

# Communication Between Black Patients With Cancer and Their Oncology Clinicians: Exploring Factors That Influence Outcome Disparities

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**PROBLEM IDENTIFICATION:** Significant cancer disparities exist between Black and White patients. One important contributor to patient outcomes disparities is patient-clinician communication. Conversations between clinicians and Black patients are often shorter and less detailed compared to White patients.

**LITERATURE SEARCH:** A systematic literature search was conducted. Databases were searched to identify studies that included (a) participants with a cancer diagnosis, (b) information specific to Black or African American participants, and (c) information on patient-clinician communication. A total of 67 articles underwent full review; 24 studies met inclusion criteria.

**DATA EVALUATION:** Each included study was scored for level of evidence, and common themes were identified across studies using the Matrix Method.

**SYNTHESIS:** The following themes were identified: relationship building, building trust, empowering patients for shared decision-making, addressing topics of patient concern, and consideration of community and family.

**IMPLICATIONS FOR RESEARCH:** Results identify several ways that nurses can improve communication with Black patients. Research aimed at identifying interpersonal strategies to mitigate cancer disparities is needed.

**KEYWORDS** cancer; oncology; African American; Black; patient education; health communication

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Significant disparities in cancer prevention, detection, treatments, outcomes, and quality of life exist between Black and White patients. Black patients have higher death rates than all other racial and ethnic groups for most cancer types (Surveillance, Epidemiology, and End Results Program, 2021). When compared to White men, Black men have a higher incidence of prostate cancer and are twice as likely to die from the disease (National Cancer Institute [NCI], 2022). Compared to White women, Black women experience higher cervical cancer incidence and mortality, as well as a higher incidence of triple-negative breast cancer, which is more aggressive than other types of breast cancer (NCI, 2021). In addition, despite similar overall breast cancer incidence among White and Black women, Black women are more likely to die from the disease (NCI, 2022). Increasingly, researchers are attempting to improve these disparate health outcomes between Black and White populations, often identifying the healthcare system as a starting point for improvement.

Nurses have frequent communication and opportunities to build relationships with patients that can improve patient outcomes. Health communication is central to the nursing practice and is essential to providing person-centered care that results in positive patient outcomes (Kourkouta & Papathanasiou, 2014). The National Institute on Minority Health and Health Disparities (2022) framework recognizes the healthcare system as having an influence on health outcomes (see Table 1). Within the healthcare system, nurses are situated at the interpersonal level of influence to affect patient health outcomes.

**TABLE 1. National Institute on Minority Health and Health Disparities Research Framework**

Domains of Influence	Health Outcomes			
	Individual Health <sup>a</sup>	Family or Organizational Health <sup>b</sup>	Community Health <sup>c</sup>	Population Health <sup>d</sup>
Behavioral	<ul style="list-style-type: none"> <li>■ Health behaviors</li> <li>■ Coping strategies</li> </ul>	<ul style="list-style-type: none"> <li>■ Family functioning</li> <li>■ School or work functioning</li> </ul>	<ul style="list-style-type: none"> <li>■ Community functioning</li> </ul>	<ul style="list-style-type: none"> <li>■ Policies and laws</li> </ul>
Biologic	<ul style="list-style-type: none"> <li>■ Biologic vulnerability and mechanisms</li> </ul>	<ul style="list-style-type: none"> <li>■ Caregiver–child interaction</li> <li>■ Family microbiome</li> </ul>	<ul style="list-style-type: none"> <li>■ Community illness</li> <li>■ Exposure</li> <li>■ Herd immunity</li> </ul>	<ul style="list-style-type: none"> <li>■ Sanitation</li> <li>■ Immunization</li> <li>■ Pathogen exposure</li> </ul>
Healthcare system	<ul style="list-style-type: none"> <li>■ Insurance coverage</li> <li>■ Health literacy</li> <li>■ Treatment preferences</li> </ul>	<ul style="list-style-type: none"> <li>■ Patient–client relationship</li> <li>■ Medical decision-making</li> </ul>	<ul style="list-style-type: none"> <li>■ Availability of services</li> <li>■ Safety net services</li> </ul>	<ul style="list-style-type: none"> <li>■ Quality of care</li> <li>■ Healthcare policies</li> </ul>
Physical/built environment	<ul style="list-style-type: none"> <li>■ Personal environment</li> </ul>	<ul style="list-style-type: none"> <li>■ Household environment</li> <li>■ School or work environment</li> </ul>	<ul style="list-style-type: none"> <li>■ Community environment</li> <li>■ Community resources</li> </ul>	<ul style="list-style-type: none"> <li>■ Society structure</li> </ul>
Sociocultural environment	<ul style="list-style-type: none"> <li>■ Sociodemographics</li> <li>■ Limited English</li> <li>■ Cultural identity</li> <li>■ Response to discrimination</li> </ul>	<ul style="list-style-type: none"> <li>■ Social networks</li> <li>■ Family or peer norms</li> <li>■ Interpersonal discrimination</li> </ul>	<ul style="list-style-type: none"> <li>■ Community norms</li> <li>■ Local structural discrimination</li> </ul>	<ul style="list-style-type: none"> <li>■ Social norms</li> <li>■ Societal structural discrimination</li> </ul>

