods to systematically define clinician “presence.” They described their design as a “human-centered approach” because it reached beyond medicine in acknowledging that solutions/definitions may already exist in other professions where human connection is pursued. These qualitative interviews were with physicians (n = 10), patients (n = 27), and nonmedical professionals whose occupations involve intense interpersonal interactions (eg, firefighter, chaplain, social worker; n = 30). Results revealed presence is a universal concept that involves intentionality, focus, and attention to time and the physical environment.

The framework wasn’t dubbed “Presence 5” until 2020 when the team used a mixed-methods study to declare 5 practice categories that can enhance physician presence and meaningful connection with patients in the clinical encounter: (1) prepare with intention; (2) listen intently and completely; (3) agree on what matters most; (4) connect with the patient’s story; and (5) explore emotional cues.² This piece also used the human-centered approach and interviewed medical and non-medical professionals from an even broader pool than the previous piece. Methods included a systematic literature review, clinical observations, and interviews with physicians and patients. Ultimately the 5 categories were derived via synthesizing the evidence with a 3-round Delphi process with multiple perspectives represented.
Since its publishing in 2020, the Presence 5 framework has been adopted in a variety of educational workshops and purposes. The Presence 5 research team explored the framework’s applications to tele-health in 2021, to pursue Racial Justice in 2022.

For the Presence 5 for Racial Justice (P5RJ) project, the team used a community based participatory research approach with partner community clinics (in Oakland, CA; Leeds, AL; Rochester, NY; and Memphis, TN). In addition to interviews with patients and discussions with clinicians, Shankar & Cox et al also used the “human-centered approach” used in the earlier pieces by investigating how nonmedical professionals address personally mediated, institutional, and internalized racism and to adapt these practices for the clinical setting. By doing so, they concluded anti-racism practices from outside the health care sector to offer innovative strategies to promote health equity by addressing racism on all levels.

Shankar & Henderson et al. took a more applications based approach, by developing the Presence 5 for Racial Justice Workshop from a preliminary literature review. Implementation included an introductory didactic, a small-group discussion, and a large-group debrief. Participants evaluated the workshop via an online survey, and they analyzed the resulting qualitative feedback in the paper. Themes that emerged from survey responses included strengths of and improvements for the workshop structure (protected time for anti-racism discussion, dialogue between learners and faculty) and content (specific phrases and language, practicing self-reflection). These results can be used by P5RJ to further develop anti-racism curriculum for medical professionals and educators.

In summary, Presence 5 has come a long way in developing an ideological framework for human connection in medicine. The pieces were novel for their use of the “human-centered approach,” such that most literature in medicine centers the perspective of clinicians and professionals inside the medical ivory tower. Models for clinician communication, such as the Presence 5 for Racial Justice (P5RJ) framework, can be applied to clinician interactions with Black pediatric patients and caregivers to begin to address disparities in clinical care through meaningful provider-patient-caregiver connection, enhanced relationships, and shared decision-making. This summer study synthesized the already existing work of Presence 5 with interdisciplinary literature to address Anti-Black racism in Pediatrics.

Methods

During the spring, the P5RJ team conducted PubMed searches to identify health disparities impacting Black pediatric patients and practices for clinicians and institutions to promote health equity. Supplement eTable 1 shows detailed search terms. Researchers (RG, TH, JB, ZK) screened articles to determine inclusion through three rounds: 1) title, 2) abstract, and 3) full text. In each round, screeners reviewed the title, abstract, and full text of each article for inclusion and exclusion criteria. Each article was screened independently by one screener, and uncertainties were discussed in weekly group meetings until inclusion/exclusion consensus was reached. Articles that did not clearly meet inclusion or exclusion criteria were labeled “uncertain” and remained in the pool for the next phase of screening.
Each article that met final inclusion criteria was reviewed by one researcher to extract information. Practices drawn from reviewed articles were organized using Excel and mapped to the P5RJ framework. Researchers conducting full-text reviews held weekly meetings to discuss emergent practices, resolve disagreements in categorization, and consolidate practices with overlapping concepts. Practices were then reviewed and finalized in large research team meetings to incorporate input from pediatric and family medicine clinicians.

This summer, my job was to familiarize myself with the work done from the preliminary literature done in the spring, and find gaps to target with a secondary targeted review. I focused my literature review to the *Prepare* domain of the Presence 5 framework.

The initial gaps categories were developed:

1) Centering Black Pediatric Patients: Prepare by knowing examples and terminology related to Anti-Black racism in Pediatrics, i.e. Adultification, Anger Bias, Pain Management
2) Centering the Black Caregiver: Prepare for conversations with caregivers and families
3) Centering Black Families and the Diaspora: Prepare by understanding social determinants of health that are specific to Black families. An intersectional and historical lens was emphasized for this gap, i.e. generational trauma, institutional racism, and resulting comorbidities such as anxiety and depression.

