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Power and Privilege

A Critical Analysis of Interpersonal Communication in Health Care as a Guide for Oncology Patient Navigation in Breast Cancer Care

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Despite advances in cancer care, inequalities in race, ethnicity, and social class in breast cancer outcomes still exist. Interpersonal communication is a critical piece to addressing health disparities and it is a core component of the oncology patient navigator role. While widely used, the concept of interpersonal communication is vague, understudied, and requires better clarification to promote equity in health communication. The aim of this article is to investigate the concept of interpersonal communication through a critical lens. Findings from this critical analysis identified a gap in the current literature addressing the intersections of race, gender, and social class. **Key words:** *health communication*, *health equity*, *interpersonal communication*

BREAST CANCER is the second leading cause of cancer death among women.[1] Despite having slightly lower breast cancer incidence rates than in White women and many advances in cancer treatment, Black women are 42% more likely to die from breast cancer than White women.[1-3] These women are more likely to receive late diagnosis, worse prognosis, and have significantly higher mortality than White women with the same type of breast cancer.[1,4] Not only are racial and ethnic disparities a major focus, but there are also socioeconomic disparities at play involving factors such as living in poverty, cultural factors, and social injustices.[3] To address disparities in breast cancer care, patient navigator programs were developed with a central aim to help these underserved patient populations address identified barriers to care and navigate the complex health care system.[5,6]

Patient navigation has numerous benefits for patients with breast cancer including increased uptake of mammograms, reduction in time to biopsy and diagnosis, and increased patient satisfaction with care.[7-9] Patient navigation is broadly defined as assistance of patients by nonclinically (lay person) or clinically trained individuals (nurses, social workers) in identifying and addressing individual and system-level barriers to prevent attrition and promote patients' progression along the breast cancer care continuum.[5,6]

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Statements of Significance

What is known or assumed to be true about this topic?

The concept of interpersonal communication in health care is well documented in the literature. The research literature identifies interpersonal communication as an essential component of any patient-provider encounter and can impact patient outcomes and engagement. Similarly, in the field of patient navigation in breast cancer care, interpersonal communication is also a key competency for patient navigators to help patients address barriers to care and promote positive cancer care outcomes.

What this article adds:

The key components of interpersonal communication in patient navigation that promote positive patient outcomes are understudied. To promote a more inclusive understanding of interpersonal communication in patient navigation and develop evidence-based interventions to support the patient navigator role, this article applied a critical lens to the traditional components of a concept analysis as outlined by Walker and Avant to highlight the gaps in our understanding of the concept of interpersonal communication at the intersection of race, gender, and social class.

Research regarding patient navigation has heavily focused on the logistical components of the patient navigator role (ie, scheduling appointments, assisting with transportation, and other resources). A critical element that is not as well understood is the interpersonal communication between patients and patient navigators.

Interpersonal communication in health care is a commonly identified competency for many health professions and plays an essential role in the clinical encounter.[9-12] Similarly, in the growing field of patient navigation in cancer care, research suggests that interpersonal communication is essential to improving the patient navigators' ability to build trust, provide culturally appropriate and relevant care, develop rapport, provide psychosocial support, increase the patients' participation in care, and address patients' barriers to care.[6,13-15] However, the key components of interpersonal communication in patient navigation that promote positive patient outcomes are understudied.[9,16] Furthermore, there is a gap in the literature surrounding the concept of interpersonal communication as it applies to oncology patient navigation. Thus, it is essential to take a step back to refine and understand the concept of interpersonal communication in health care to highlight particular components of the concept that will aid patient navigators in promoting health equity in oncology care. A clearer and more inclusive understanding of interpersonal communication in patient navigation will assist us in further refining the role of the patient navigator and the development of evidence-based interventions to support oncology patient navigators. This concept analysis aims to utilize a critical lens to explore and critically reflect upon interpersonal communication in the context of health care at the intersection of race, gender, and social class.