<sup>a</sup> Individual level of influence

<sup>b</sup> Interpersonal level of influence

<sup>c</sup> Community level of influence

<sup>d</sup> Societal level of influence

**Note.** Based on information from National Institute on Minority Health and Health Disparities, 2022.

Nurses make up the largest group of clinicians in the healthcare system, with more than three times as many nurses as physicians, and they have the most contact with patients (American Association of Colleges of Nursing, 2019). Therefore, cancer disparities could greatly decrease if oncology nurses work at the interpersonal level to improve outcomes for Black patients within the healthcare system. However, little has been established about how nurses may optimally communicate with Black patients for improved experiences within the medical system. This problem is compounded because Black nurses are underrepresented in health care, with only 6.2% of RNs in 2017 identifying as Black or African American (Smiley et al., 2018). Because of structural racism, Black nurses are underrepresented in the healthcare system, leading to frequent patient–clinician racial discordance, and perpetuating the effects of structural racism on patient outcomes (Jones, Hirschev, Campbell, Cooley, Somayaji, et al., 2021). Black patients who receive care from racially discordant providers report less satisfying care than

their White peers, citing a decrease in communication quality as evidenced by receiving less information, participating less in conversations, and engaging in less joint decision-making (Shen et al., 2018). The purpose of this literature review is to provide a synthesis of what has been identified about patient–clinician communication to inform how nurses can improve interpersonal interactions in the oncologic healthcare system, thus improving cancer outcomes for Black patients.

### Methods and Design

This literature review was conducted following Preferred Reporting Items for Systematic Reviews and Meta-Analyses guidelines (Moher et al., 2009), and the protocol is not published elsewhere.

### Researcher Positionality

This research was conducted and interpreted by individuals who carry with them identities and experiences that affect how they interpret the world, including research. Despite the traditional objective approaches

to science, the team actively acknowledged and considered their relative position to the focus of this study: Black individuals living beyond a cancer diagnosis. Positionality refers to where one is socially located, which shapes one's worldviews and has a significant effect on how researchers interpret data (Darwin Holmes, 2020; Jacobson & Mustafa, 2019). Particularly relevant identities of this research team included Black women (three scholars), White women (three scholars), nurses (four), and health equity scholars (four). Their backgrounds have given this team access to unique experiences, including advocating for health equity in their communities and families, and being or having been a first-generation college student, a low-income college student, and a recipient of formal racial equity training. As part of the team's process, each member's unique positionality was acknowledged, and their experiences were applied to interpret data respectfully and meaningfully.

#### Literature Search and Study Selection

A health sciences librarian systematically searched for studies in PubMed®, CINAHL® with Full Text (EBSCOhost), and Scopus® with the last search date of September 29, 2021. Initial searches included only articles that focused on nurse-patient communication; however, because of few results, the search was expanded to include oncology clinicians. A combination of subject headings and keywords were searched for the following main concepts: (a) cancer, (b) African American, and (c) health communication. Each concept was searched with synonyms separated by the Boolean operator "or."

After duplicates were removed, 935 titles and abstracts were screened independently by two researchers for eligibility. Subsequently, 71 full-text articles were reviewed to determine if they met criteria for inclusion. Studies were included if they (a) had a sample population with a cancer diagnosis of any kind; (b) included information specific to Black or African American participants; and (c) included information on patient-clinician communication. All study designs were included, and no date restrictions were set. With an aim to understand communication with people who had been diagnosed with cancer, articles that focused on screening or prevention were excluded. Ultimately, 24 full-text articles met criteria and were included in this review (see Figure 1).

#### Data Abstraction, Synthesis, and Evaluation

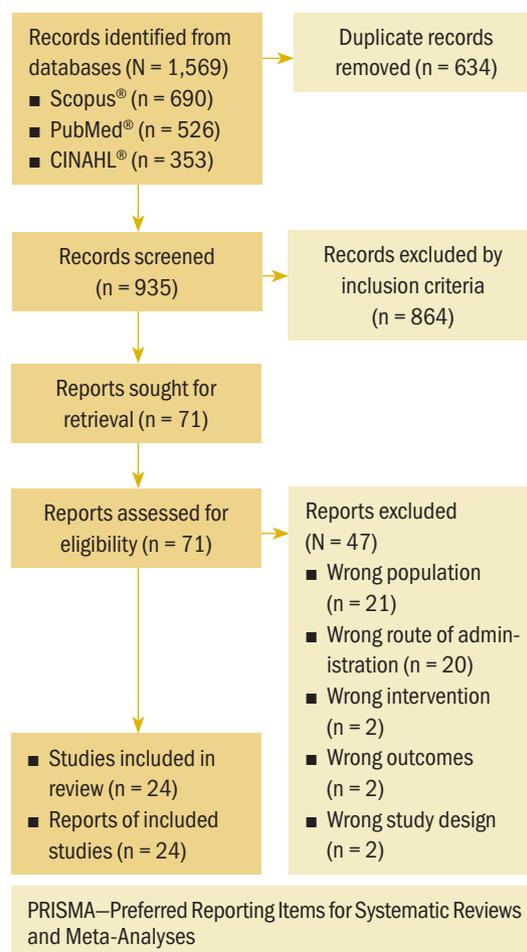
Data were abstracted from the 24 articles by one author and then were reviewed by two authors to

confirm accuracy. Information about each study was abstracted, including the study purpose, design, methods, limitations, location, sample size, and sample characteristics. The main findings and conclusions were also abstracted from each article and were later synthesized by two authors. Following the Matrix Method (Garrard, 2013), data from each study were reviewed by two authors to synthesize this body of research and identify common themes across the studies. Each article was scored using Melnyk's Levels of Evidence (Melnyk & Fineout-Overholt, 2015).