Given these three categories, the gaps were refined to the following: Gap 1) Examples of anti-Black racism, 2) Racial Socialization, 3) Medical Mistrust, and an additional Gap 4) Frameworks for Reflection: Positionality, Reflexivity, and Intersectionality

We excluded non-English articles, work conducted outside the U.S., and articles published before 2012. Articles were included if: 1) the target patient population was Black families and/or pediatric patients and/or their caregivers or 2) if the work pertained to health disparities due to physician communication or biases or 3) if communication frameworks, toolkits, or strategies were mentioned. Articles were to be excluded if they focused on communication from patient and/or caregiver rather than provider communication practices, or if the pieces broadly addressed racial disparities, but not specifically Black patient disparities. The PubMed search terms used are outlined in Table 1 below.
### PubMed Search Terms by Gap

#### Gap 1) Examples of anti-Black pediatric biases/practices/outcomes:

Search: 
(`black*`[tw] OR "African American*" OR "African diaspora") AND ("Adolescent*" OR "Child*" OR "pediatric*" OR "Youth" OR "neonat*" OR "teen*") AND ("family" OR "care*" OR "father" OR "Mother" OR "Parent" OR "guardian") AND ("HealthCare" OR "patients*" OR "clinic*") AND ("bias" OR "anti-black" or "racism") AND "pain"

Filters: in the last 10 years, English, Child: birth-18 years, Newborn: birth-1 month, Infant: birth-23 months, Preschool Child: 2-5 years, Child: 6-12 years, Adolescent: 13-18 years

#### Gap 2) Understanding Racial Socialization for an interaction with the caregiver & family unit:

Search: 
(`black*`[tw] OR "African American*") AND ("Adolescent*" OR "Minority children" OR "black adolescents") AND ("family" OR "Parent*") AND ("bias" OR "anti-black" or "racism") AND ("caregiving" OR "family dynamics" OR "parenting" OR "mother" OR "father" OR "parent")


#### Gap 3) Medical Mistrust-- Prepare to navigate medical mistrust by understanding how historical and ongoing negative experiences with the healthcare system have earned mistrust from Black patients and families.

Search: 
(`black*`[tw] OR "African American*" OR "African diaspora") AND ("HealthCare" OR "patients*" OR "clinic")

Filters: in the last 10 years, English

#### Gap 4) Prepare to evaluate your anti-Black biases by reflecting on your positionality:

Search: 
"Positionality" OR "reflexivity"

Filters: in the last 10 years, English

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**Table 1: PubMed Search Terms**
RESULTS

Of the 240 articles identified with the targeted search terms, 89 were accepted and evaluated for the narrative literature review. Figure 1 outlines the number pieces identified, screened, and evaluated for each gap.

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Figure 1: Literature Review Results by Gap

For all gaps, a majority of rejections in the selection phase were because the pieces described anti-Black racism towards adult patients, rather than a pediatric population. Other exclusion justifications included that the pieces did not focus specifically on Anti-Black racism, but rather broad racial disparities and/or outcomes rather than interpersonal examples of racism.

Of the 30 pieces used in the literature review, they were then separated into two core components 1) Preparing to prevent interpersonal Anti-Black racism and 2) Preparing materials for care that are specific to the family and conscious of accessibility. The practices in this domain are intended to be used in the several minutes before the interaction, while reviewing the patient chart and notes. Because the time scope of this domain is limited, these practices can be expanded to include an additional component 3) Practicing anti-racism as a lifelong learning pursuit, in order to further support the core components 1 & 2.

DISCUSSION

1. **Addressing interpersonal Anti-Black Racism**

Interpersonal Anti-Black racism can manifest before and during the clinical interaction. While reviewing the patient’s chart, clinicians can familiarize themselves with the child and family they are about to
meet. While doing this, it is important clinicians stay mindful of how Anti-Black racism can produce implicit and explicit biases, stereotypes, or assumptions that can influence the upcoming visit.

Until recently, the research on implicit bias among health professionals has focused on bias toward adults. However, a recent study found that resident physicians showed that implicit racial bias against Black children was similar to levels of bias against Black adults. Both forms of implicit bias are important to prepare for because pediatric clinical encounters are with patients (children) and caregivers/family (adults). Evidence shows that bias can impact clinical decision-making and consequently pediatric health outcomes, namely increased rates of adverse health outcomes across a wide range of conditions, including asthma, obesity, diabetes mental health, and pain management. The literature suggests a variety of anti-bias interventions including stereotype replacement, counter stereotype imaging, individuation, perspective taking, increasing intergroup contact, education about implicit bias, accountability for bias, understanding others viewpoints and increasing empathy, self-monitoring, and building a partnership building between patients and providers.

