VIEWPOINT

Patient- and Family-Centered Hospital Care—The Need for Structural Humility

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"How was her night?" or "What questions or concerns do you have?" These common open-ended questions are often directed to caregivers (parents, family members, or guardians) of hospitalized children at the start of family-centered rounds. While these questions meet a lot of best practices for family-centered rounds, such as being open ended and starting with caregiver input, the level of caregiver engagement following these questions varies greatly. For example, while one parent might answer "fine," another might describe symptoms and events in detail, including their opinions and preferences on their child's care. This variability in participation is important given the critical role of caregivers in preventing medical errors, aligning goals of care, and optimizing pediatric hospital outcomes.

The current approach to communication during family-centered rounds operates under the assumption that patients and families will feel safe and empowered to participate when given the opportunity. However, this pretense fails to address how systemic inequities and lived experiences of individuals may influence interactions with health care systems. Several recent studies have demonstrated Black, Latinx, and other racial and ethnic minoritized groups feel less comfortable and empowered speaking up on family-centered rounds.[1] While individual clinician biases and differences in communication likely contribute to this inequity, factors beyond that single encounter may also play a role. Indeed, factors both within the health care system (eg, past discrimination by clinicians, lack of language accessibility in the form of interpreters or signage, lack of diverse representation of clinicians and staff) and outside of the system (eg, racism, stigma, acculturative stress, social needs) can influence caregiver-clinician communication. Thus, even if medical teams use standardized and bias-free communication, family engagement and participation may not be equal across patients from different backgrounds.[2] Without awareness of the structural factors that influence such communication, clinicians may interpret caregiver differences in communication in ways that reinforce stigma and stereotypes.

Importantly, past, present, and anticipated discrimination in health care settings has been shown to affect communication.[3] Caregivers from minoritized (systematically excluded, disenfranchised, and/or oppressed) backgrounds who are primed to expect negative attitudes based on their lived and group experiences with clinicians may understandably walk into the medical encounter with a high level of vigilance for cues of threat.[4] This response to discrimination or fear of discrimination, called *stereotype threat*, can reduce cognitive function, impair effective communication, and lead to coping strategies, such as disengagement or emotional activation.[4] Clinicians may pejoratively view these behaviors as not caring or difficult, leading to a cycle of clinician disengagement, poor communication, and conflict. To address these external influences, clinicians must strive for cultural and structural humility. While cultural and structural humility overlap in their goal of building rapport among clinicians and patients with differences in culture, beliefs, or lived experiences, the focus is different. In the practice of cultural humility, clinicians reflect on their personal biases and aim to harmonize care with an individual patient's culture, beliefs, and preferences. In the practice of structural humility, clinicians reflect on forces (ie, disenfranchisement and systematic oppression of minoritized communities) that influence communication and health outcomes at levels above individual interactions.[5] To achieve structural humility, we propose incorporating principles from trauma-informed care and racial equity into the practice of patient- and family-centered care (**Figure**).

The practice of trauma-informed care can be applied to disrupt cycles of negative communication and augment collaboration among patient caregivers and clinicians. Exposure to potentially traumatic events, including interpersonal and structural racism, is common and inequitable, and often affects communities that have been minoritized.[6] Trauma can have devastating mental, physical, emotional, and behavioral consequences that affect caregiver coping strategies, communication, and behavior.[7] In a trauma-informed approach, clinicians recognize how past experiences of trauma can affect patient behaviors and health care decisions. Clinicians practicing trauma-informed care interpret caregiver behaviors as adaptive responses to their lived experience. Rather than judge caregivers as difficult, clinicians attempt to support and connect with caregivers through empathy and perspective-taking. In this approach, when caregivers are silent on rounds, clinicians do not assume caregivers are disengaged or not intelligent but view the silence as a coping mechanism to stressful and/or traumatic lived experiences and/or social exclusion. Clinicians recognize the need to avoid retraumatization, promote psychological safety, and demonstrate trustworthiness over time.

In addition to trauma-informed care, principles of racial equity from fields of sociology, psychology, and education can be applied to address structural influences on the clinical encounter. For example, affirming students from minoritized backgrounds has been associated with better test and academic performance.[8] Affirmation comprises gestures that foster inclusion, listening, comfort, and support for people who may feel unwelcome or invisible in an environment.[8] In health care, affirmation has been described previously as a communication tool that is likely beneficial for all caregivers.[9] It may be particularly important in encounters with minoritized caregivers, in which in-

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Figure. Shared and Unique Elements of Patient- and Family-Centered Care, Trauma-Informed Care, and Racial Equity

Element	Patient- and family-centered care	Trauma-informed care	Racial equity
Attention to patient/family values and preferences	✓		
Encourage patient/family participation	✓		
Provide language-concordant information that matches patient/family health literacy level	✓		
Recommend sharing of information	✓	✓	
Respect patients/families as individuals of equal intelligence and worth	✓	✓	✓
Promote shared decision-making	✓	✓	✓
Recommend cultural humility	✓	✓	✓
Recognize the impact of lived experience and prior traumatic events in medical interactions		✓	
Prevent further medical trauma (emotional support)		✓	
Recognize need to build (not assume) trust and safety		✓	✓
Share power and address power differentials		✓	✓
Recognize that social systems of privilege/oppression impact clinicians (bias) and patients/families (identity threat)			✓
Need to actively promote inclusion and belonging (affirmation)			✓

An equity-focused and trauma-informed approach overlaps with patient- and family-centered communication through recommendations of cultural humility, shared decision-making, and patient/family empowerment. However, it adds unique contributions, such as addressing emotional distress, building trust, affirming patients/families, and promoting clinicians to recognize how one's lived experiences may influence their medical decisions and behaviors.

equities in patient communication in domains of positive affect, empathy, and respect have been described by investigators.[10] Affirmations include praising empowered behaviors, validating experiences and emotions, and reinforcing positive behavior. In addition, teaching clinicians core principles of racial equity, such as the social construction of race, relearning history through the narratives of marginalized groups, and structural racism promotes structural humility.

In conclusion, individual and systemic factors contribute to a caregiver's participation on rounds. Disproportionately, minoritized caregivers have experiences, both within and outside of health care settings, that may negatively influence participation. Tenets of racial equity and trauma-informed care can add unique contributions to contemporary practice of patient and family-centered care that can empower minoritized caregivers. These approaches may be particularly salient in situations of conflict to avoid labeling and stereotyping patients. Given the importance of family engagement in delivering safe, high-quality inpatient care, the concept of patient- and family-centered care needs to be expanded to acknowledge the structural forces that impact individual clinical interactions.

ARTICLE INFORMATION

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