#### Results

Although no date restrictions were set, articles that met inclusion for this review were published between 2001 and 2018. Most studies were qualitative ( $n = 14$ ) or cohort designs ( $n = 8$ ). There were also two expert

**FIGURE 1. PRISMA Flow Diagram for Identification of Studies Via Databases and Registries**



opinion manuscripts. Overall, this body of literature provides a low level of evidence for translation of findings into clinical practice (Melnyk & Fineout-Overholt, 2015) and highlights the need for nursing research focused on how nurses can best communicate with Black patients to produce meaningful improvements in patient outcomes. Study samples included participants with many different cancer diagnoses across the southern, western, and northeastern regions of the United States. Sample sizes ranged from 14 to 1,572. Racial categories are reported as they were reported in the original studies (e.g., if a study reports a group as African American, this study reports African American; if a study reports a group as Caucasian, this study reports Caucasian). Table 2 presents an overview of included studies, and Table 3 provides an overview of clinicians referred to in each manuscript as well as the racial and ethnic descriptions of study participants and referenced clinicians.

Across studies, the following common themes related to quality patient–clinician communication were identified: relationship building, building trust, empowering patients for shared decision-making, addressing topics of patient concern (e.g., psychosocial needs, long-term needs including follow-up care, pain management, side effects and treatment, end-of-life discussions), and consideration of community and family.

### Relationship Building

Across studies, the patient–clinician relationship emerged as a significant factor in communication. Numerous studies identified a need for improved relationships between clinicians and Black patients (Gordon, Street, Sharf, Kelly, & Soucek, 2006; Siminoff et al., 2006; Song et al., 2012; Trice & Prigerson, 2009). Trice and Prigerson (2009) noted that strong patient–clinician relationships improve both the clinician’s ability to share difficult information with a patient and the patient’s emotional acceptance of the information; gaps in this communication process arise when clinicians paternalistically limit the information shared with patients. A mixed-methods study by Gordon, Street, Sharf, Kelly, and Soucek (2006) found that doctors may recommend different courses of treatment to Black patients (compared to White patients) based on their assumptions about the patients’ desires. Importantly, these assumptions were affected by providers’ biases (Gordon, Street, Sharf, Kelly, & Soucek, 2006), which do not go unnoticed by patients. Song et al. (2012) identified that relationships between African American patients and

their providers deteriorate upon the patients’ perception that a clinician does not care if they understand the information being communicated. Siminoff et al. (2006) explained that oncologists engage in less relationship building with non-White patients compared to White patients, particularly by engaging in less personal or social conversation. Taken together, these studies suggest that provider bias may limit the extent to which clinicians attend to patient comprehension during relationship building, which has deleterious effects on patient outcomes.

### Building Trust

Trust emerged as a central component of positive and effective patient–clinician communication across studies. Manfredi et al. (2010) identified that when Black patients with cancer trust clinicians, they are more active in conversations and seek additional information. However, several studies identified a lack of trust as a barrier to positive communication between clinicians and Black patients (Gordon, Street, Sharf, Kelly, & Soucek, 2006; Matthews et al., 2002; Song et al., 2014). Matthews et al. (2002) found 24%–33% of African American patients with cancer reported they felt their providers withheld information, did not understand information given to them, left their appointment with unanswered questions, and had problems telling providers about new symptoms.

Several studies also identified factors that improve trust among Black patients. Song et al. (2012) reported that trust increases among African American patients when providers (a) convey that they care for and respect the patient, (b) include references to religion in conversations, and (c) share anecdotal evidence of their own experiences. The importance of religion was further supported in a study where religious individuals (who self-identified as African American or Caucasian American) reported higher levels of trust in their physicians (Song et al., 2014). Finally, Black patients reported greater trust when they were cared for by Black clinicians (Gordon, Street, Sharf, Kelly, & Soucek, 2006).

### Shared Decision-Making

Shared decision-making and active participation improve the quality of communication. Multiple studies found that most patients rely on their clinicians to provide the information necessary for effective decision-making (Anderson et al., 2002; Cohen et al., 2013; Eggly et al., 2013; Royak-Schaler et al., 2008; Schubart et al., 2015). Breakdowns in this

**TABLE 2. Study Characteristics (N = 24)**

Study	Design	N	Level of Evidence	Purpose	Cancer Diagnosis in Sample (%)
Anderson et al., 2002	Qualitative	31	6	Examine pain management barriers among African American and Hispanic patients with cancer.	<ul style="list-style-type: none"> <li>■ Breast (35)</li> <li>■ Gastrointestinal (16)</li> <li>■ Lung (16)</li> <li>■ Hematologic (13)</li> <li>■ Prostate (13)</li> <li>■ Other (7)</li> </ul>
Bires et al., 2018	Qualitative	30	6	Examine challenges and beliefs about advance care planning among patients undergoing cancer treatment.	<ul style="list-style-type: none"> <li>■ Breast (25)</li> <li>■ Not reported (75)</li> </ul>
Christian et al., 2017	Qualitative	34	6	Assess patient-provider communication about cardiovascular risk factors and information needs among breast cancer survivors.	<ul style="list-style-type: none"> <li>■ Breast (100)</li> </ul>
Cohen et al., 2013	Qualitative	60	6	Describe the role of health literacy on patient experiences with hematopoietic stem cell transplantation.	<ul style="list-style-type: none"> <li>■ Hematologic undergoing stem cell transplantation (100)</li> </ul>
Eggly et al., 2013	Qualitative	19	6	Inform an intervention focused on improving oncologist communication with Black patients.	<ul style="list-style-type: none"> <li>■ Breast (58)</li> <li>■ Colorectal (26)</li> <li>■ Lung (16)</li> </ul>
Gordon, Street, Sharf, Kelly, & Soucek, 2006	Cohort	103	4	Assess if racial differences in trust are related to patient-physician communication.	<ul style="list-style-type: none"> <li>■ Lung (100)</li> </ul>
Gordon, Street, Sharf, & Soucek, 2006	Qualitative	137	6	Examine variation in information that doctors give to Black patients compared to White patients.	<ul style="list-style-type: none"> <li>■ Lung (100)</li> </ul>
Huskamp et al., 2009	Cohort	1,517	4	Identify factors associated with patient-physician discussions about hospice within 7 months of a lung cancer diagnosis.	<ul style="list-style-type: none"> <li>■ Lung (100)</li> </ul>
Ingersoll et al., 2019	Cohort	231	4	Examine differences in conversations about prognosis by race.	<ul style="list-style-type: none"> <li>■ Breast, prostate, or colorectal (22)</li> <li>■ Lung (22)</li> <li>■ Gastrointestinal/noncolorectal (18)</li> <li>■ Other/unknown (38)</li> </ul>
Jean-Pierre et al., 2010	Cohort	973	4	Examine the role of the patient demographics in a patient's concern over understanding a cancer diagnosis and various treatments.	<ul style="list-style-type: none"> <li>■ Breast (47)</li> <li>■ Genitourinary (16)</li> <li>■ Lung (14)</li> <li>■ Gastrointestinal (9)</li> <li>■ Hematologic (8)</li> <li>■ Gynecologic (5)</li> <li>■ Other (1)</li> </ul>