Complementary to addressing bias, clinicians can also familiarize themselves with pediatric specific forms of anti-Black racism. One example is the Adultification of Black children. This is a type of bias that assumes Black children need less nurturing, protection, and comfort. Previous studies have shown unconscious racial bias in anesthesiologists and possible variation in anesthetic practice by race for pain management. Another Pediatric specific example of bias is termed Anger bias: perceiving anger where it does not exist and is disproportionally imposed on Black children compared to White children. The effects of anger bias exceed the clinic and follow Black children in education and the justice system, namely with harsher punishments—ultimately leading to disruptions in learning and success. Moreover, because Adultification and Anger bias affect Black girls differently than boys, understanding intersectionality has been cited as a complementary practice to bias mitigation.

2. Preparing Materials & Resources

One way to address the structural racism that produces social determinants of health is by preparing resources and materials that are specific to the accessibility and identity(s) of the patient’s family. Moreover, with an awareness and understanding of the effects of poverty and racism on children, pediatricians and other pediatric health practitioners in a family-centered medical home can assess the financial stability of families, link families to resources, and coordinate care with community partners. The pediatric medical home model is an approach to providing comprehensive primary care that facilitates partnerships between patients, clinicians, medical staff, and families. The medical home model can be expanded to help families address unmet social and economic needs by using a combination of clinical care coordination and community partners and resources.

However, in order to know what resources to compile and distribute, the right questions need to be prepared. Clinicians can inquire about a family’s needs of services by using screening tools before the interaction. In the policy statement “Promoting Food Security for All Children,” the AAP recommends the use of a 2-question survey that has a high sensitivity to detect food insecurity. Additionally, inquiring
whether families have moved frequently in the past year or have lived with another family for financial reasons can reveal housing insecurity. It is also important to inquire about the positive, protective factors that are present in children and families that can help clinicians build on their strengths. A commonly used instrument to assess protective factors in high-risk families is available through the FRIENDS National Resource Center. The Protective Factor Survey is used to assess current status as well as change over time in family resiliency, social connectedness, quality of attachment, and knowledge of child development.

Effective early identification of families in need may facilitate prevention services, including nutritional supplements for young children, preventive health services, socioemotional support of parents, and age-appropriate learning opportunities. Early literacy promotion in the medical home with programs such as Reach Out and Read advances reading readiness by approximately 6 months when compared with controls. Additionally, preparing early literacy resources that promote positive racial socialization and cultural pride can be a means of supporting Black parents in their discussion of race and racism with their children.

3. Lifelong Learning & Advocacy

Lastly, it is crucial to remember that racism takes systemic, institutional, and interpersonal forms; anti-racist work targets all. Complementing the first two subdomains: bias mitigation and resource preparation, is lifelong engagement with self-reflection, self-education, and advocacy. These are named lifelong commitments because they will require time, patience, and humility inside and outside the clinic, well beyond the initially defined time and throughout one’s career.

Engaging in deep reflection for anti-racist communication includes considering how one’s identities can influence power dynamics. However in order to do so, requires understanding how they came to exist and are perpetuated. Positionality can provide a guiding framework for understanding power dynamics because it helps one understand their place within a complex network of societal structures and relationships. Positionality was originally introduced to social science research to understand how one’s social position (racial identity or class background, for example) affects one’s scientific analyses. Another framework for reflection is Reflexivity. Reflexivity is the questioning and challenging of one’s own thoughts and beliefs. Reflexivity has been named as one way to deconstruct stereotypes and to prevent their reproduction. Lastly, learning the concept of Intersectionality, which is understanding oppressions intersect, can combat essentializing and decontextualising group characteristics can reproduce bias and stereotypes. Intersectionality has also been cited by sources as a compliment to bias mitigation

Positionality, Reflexivity, and Intersectionality are best complemented with historical understandings of anti-Black racism. Furthermore, clinicians can also familiarize themselves with the history of anti-Black racism to better understand and prepare for Earned Medical Mistrust. Earned Medical Mistrust among Black patients has been shown to lower utilization of healthcare & poorer management of health conditions. Despite the extensive literature describing medical mistrust, only recently has the literature
redirected focus to the systemic underpinnings of its development. While mistrust is often referred to as a phenomenon existing within an individual or community, we must rethink this conceptualization and instead locate mistrust as a phenomenon created by and existing within a system that creates, sustains and reinforces racism. Therefore, one way to respond to mistrust from Black patients and families is to understand its roots and ongoing systemic contributors. Additional practice recommendations to responding to Earned Medical Mistrust include working with community workers, working with faith-based organizations, hiring health care staff who reflects the population, and respecting people’s time and effort by providing participant compensation. Moreover, clinic- and system-level practices can include clinical teams staying 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. Additional means of addressing anti-Black racism in medicine at the structural and institutional level include building a diverse workforce, prioritizing research to describe the impact of racism, initiating improvement efforts to close equity gaps, building community partnerships, co-designing solutions alongside patients and families, and advocating for policy change to address the social conditions that impact children and adolescents of color.

