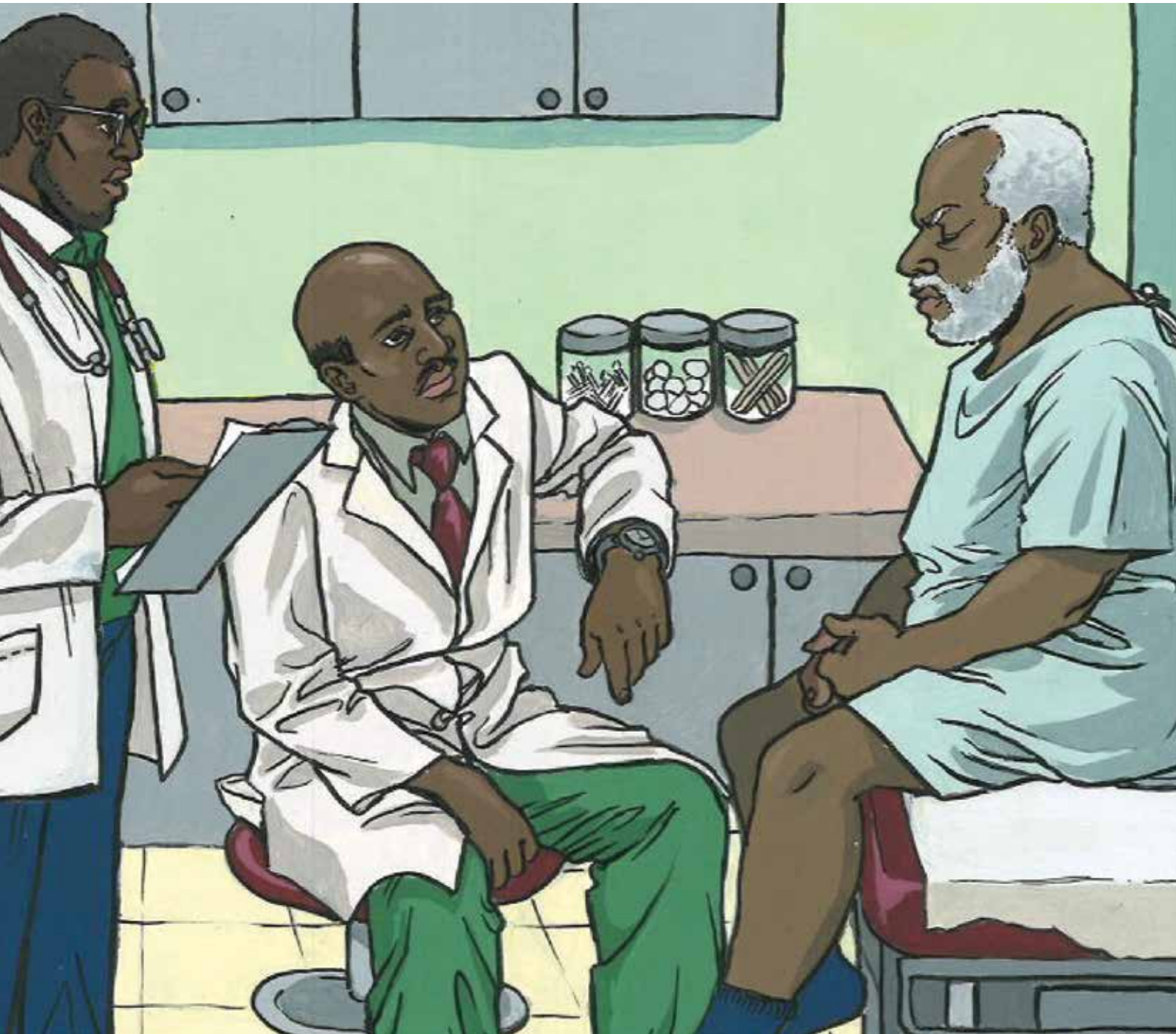
# Historic context and communication: Undoing medical mistrust

Illustration by Claire Gilmore



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To feel overwhelmed is to be expected as a medical student, especially being a medical student from a group that is underrepresented in medicine but overrepresented in disparities. As a Black, bisexual man from an immigrant family, I sometimes feel as though I walk with a target on my back, not just one as explicit as police brutality, but one deeply intertwined with social determinants: diabetes, hypertension, heart disease, HIV, and COVID-19. With each lecture, I am reminded that Black people are disproportionately affected by chronic disease. How does one begin breaking past these disparities to create a positive impact for patients? How can it be done when they have so many reasons to distrust us?