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**TABLE 2. Study Characteristics (N = 24) (Continued)**

Study	Design	N	Level of Evidence	Purpose	Cancer Diagnosis in Sample (%)
Kantsiper et al., 2009	Qualitative	52	6	Explore the needs and priorities of oncology providers, primary care providers, and breast cancer survivors.	■ Breast (100)
Maliski et al., 2006	Qualitative	28	6	Describe baseline knowledge, information received, information sources, and helpful knowledge among men of various ethnicities diagnosed with prostate cancer.	■ Prostate (100)
Manfredi et al., 2010	Cohort	492	4	Determine factors that explain race differences in patient-physician communication.	■ Prostate (100)
Matthews et al., 2002	Qualitative	21	6	Examine challenges and beliefs about advance care planning among patients undergoing cancer treatment.	■ Breast (76) ■ Colon (14) ■ Ovarian (5) ■ Prostate (5)
Mott-Coles, 2014	Qualitative	14	6	Describe providers' perceptions of their communication with African American and Latina patients with breast cancer.	■ Breast (100)
O'Malley et al., 2016	Cohort	278	4	Determine characteristics that influence follow-up care among cancer survivors.	■ Breast (68) ■ Prostate (32)
Rice & Sheridan, 2001	Expert opinion	-	7	Discuss ways that underrepresented groups access health care and their concerns.	-
Royak-Schaler et al., 2008	Qualitative	39	6	Investigate patient perspectives about patient-physician communication on breast cancer survivorship care.	■ Breast (100)
Royak-Schaler et al., 2009	Qualitative	39	6	Investigate African American and Caucasian breast cancer survivors' follow-up care and perspectives about physician communication of survivorship guidelines.	■ Breast (100)
Schubart et al., 2015	Qualitative	14	6	Identify key issues that affect treatment in Black women diagnosed with breast cancer.	■ Breast (100)
Siminoff et al., 2006	Cohort	405	4	Examine characteristics that influence patient-physician communication.	■ Breast (100)
Song et al., 2012	Qualitative	28	6	Explore the perspective of Black patients on provider communication and how it affects patient outcomes.	■ Breast (54) ■ Prostate (46)
Song et al., 2014	Cohort	1,854	4	Examine racial differences in associations between sociocultural factors and patient-provider communication.	■ Prostate (100)

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**TABLE 2. Study Characteristics (N = 24) (Continued)**

Study	Design	N	Level of Evidence	Purpose	Cancer Diagnosis in Sample (%)
Trice & Prigerson, 2009	Expert opinion	-	7	Review differences by race and ethnicity in end-of-life communication between oncologists and patients with cancer.	-

**Note.** For levels of evidence, 1 indicates the highest quality and 7 indicates the lowest quality, as determined using Melnyk’s Levels of Evidence.

**Note.** Racial categories reflect the studies’ classifications and categories.

**Note.** Some data are unavailable because the study’s design was an expert opinion that discussed cancer broadly without evaluating specific cancer types.

communication process have tangible effects on patient outcomes. A qualitative study with 39 African American female survivors of breast cancer found that more complete conversations led to greater adherence to care plan guidelines (Royak-Schaler et al., 2009). A correlation between free-flowing information and active patient participation also emerged across studies. A quantitative study with 325 survivors of breast or prostate cancer (86% of survivors were White and 14% were Black) found that patients who actively seek information are more likely to comply with the care plan (O’Malley et al., 2016). Schubart et al. (2015) found that patients are more likely to be active participants when they are given information to feel empowered to make decisions. Similarly, Song et al. (2012) found that patients with insufficient knowledge surrendered decision-making power to physicians.

Researchers found that race plays a significant role in the quality of shared decision-making and the patient’s active participation in care because Black patients consistently receive less information from clinicians compared to White patients. For example, one study in which patient–physician consultations were audio recorded and coded to objectively identify physicians’ information-giving patterns and patients’ active participation, identified that Black patients received significantly less information about lung cancer treatment options from a doctor or physician assistant compared to White patients (Gordon, Street, Sharf, & Soucek, 2006). Similarly, in another mixed-methods study, through analysis of audio-recorded consultations, using established and reliable methods to code for presence of prognosis communication, it was identified that providers discussed prognosis more frequently with non-Black and non-Latino patients, as compared to Black and Latino patients (Ingersoll et al., 2019). These results are further supported by the findings of Trice and