Social Action Plan

This project hopes to advance research on anti-racist clinician communication strategies by adapting Presence 5 for Racial Justice (P5RJ) curriculum to pediatrics with input from key stakeholders including: pediatric patient caregivers, clinic staff, and pediatricians. In addition to adapting P5RJ, we are seeking face and content validation of P5RJ-Pediatric strategies with and for our community partners: Gardner Packard Children’s Health Center and Roots Community Health Center.

P5RJ-Pediatrics curriculum workbook, will be disseminated to clinical partners at Roots, Gardner, Mid-Peninsula Advocacy Coalition (iMPACt) which includes local safety net clinics caring for local low income children and families of color, and to participants in Stanford Pediatrics HEAL (Health Equity Advanced through Learning) initiative. HEAL is a multimodal training initiative for Stanford School of Medicine Department of Pediatrics. One aspect of the HEAL Initiative is huddle guides, which will be 1-page resource guides for clinic leaders that condense complex anti-racism concepts into bite-sized learning modules that can be incorporated into daily team huddles in clinical spaces to promote continuous learning, shared language, and discussion of anti-racism. Evaluation activities will include content and face validation of the Presence 5 for Racial Justice practices with clinical staff, providers, and pediatric patient caregivers to build preliminary evidence that the practices address racism and build trusting clinical relationships.

Curriculum Dissemination

We will produce and disseminate a concise curriculum guide (5-10 pages) to community clinic partners, including the Gardner Packard Children’s Health Center, Roots Community Health Center and members of the standing Mid Peninsula Advocacy Coalition (iMPACt), composed of representatives of local clinics whose patients are admitted to LPCH. The curriculum will resemble a similar curriculum developed by the Presence 5 research team for the Presence for Racial Justice project. This curriculum will also be
integrated to the Stanford Pediatrics HEAL Initiative huddle guides as part of the Stanford Department of Pediatrics’ anti-racism training initiatives. The huddle guide effort will include 1-page curriculum guide that condense complex anti-racism concepts into bite-sized learning modules that can be taught in daily clinical team huddles to promote continuous learning, shared language, and ongoing discussion of anti-racism and communication best practices. We plan to create 10-12 huddle guides, with a new guide implemented monthly throughout LPCH and outpatient clinics. We will assess the effectiveness of the curriculum in both its implementation and its effectiveness in teaching communication principles. The design, implementation, and assessment of the curriculum will be disseminated by publishing it in the peer-reviewed curriculum database MedEdPORTAL.

Community Partnership and Engagement

The Stanford Presence 5 team in collaboration with the Gardner Packard Children’s Health Center (GPCHC—a local pediatric federally qualified health center that is part of Gardner Family Health Network), seeks to advance research on anti-racist clinician communication strategies by adapting Presence 5 for Racial Justice (P5RJ) curriculum to inpatient pediatrics.

The Gardner Packard Children’s Health Center mission aligns with the vision of the grant: Gardner is dedicated to improving the health status of the communities we serve, especially the disenfranchised, disadvantaged and most vulnerable members. Our mission is to provide high quality, comprehensive health care, including prevention and education, early intervention, treatment and advocacy services which are affordable, respectful, culturally, linguistically and age appropriate. Similarly, Roots’ mission is to uplift those impacted by systemic inequities and poverty.

P5RJ is utilizing and compensating the lived experiences and skills of community members to be implemented in the ongoing revising of the research and curriculum. We will leverage the Presence 5 team’s additional sources of funding to support community partnership and engagement in Santa Clara County and San Mateo. We have received funding through Stanford Medicine Teaching & Mentoring Academy Grant and through the Stanford Center for Comparative Studies in Race & Ethnicity Grant to develop a national community advisory board (CAB) to design, develop, and evaluate an online P5RJ Continuing Medical Education curriculum that teaches clinicians practical anti-racist communication strategies. Interest permitted, focus group participants recruited from the Gardner Packard Children’s Health Center and Roots are welcome to serve on our compensated national community advisory board.

The necessary work to uproot racism (and specifically anti-Black racism) starts but certainly does not end with this curriculum and research. Our research aims to understand and eventually positively change staff and parent/caregiver relationships with participatory work. The research project may end, but we hope to see the organizing and planning put forth by participatory work sustain itself for many years to come.
References

Literature Review


Discussion


