

Communication as a Tool for Addressing Racial Disparity: Reflections from the COVID ICU

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Staub S. Communication as a tool for addressing racial disparity: reflections from the COVID ICU. *Harvard Public Health Review*. 2020; 26.

Abstract

It was early in the afternoon when Mr. G was transferred to our intensive care unit (ICU) for hypoxia and an increasing oxygen requirement. SARS-CoV-2 positivity was a given. At the time, our state was tallying some of the highest incidence rates of COVID-19 in the nation, and I was working one of several “COVID-only” ICU units- a ragtag collection of beds in a reinvented neonatal nursery. The majority of our patients were either mechanically ventilated on arrival or rapidly approaching the need for it. I was placing orders into the computer when Mr. G’s nurse informed me he was refusing intubation.

“He said that?”

“He was pretty adamant.”

I entered his unit expecting to encounter hypoxia-driven confusion, but instead found his true pathology to be anxiety. Mr. G was suffering from the “silent hypoxia” seen in certain COVID patients – his oxygen needs had been steadily increasing, but subjectively he felt the same.¹ He had been declining- innocently and unknowingly teetering on an invisible ledge that only we could see. All he saw was a more intimidating room with restless commotion and talk of very invasive therapies. He was overwhelmed and had declined intubation in an attempt to gain control of a rapidly changing environment.

From a decision-making standpoint, he had capacity. But even registering this, I could feel myself strategizing against his decision. Emotionally, I needed him to change his mind- I had already seen many die from this virus, and I was not open to a patient refusing therapy from fear alone.

“Do you mind if we call your wife and daughter so we can all discuss this together?” It was a cheap shot. Certainly, I advocate for joint decision-making and open communication with families, but at this moment, my goal was to gain allies against his decision.

On speakerphone, I began to explain the situation but was soon interrupted by his daughter. “No,” she sighed. “Look, my daddy is not against intubation. He is just *scared*. He comes in with what feels like a cold and now we have a different doctor every day and y’all are talking about putting him on a ventilator and using him to test *experimental treatments*. Do you know how that *sounds*? . . . like Tuskegee.” I felt my stomach drop as the realization of what she was saying settled in. I had already identified his fear, but not the racial implications inherent to his decision.

In a matter of months, we have watched COVID-19 cripple economies and throw health care workers into a desperate frenzy to discover effective treatment strategies. A sea of proposed treatments, emerging evidence, redactions, and optimistic protocols continues to ebb and flow. This is the first pandemic to affect the United States since the 1918 influenza, and for those of us not practicing during the AIDS epidemic of the 1980s, this is our first large-scale public health scare.

The notion that we are fighting a universal illness has made it easy to assume equity and to overlook the history of our profession; however, we have a profound record of mistreatment of minority and vulnerable populations. The obstetrics techniques developed by James Marion Sims’ were perfected on enslaved women without anesthesia. The cancer cells stolen from Henrietta Lacks without her consent continue to be used in research. And, while most have heard of the Tuskegee Syphilis Study, few remember that it lasted for 40 years and was not discontinued until 1972. A distrust in medicine is not without reason, particularly for minority patients like Mr. G and his family.

While the COVID-19 virus feels omnipresent, the truth is, this virus has *not* affected us all equally. COVID case incidence and need for hospitalization has been disproportionately higher among minority populations.³ Long-standing systemic health and social inequities contribute to this trend, including the increased prevalence of minorities in “essential businesses” and the lack of compensation for the risks workers assume. The disparity is further propagated by discrimination and inequalities in housing, healthcare access, and education. Glancing up from the computer, I acknowledged that seven of the eight patients in Mr. G’s ICU unit were people of color.

Pandemics notwithstanding, racial bias and diversity disparities have long been a systemic issue in medicine. At a provider-level, 2018 data found that only 5 percent of current US physicians identify as Black or African American, despite making up 13 percent of the US population at the time.⁴ And where representation lacks, misconceptions abound. Racial biases, even retained beliefs of biological differences in White versus Black patients, exist among providers. The misconceptions have led to differences in medical management between the two groups ranging from pain management to anticoagulation use.⁵ Bias exists in more subtle aspects of care as well, with calculators continuing to assign higher estimated renal function to Black patients based on the fallacy that they have higher muscle mass than White patients. On a patient level, Black patients who identify as victims of racism are at higher risk for chronic medical conditions such as hypertension. Even those who identify *with* victims but have not themselves been directly targeted can hold a heightened mistrust of the medical profession and suffer worse outcomes.²

The desperation of the medical community to combat COVID-19 has made providers quick to embrace novel treatment options and practice changes. Our institution had already barred families and friends from visiting patients for fear of infection risk, and the general assumption was that patients would accept the experimental treatments unless they had a medical or religious contraindication against them. *Surely*, we felt, *patients would trust our methods and be grateful for any treatment we could offer*. But this conversation with Mr. G and his family was the first time I saw our conjectures from this historical context. The profession which has failed to earn full trust was telling families, *No, you cannot see your loved one, but don't worry- we have an experimental drug that we're willing to try on them*.

The inadequacy of our communication was apparent. We had not explained our care plan well enough to Mr G., and as a result we saw the situation through vastly different lenses. Clear communication, particularly within racially discordant patient-physician interactions, has a well-documented positive impact on patient-centeredness, information sharing, and patient engagement.⁶ These values were taught in my medical school curriculum and continue to shape some of the Core Competencies listed by the Accreditation Council for Graduate Medical Education, which oversees US Medical Residency programs. Even in my limited time as a provider, I have seen how communication influences patient satisfaction, safety, and participation in care. Yet, it had been one of the first tools I lost during a stressful ICU rotation.

As an individual resident physician, one may not feel empowered to influence the larger issues of racial inequity; it is often easier to argue that your focus as a provider should be insulated from these large-scale issues, and instead be focused on the medical pathologies at hand. But while this focus is important, it risks overlooking both the role that racial inequities play in patient health and our opportunity to mitigate them. If instead we choose to acknowledge the disparities, we can take an opportunity to better understand our patients and align our goals of care with theirs. Communication then becomes the decisive tool in shared progress.

The voice of Mr. G's daughter brought me back to the matter at hand. "We're not refusing intubation for my daddy, and we're not refusing these treatments. All we are asking for is for someone to take the time to *explain* to us what is going on."

This talk with Mr G.'s daughter was- and remains- a call to do better.

Acknowledgments

The author would like to acknowledge the following people who reviewed this piece and offered their editorial recommendations: Dr. Maggie Thomas, Dr. Elizabeth Kirkland

Citations

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