Prigerson’s (2009) expert opinion article that identified patient-reported quality of physician communication as lower for Black patients compared to White patients. Because Black patients may not be given sufficient information to feel empowered to be involved in their own care, they may engage in less shared decision-making. Another study of 137 Black and White patients with lung cancer found that Black patients were less likely to be active participants in their care and to participate in shared decision-making conversations (Gordon, Street, Sharf, Kelly, & Soucek, 2006). Several studies noted a difference in information gathering between White and Black patients. O’Malley et al. (2016) found that the level of active participation was not a significant indicator of whether the patient would want additional information. In a quantitative cross-sectional survey of 492 patients with cancer who identified as Black or White, Manfredi et al. (2010) found that, after controlling for socioeconomic factors, Black patients were just as likely to be comfortable asking questions as White patients, but still felt they needed more information, even after asking questions. Similarly, Jean-Pierre et al. (2010) reported that White and non-White patients demonstrated a significant difference in understanding diagnosis and treatment plans after controlling for education, age, gender, and occupation. A final component of shared decision-making is an awareness of the patient’s cultural values. However, a qualitative study of 14 providers found that they did not address cultural needs when offering education (Mott-Coles, 2014).

**Influences on Patients’ Active Participation and Shared Decision-Making**

Several studies found that patient–provider communication is also affected by socioeconomic characteristics (Manfredi et al., 2010; Rice & Sheridan, 2001; Royak-Schaler et al., 2009; Song et

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al., 2014). For example, a qualitative study with 39 African American female survivors of breast cancer found that patients with lower literacy levels were less likely to ask questions compared to patients with higher literacy levels (Royak-Schaler et al., 2008). Manfredi et al. (2010) identified that patients with higher income were more likely to ask questions, regardless of race.

Although socioeconomic differences may contribute to patient participation, racial differences remain. In a qualitative study of 973 patients with cancer (904 reported as White and 69 reported as non-White), socioeconomic variation was controlled, yet behavioral differences were identified between racial groups (Jean-Pierre et al., 2010). These findings are underscored by a qualitative study of 21 African American men and women with cancer that found African American individuals may decide not to seek information because of fear of what they will be told, because of traumatic emotional experiences of witnessing family members go through cancer, or because they may consider cancer taboo and feel ashamed to have cancer (Matthews et al., 2002). However, several other studies showed no difference in the desire to actively participate between Black and White patients and reported that Black patients wanted to be more involved in their own care (Manfredi et al., 2010; Royak-Schaler et al., 2008; Schubart et al., 2015). Yet, in a quantitative cross-sectional survey of 492 patients with cancer who identified as either Black or White, Black patients reported more interpersonal communication differences and unmet information needs than their White counterparts (Manfredi et al., 2010). This may be related to the physician's race. A mixed-methods study of 137 Black and White patients with lung cancer found that racial concordance between patients and clinicians increased active participation in both groups (Gordon, Street, Sharf, Kelly, & Soucek, 2006).

## Topics of Patient Concern

### Psychosocial Needs

The literature suggests that Black patients with cancer are in need of more psychosocial support from their clinicians. A study examining conversations between 58 oncologists (33% non-White, 67% White) and 405 patients with cancer (20% non-White, 80% White) found that psychosocial assessments were less present in conversations with Black patients compared to White patients (Siminoff et al., 2006). Similarly, in another study, African American men and women

with cancer (n = 21) reported a need for more emotional support (Matthews et al., 2002). The findings are consistent with prior research demonstrating that African American, Chinese, and Filipino patients with prostate cancer (n = 41) reported concerns about psychosocial side effects (Maliski et al., 2006).

Importantly, studies identified that these unmet psychosocial needs affect patient outcomes. For example, African American survivors of breast cancer associate emotional support from their clinicians with effective treatment (Kantsiper et al., 2009). The need for such emotional support increases with patients' understanding of their situations. One study found that Black and White patients with breast or prostate cancer (n = 325) who actively sought information reported needing more psychological support, suggesting that increased participation in care increases understanding, which may in turn increase psychological needs (O'Malley et al., 2016).

### Pain

Only one study assessed pain management. Anderson et al. (2002) identified several shortcomings in pain management for Black patients, including (a) lack of information about pain management, (b) most patients not asking for medication until pain was rated 10 of 10, (c) patients taking less than prescribed pain medication doses, and (d) physicians not assessing pain and not using pain scales. This study found that 25% of Black participants reported difficulty receiving opioid prescriptions, and nearly 50% reported difficulty talking to providers about their pain. Hispanic participants did not report either of these problems (Anderson et al., 2002).

### Side Effects and Treatment

Across studies, Black patients with cancer reported a need for more information about their prescribed treatments and the side effects of cancer and treatments (Eggly et al., 2013; Jean-Pierre et al., 2010; Maliski et al., 2006). For example, in a qualitative study of Black breast, colorectal, and lung cancer survivors, participants stressed the importance of clinicians discussing potential causes of their cancer, including genetic information, as well as treatment options, schedules, and potential impacts on life (Eggly et al., 2013). In another qualitative exploratory study with 41 patients with prostate cancer (15 Black, 13 White, 6 Chinese, 7 Filipino), Black participants wanted more information about treatment side effects and efficacy, while White participants wanted more information about treatment