METHODS

This critical concept analysis was conducted to examine the concept of interpersonal communication in health care. A critical concept analysis differs from a traditional concept analysis in that it follows the traditional concept analysis steps, as described by Walker and Avant,[17] but also has an emphasis on incorporating a critical lens at each step (see Figure).[18-21] A critical lens is a systematic process of reviewing literature from the perspective of the marginalized and seeking to bring to light oppressive conditions and structures. The stance of critical scholarship is to give voice to and empower those who are marginalized. This stance is intentional and explicit, and it is through this

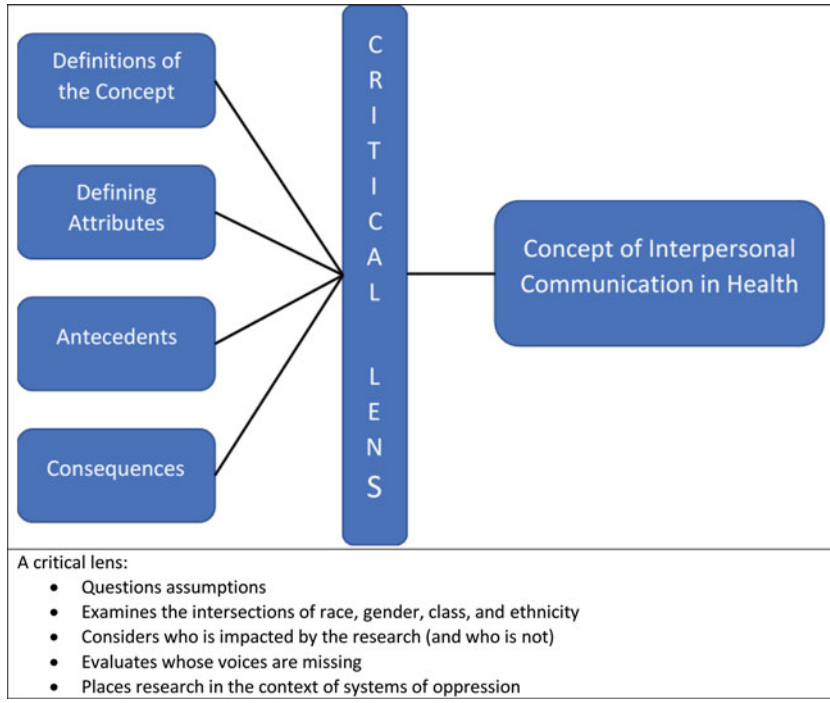

Figure 1. Framework for critical analysis in interpersonal communication in health care. This figure is available in color online (www.advancesinnursingscience.com).

active process of deconstruction and offering alternative perspectives that we seek social change and innovation.[22] Prominent theoretical schools of thought that guided this critical analysis include feminist theory, critical race theory, and emancipatory inquiry, which seek ways to challenge inequities and provide new ways from which to examine the intersection of race, ethnic background, gender, and social class.[18-22] Through the incorporation of the voices of commonly underrepresented groups, such as women and people of color, the goal is to produce a more meaningful and relevant conceptualization of interpersonal communication to ultimately guide the ever-expanding role of oncology patient navigators. We recognize that sexual minorities represent a growing and medically underserved group in the United States; however, for the purposes of this analysis, we are focusing primarily on cisgender women (those whose gender identity aligns with their sex assigned at birth).

The review of the scientific and theoretical literature included relevant articles and information retrieved from both PubMed and Google Scholar, as well as searching reference lists, conference abstracts, and other gray literature. The key concepts, key words, and MeSH terms included "Patient-provider communication," "interpersonal communication," "effective communication," and "interpersonal skills." Criteria for inclusion in the review included availability in the English language and full-text format. The abstracts were reviewed by the first author (S.G.) to assess for inclusion and relevance of the content.