Exposure to these realities not only highlights the salience of race, sexuality, and class in the lives of patients, but it contextualizes the medical mistrust endemic to our country. This mistrust, especially for marginalized groups, is a response to historic and contemporary exposure to hostile environments and actions perpetrated by the health care system.[1]

The vestiges of antiquated racist medical practice and thought persist, in part, through medical bias. They are present when trainees and budding doctors inaccurately believe that African-Americans have higher pain thresholds than their white counterparts, they are present when a urine drug test and HIV test are ordered for a Black patient when it might not be indicated and is not being done for white patients with the same presenting condition.[2,3] In instances such as these, medical mistrust is not only a learned response to these explicit and implicit racist encounters, but a logical one.

What will donning a white coat mean for patients if it's the very symbol they might grow to distrust? How can history and effective communication deconstruct the barrier that is medical mistrust?

I first encountered an answer while shadowing and working alongside Dr. Edwin McDonald (ΑΩΑ, Northwestern University Feinberg School of Medicine, 2019, Alumni), a gastroenterologist, a Black doctor, a community advocate, and a Chicago native. He is all too familiar with the ways the medical system fails its community. He is dedicated to practicing medicine in a way that mitigates medical mistrust.

One day in Dr. McDonald's clinic, an older Black patient, wore a look of impatience that was matched by his curt tone and brief responses. He was upset and distrustful. He was dismissive of McDonald's initial attempts to communicate. The clinic visit reached its climax when the patient sternly declared, that he was no "experiment" or "monkey" to be played with. "I'm not no n*****," he acknowledged.

Me. Dr. McDonald. Our patient. The legacy of mistrust and racism brought three different generations of Black men walking on different sides of the doctor-patient relationship into that room. "I'm not no n*****" was not just the patient's response to his physician, but an invocation against the history of American medicine.

In this man's words and disposition, I was reminded of the ways in which medical mistrust took root in my own life. It took me back to the days I would spend sitting in the doctor's office as a child, rehearsing the responses my parents trained me to give when a doctor would ask me questions during an appointment; limiting information about my sexuality so as not to have conversations with physicians that might immediately shift to HIV prevention; thinking about the time I opted not to list myself as an organ donor when I got my driver's license because of the age-old tale I first heard in a [Black] barbershop that doctors would prefer to harvest my organs than save my Black life.

I learned these behaviors from the media, my family, and Black community spaces. Medical mistrust is learned, emulated, and passed down from generation to generation. By virtue of living and carrying these identities, this target on my back accompanies me into many spaces. I imagine our patient felt similarly.

This was no "difficult" patient. My personal experiences and understanding of social determinants made what typically goes invisible or unspoken in daily clinical encounters tangible and present. This was medical mistrust.

Although I always knew about medical mistrust, this was the first time I experienced it while wearing a white

coat—no longer as the patient or a member of the outgroup, but as someone who could be perceived as a perpetrator, an agent of the dominant culture.

Dr. McDonald acknowledged and validated the patient's feelings. Dr. McDonald addressed the historic context of Black people in medicine, and ensured the patient that as a Black doctor his goal is to create partnerships. Though the patient was pressed for time and could not stay for his full visit, he showed a remarkable change in demeanor. The rapport Dr. McDonald began to build meant they could resume their next visit on a better note.

Patients carry culture, context, and history into the clinic. In just a year of medical education, I have learned and experienced the value of patient trust. However, I have only begun to learn strategies to mend the doctor-patient relationship, especially when it is complicated by systemic issues that make patients feel misunderstood, unheard, or objectified.

It is not enough to be well-intentioned, it is not enough to have race-concordant doctor-patient relationships. It is not enough to include the word "diversity" as garnish in mission statements and institutional websites. It requires real work that can be uncomfortable, humbling, and awkward. No matter one's identity, the privilege associated with a white coat can potentially blind its wearer to patient needs. Mitigating the effects of medical mistrust is everyone's responsibility.

One of the most effective metrics for gauging institutional change that mitigates medical mistrust is listening to the community. Organizations must invest in an advocacy plan that champions health communication strategies that are intersectional and cognizant of the historic and contemporary challenges shouldered by its patient populations.

In an age when an unforgiving pandemic disproportionately impacts communities of color and a slow national vaccine rollout is received with suspicion, it is essential to address the role of medical mistrust. Vaccine-related concerns of a Black patient who cites the Tuskegee Syphilis Study need to be met with full acknowledgment of racism and the complicity of doctors in the past. A strong connection to the patient must be built. It is a privilege to be allowed entry into the lives of patients. They gift us vulnerability, and we must do the work in order to ensure that gift is not abused.

Dr. McDonald's awareness of the historic context of his patient's experiences allows him to employ a communication strategy that builds rapport and establishes trust. It afforded him the opportunity to address the deep wounds of American medicine on marginalized groups.

These wounds are the legacy that medical professionals inherit, but by no means are they scars to be deepened. If medicine can unlearn these practices, then the trust granted by patients can create a new standard for the doctor-patient relationship and for health outcomes. There is no better way to uphold the edict of "Do No Harm."

**References**

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