**TABLE 3. Type of Clinicians and Racial and Ethnic Characteristics of Patients and Clinicians Reported in Each Study**

Study	Reported Race and Ethnicity of Patients (%)	Reported Race and Ethnicity of Clinicians	Type of Clinicians
Anderson et al., 2002	<ul style="list-style-type: none"> <li>■ African American (45)</li> <li>■ Hispanic (55)</li> </ul>	-	<ul style="list-style-type: none"> <li>■ Asked open-ended questions not focused on a specific type of clinician</li> </ul>
Bires et al., 2018	<ul style="list-style-type: none"> <li>■ Black (55)</li> <li>■ White (45)</li> </ul>	-	<ul style="list-style-type: none"> <li>■ Physicians</li> <li>■ Nurse practitioners</li> <li>■ Healthcare providers</li> </ul>
Christian et al., 2017	<ul style="list-style-type: none"> <li>■ African American (44)</li> <li>■ Caucasian/White (56)</li> </ul>	-	<ul style="list-style-type: none"> <li>■ Physicians</li> </ul>
Cohen et al., 2013	<ul style="list-style-type: none"> <li>■ African American (33)</li> <li>■ Caucasian (33)</li> <li>■ Latino (33)</li> </ul>	-	<ul style="list-style-type: none"> <li>■ Nurses</li> <li>■ Doctors</li> </ul>
Eggy et al., 2013	<ul style="list-style-type: none"> <li>■ Black (100)</li> </ul>	-	<ul style="list-style-type: none"> <li>■ Oncologists</li> </ul>
Gordon, Street, Sharf, Kelly, & Soucek, 2006	<ul style="list-style-type: none"> <li>■ Black (22)</li> <li>■ White (78)</li> </ul>	<ul style="list-style-type: none"> <li>■ White concordant (White patient and physician) (50%)</li> <li>■ White discordant (White patient and non-White, Asian, or Hispanic physician) (28%)</li> <li>■ Black discordant (Black patient and non-Black physician) (22%)</li> </ul>	<ul style="list-style-type: none"> <li>■ Physicians</li> </ul>
Gordon, Street, Sharf, & Soucek, 2006	<ul style="list-style-type: none"> <li>■ Black (22)</li> <li>■ White (78)</li> </ul>	<ul style="list-style-type: none"> <li>■ Asian (n = 5)</li> <li>■ Black (n = 2)</li> <li>■ White Hispanic (n = 2)</li> <li>■ White non-Hispanic (n = 8)</li> </ul>	<ul style="list-style-type: none"> <li>■ Medical doctors</li> <li>■ Physician assistants</li> </ul>
Huskamp et al., 2009	<ul style="list-style-type: none"> <li>■ Asian (5)</li> <li>■ Black (11)</li> <li>■ Hispanic (6)</li> <li>■ White (74)</li> <li>■ Other (4)</li> </ul>	-	<ul style="list-style-type: none"> <li>■ Physicians</li> </ul>
Ingersoll et al., 2019	<ul style="list-style-type: none"> <li>■ Black or Latino (21)</li> <li>■ Non-Black or non-Latino (79)</li> </ul>	<ul style="list-style-type: none"> <li>■ Black or Latino (4%)</li> </ul>	<ul style="list-style-type: none"> <li>■ Physicians</li> <li>■ Nurse practitioners</li> </ul>
Jean-Pierre et al., 2010	<ul style="list-style-type: none"> <li>■ Non-White (7)</li> <li>■ White (93)</li> </ul>	-	<ul style="list-style-type: none"> <li>■ Providers</li> </ul>
Kantsiper et al., 2009	<ul style="list-style-type: none"> <li>■ Caucasian (76)</li> <li>■ Unspecified (but includes African American) (24)</li> </ul>	-	<ul style="list-style-type: none"> <li>■ Physicians</li> <li>■ Nurses</li> </ul>
Maliski et al., 2006	<ul style="list-style-type: none"> <li>■ African American (36)</li> <li>■ Caucasian (32)</li> <li>■ Chinese (15)</li> <li>■ Filipino (17)</li> </ul>	-	<ul style="list-style-type: none"> <li>■ Asked open-ended questions not focused on a specific type of clinician</li> </ul>
Manfredi et al., 2010	<ul style="list-style-type: none"> <li>■ African American (50)</li> <li>■ White (50)</li> </ul>	-	<ul style="list-style-type: none"> <li>■ Physicians</li> </ul>

*Continued on the next page*

**TABLE 3. Type of Clinicians and Racial and Ethnic Characteristics of Patients and Clinicians Reported in Each Study (Continued)**

Study	Reported Race and Ethnicity of Patients (%)	Reported Race and Ethnicity of Clinicians	Type of Clinicians
Matthews et al., 2002	■ African American (100)	-	■ Most interview questions focused on physicians; one focused on nurses.
Mott-Coles, 2014	-	■ African American (21%) ■ Caucasian (58%) ■ Latino (21%)	■ Physicians ■ Nurses ■ Ultrasound ■ Mammography technicians
O'Malley et al., 2016	■ Black/African American (14) ■ White (86)	-	■ Cancer-related clinicians ■ Primary care providers
Rice & Sheridan, 2001	-	-	■ Nurses
Royak-Schaler et al., 2008	■ African American (100)	-	■ Physicians
Royak-Schaler et al., 2009	■ African American (30) ■ Caucasian (70)	■ African American (5%) ■ Caucasian (68%) ■ Other (27%) ■ Racial concordance among Caucasians (75%) and African Americans (17%)	■ Physicians
Schubart et al., 2015	■ African American (100)	-	■ Asked open-ended questions not focused on a specific type of clinician
Siminoff et al., 2006	■ Non-White (20) ■ White (80)	■ Non-White (33%) ■ White (67%)	■ Physicians
Song et al., 2012	■ African American (100)	-	■ Physicians ■ Nurses ■ Other medical personnel
Song et al., 2014	■ African American (50) ■ Caucasian American (50)	-	■ Physicians ■ Nurses
Trice & Prigerson, 2009	-	-	■ Physicians

**Note.** Some data are unavailable because the study did not collect it or the study's design was an expert opinion.

**Note.** Racial categories reflect the studies' classifications and categories.

**Note.** Because of rounding, percentages may not total 100.

options (Maliski et al., 2006). Similarly, in a qualitative survey for a needs assessment of 973 patients with cancer (904 White, 69 non-White), non-White patients showed more desire for information about diagnosis and treatment plans than White patients (Jean-Pierre et al., 2010).

Although some studies have identified that patient concerns vary by race, others have found similarities across all racial or ethnic groups and genders. For

example, one study in which 20 Caucasian, 20 Latino, and 20 Black cancer survivors were interviewed, the same concerns emerged across all participants as follows: (a) providers not assessing patient understanding, (b) patients not receiving enough information for treatment decisions, (c) fear of dying, (d) tough symptoms and side effects, and (e) relying on others (Cohen et al., 2013). Similar concerns were identified in a quantitative study containing 325

patients with breast or prostate cancer (86% White, 14% Black). Patients requested that their long-term care include coordination of all aspects of care, follow-up care, and continuing discussions about care plans (O'Malley et al., 2016).

### Health Behaviors

Multiple studies identified health behaviors that require increased attention in the Black population. Across studies, Black patients felt that discussion of diet and physical activity was missing in their care (Christian et al., 2017; Kantsiper et al., 2009; Royak-Schaler et al., 2008). In particular, Christian et al. (2017) found that Black survivors of breast cancer did not receive the assessment and follow-up care necessary to prevent cardiovascular incidents. In particular, although 47% of Black participants were obese, 90% of Black participants said that there was no mention of diet or exercise in follow-up care (Christian et al., 2017).

### End-of-Life Discussions

Two studies highlighted the need for better discussions about end-of-life care with Black patients. One study found that among 1,517 patients diagnosed with metastatic lung cancer, Black and Hispanic patients were significantly less likely to have discussed hospice with a provider compared to White or Asian patients ( $p < 0.001$ ) (Huskamp et al., 2009). In another qualitative study involving 20 patients with cancer and 10 providers in which 55% of patients were Black, all White participants were familiar with advance directives, while only 45.5% of the Black participants were (Bires et al., 2018). The same study reported that 55.6% of White participants had completed an advance directive, while only 18.2% of Black patients had (Bires et al., 2018). However, Bires et al. (2018) also found that 72.7% of Black participants, compared to only 11.1% of White participants, preferred that their doctor initiate conversations about advance care planning. Although these differences were not statistically significant, they were clinically significant. Bires et al. (2018) suggested that the lack of discussions about advance care planning, particularly with Black patients reporting a preference for providers to initiate these conversations, may be because the provider assumes the patient would likely choose aggressive treatment options.

### Consideration of Community and Family

Family support and community beliefs about cancer

were shown to be major influences on patients' ideas about treatment, diagnosis, and coping (Kantsiper et al., 2009; Matthews et al., 2002; Schubart et al., 2015; Song et al., 2012). For example, in a qualitative descriptive study with 14 African American patients with breast cancer, prior experiences with cancer through friends and family frequently shaped the participant's views about treatment, regardless of the information they were given (Schubart et al., 2015). In addition, patients relied heavily on family and community members for medical information (Schubart et al., 2015). In a qualitative study of 21 Black individuals with cancer, family members and friends were cited as the largest providers of health information, followed by pamphlets and doctors (Matthews et al., 2002). Maliski et al. (2006) reported that African American men associated prostate cancer with death. Similarly, a qualitative study of 21 Black men and women with cancer found that many Black patients believe cancer means death and value anecdotal evidence from family and friends, which perpetuated a lack of understanding among study participants (Matthews et al., 2002).

Religion also played a large role in perceiving the disease for many Black patients across studies. A qualitative study of 21 Black men and women with cancer found that patients were fearful of learning medical information because they may "lose faith in God" (Matthews et al., 2002, p. 216). In contrast, in another qualitative study with 60 (20 Black, 20 Caucasian, and 20 Latino) patients, researchers found that religion was a large source of support (Cohen et al., 2013). Across studies, it was found that religious beliefs could affect patients' beliefs in different ways; some may believe that God's will would guide their cancer outcomes regardless of treatments, others may believe that God put the needed clinicians in their life to care for them, and some simply found support in their religion to deal with illness.

Addressing views and information given by family and community members is integral to understanding the patient's treatment preferences. However, some patients may not want to talk about their cancer with family and friends. A secondary data analysis of qualitative interviews of 28 Black patients with cancer found that Black patients are not likely to discuss cancer openly in their community (Kantsiper et al., 2009; Song et al., 2012). In some communities, cancer is a taboo topic, and inaccurate or incomplete information within the community can cause misinformation for patients with cancer (Matthews

et al., 2002). Such beliefs may create a cognitive dissonance from cancer. For example, a qualitative exploratory study with 41 (15 Black, 6 Chinese, 7 Filipino, 13 White) patients with prostate cancer found that many African American participants indicated that despite knowing the increased prostate cancer risk among African American men, they did not internalize this risk (Maliski et al., 2006).

## Discussion and Findings

This review found the following considerations important for improving communication between clinicians and Black patients: relationship building, building trust, empowering patients for shared decision-making, addressing topics of patient concern, and consideration of community and family. These findings are supported by another scoping review that highlighted needs for improving culturally appropriate nursing care, empowering patients, and managing adverse effects of cancer treatment to improve patient outcomes for Black survivors of cancer (Vo et al., 2021).

Several articles included in this review point to the need for positive clinician–patient relationships. This is particularly important among patients with cancer, because a cancer diagnosis is accompanied by fear and uncertainty as well as the need to understand new, complex information and to make timely decisions about treatment (Song et al., 2014; Trice & Prigerson, 2009). In addition, Palmer Kelly et al. (2021) highlighted the need for improved patient–provider relationships beyond the initial cancer diagnosis. Positive relationships are built on trust, yet Black patients have experienced centuries of mistreatment and violence at the hands of the medical system, which has made the medical system untrustworthy (Jones, Hirschey, Campbell, Cooley, Somayaji, et al., 2021). As the most trusted profession (Reinhart, 2020), nurses can lead the way in rebuilding the healthcare system to be trustworthy. These efforts will take time and dedication from nurses, and should include empathetic curiosity, learning focused on the injustices patients face, engagement with communities, self-reflection, and cultural humility (Gray et al., 2021; Nolan et al., 2021). Updates to the Oncology Nursing Society Research Agenda provide guidance for oncology nurses to earn patient trust by listening with humility and engaging in culturally targeted communication to provide person-centered care (Jones, Hirschey, Campbell, Cooley, Lally, et al., 2021; Jones, Hirschey, Campbell, Cooley, Somayaji, et al., 2021). These recommendations also highlight

the critical need for efforts focused on developing a trustworthy nursing workforce that is racially and ethnically representative of the population (Jones, Hirschey, Campbell, Cooley, Lally, et al., 2021).

Findings in this review indicate that religious beliefs may have variable impacts on patient beliefs about cancer and treatment decisions. These findings are supported by another review, which highlighted how religion is related to improved patient outcomes in cancer care for some, yet associated with adverse outcomes for others (Palmer Kelly et al., 2020). These findings point to the need for a person-centered approach, which can be guided by transcultural nursing theory, highlighting the understanding and respect of a patient’s culture as foundational to meeting a patient’s needs (Giger & Davidhizar, 2002; Papadopoulos & Omeri, 2008). In addition, communication can be guided by the Giger and Davidhizar (2002) Transcultural Assessment Model, which includes an assessment of communication (e.g., between the patient or family, language, body language, vernacular language, slang), space (non-verbal communication), social organization (how the patient or family views themselves within the culture of religion, values), time (the patient’s or family’s view of time), disease environment control (i.e., whether the disease was placed by a deity or if there is an environmental cure), and biologic variations (genetic variations that may affect a specific cultural group) (Giger & Davidhizar, 2002). These models provide a framework for understanding and caring for patients with beliefs that may be different from members on the care team. Holistic, person-centered care focused on building trust and respecting culture can facilitate improved patient–clinician communication and, ultimately, better patient outcomes.

Finally, these findings indicate that nurses should focus on a comprehensive approach to nursing care that promotes wellness through diet, physical activity, and communication around pain management. Pain assessment is a core responsibility of oncology nurses and is an area where nurses are integral to achieving equitable patient outcomes.

## Limitations

This review had limitations that need to be taken into consideration when interpreting its results. First, despite following a methodologic protocol and the objective procedures of scientific inquiry, people inherently and subconsciously bring their identities and experiences to their interpretation and synthesis of

information. Thus, it is possible that the lived experiences of the first and senior author of this review—both White nurses—may have introduced bias into the interpretation of findings in this review. To decrease this risk, the racially diverse team of authors were reflective and collaborative throughout analysis and interpretation to consider how their identities and experiences relate to those of Black patients with cancer.

Second, although the initial intent of this review was to focus on nurse communication with Black patients being treated for cancer, too few articles had been published on this topic; therefore, the scope was expanded to include all oncology clinicians. The majority of included articles focus on physician–patient communication; consequently, findings must be interpreted within that context. Future nursing research should focus on establishing best practices for oncology nurse–patient communication. In addition, it is noted that this body of literature contains mostly descriptive work. Rich qualitative research is valuable to understand experiences and inform real change. However, it is important that future research move beyond simply describing problems and disparities, and focus on establishing nursing interventions to achieve equitable outcomes for all patients.

### Implications for Nursing

For a multitude of reasons, nurses are ideally positioned to work for equitable outcomes among all patients with cancer. As the most trusted profession, nurses may lead the way for establishing a trustworthy healthcare system for Black patients (Reinhart, 2020). In addition, nurses have more face-to-face time with patients compared to other members of the oncology care team. Nurses may use this time to listen to patients with cultural humility and build new understandings of patient–community experiences and needs that may inform practice change across disciplines. As recommended by Nolan et al. (2021), nurses can equip themselves to provide care with cultural humility by assessing their implicit and unconscious bias through the Harvard Implicit Association Test (Project Implicit, 2011), and seeking antiracism training through organizations, such as the Racial Equity Institute (2022) and Academics for Black Survival and Wellness (2021). Finally, patient advocacy is at the core of the nursing profession, and oncology nurses may therefore contribute to significant systemic change through policy action with support from the Oncology Nursing Society (2021). Findings indicate a need for research

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### KNOWLEDGE TRANSLATION

- Oncology nurse clinicians can lead the way in increasing trustworthiness of the oncology care system.
  - It is critical for oncology nurse clinicians to provide person-centered care and to practice cultural humility to mitigate racial disparities in cancer care using interpersonal approaches.
  - There is a need for research to expand the role of the patient–nurse relationship and improve communication to alleviate cancer care disparities.
- 

to identify and test multilevel strategies that oncology nurses can use to promote health equity for all patients through individual, interpersonal, and systems-level change.

### Conclusion

Oncology nurses can lead the way in building trustworthy systems for Black patients with cancer to experience improved and equitable health outcomes. It is critical that person-centered approaches focused on relationships, trust, and shared decision-making are applied. In addition, cultural humility must be practiced by nurses when assessing patient concerns and integrating the role of family and community into plans of care. Finally, nurses must also work to increase and support representation of Black nurses in the oncology workforce. In summary, there are a multitude of interpersonal actions that oncology nurses can take to improve communication and health outcomes for Black patients with cancer.

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