RESULTS

The final sample of publications for this analysis included 26 sources (Table 1). Analysis of the 26 sources representing the scientific and theoretical literature revealed a variety of types of literature. The sample included 9 quantitative research articles,

Table 1. Overview of Included Articles (N = 26)

Author and Year	Purpose	Type of Source
Krauss and Fussell[23] (1996)	Explore models of interpersonal communication in social psychology and investigator's assumptions about communication in research.	Book
Zank and Braiterman[24] (2004)	Brief overview of Martin Buber's philosophical work and history.	Online database
Beualieu et al[25] (2011)	Examining interpersonal communication in validated instruments.	Quantitative research article
Roter and Larson[26] (2001)	Describe communication profiles of residents and attendings and their patients.	Quantitative research article
Lupton[27] (1994)	Argues that scholarly inquiry related to health communication needs to incorporate more critical cultural and political theory to better inform practice.	Framework-focused
Hanks[28] (2013)	Explores the history of nursing advocacy and social justice and discusses implications for nursing and nursing research.	Literature review
Vanderford et al[29] (1997)	Explore patient experiences, identity, and context to better inform researchers' assumptions about patient-centered health communication.	Qualitative research article
Manning and Denker[30] (2015)	Explore the ways in which scholars can integrate feminist approaches and perspectives in their study of interpersonal communication.	Framework-focused
Carney et al[31] (2005)	Examined beliefs about nonverbal behavior and communication associated with both high and low social power.	Quantitative research article
Hagiwara et al[32] (2017)	Investigated provider racial bias association with their word use during an encounter with Black patients.	Quantitative research article
Agency for Health Care Research and Quality[33] (2015)	National trends in the quality of health care and disparities in health care delivery based on social determinants of health.	Government agency report
Epstein et al[34] (2010)	Highlights the poorly understood nature of patient-centered care and the need for policy to advance it in practice.	Literature review
Ells et al[35] (2011)	Argue that providers should adopt a relational conception of patient autonomy if we want to enhance patient-centered care.	Framework-focused
Filler et al[36] (2020)	Reviewed research on barriers and facilitators of patient-centered care for immigrant and refugee women.	Scoping review

(*continues*)

Table 1. Overview of Included Articles (N = 26) (*Continued*)

Author and Year	Purpose	Type of Source
Roter et al[37] (1997)	Describe communication patterns in primary care settings and explore their association with provider and patient satisfaction.	Quantitative research article
Roter and Hall[38] (2004)	Synthesize the results of 2 meta-analytic reviews on the impact of provider gender on communication in medical encounters.	Literature review
Montague et al[39] (2013)	Examined associations between provider nonverbal communication (ie, eye contact and social touch) and patient perspectives on clinician empathy, connectedness, and liking their provider.	Quantitative research article
Elliott et al[40] (2016)	Randomized trial of physicians comparing their verbal and nonverbal communication scores with Black and White patients.	Quantitative research article
Roter[41] (2010)	Explore philosophical and theoretical basis for the therapeutic relationship between providers and patients and discuss patterns of provider communication.	Scientific presentation
Ellingson and Buzzanell[42] (1999)	Explored women's narratives of their breast cancer treatment to examine their preferences for communication styles and ways of knowing.	Mixed-method
Ackerson and Viswanath[43] (2009)	Examine the role of the social context in interpersonal communication inequalities.	Framework-focused
Govender and Penn-Kekana[44] (2008)	Highlights how gender as well as other social determinants of health influences the interactions between patients and providers.	Literature review
Hall et al[45] (2015)	Examined the literature regarding implicit attitudes among providers, particularly focusing on race.	Systematic review
Cooper et al[46] (2012)	Cross-sectional study examining the association of clinician implicit racial bias and patient-provider communication and patient ratings of care.	Quantitative research article
Fitzgerald and Hurst[47] (2017)	Examined health care professional implicit bias toward patients	Systematic review
Penner et al[48] (2016)	Measured implicit racial bias effects on racially discordant oncology interactions, particularly communication and patient perceptions.	Quantitative research article

4 framework-focused articles, 1 qualitative research article, 4 literature reviews, 1 scoping review, 2 systematic reviews, 1 mixed-methods research article, 1 government agency report, 1 book, 1 online database, and 1 scientific presentation. The results of the analysis are summarized in Table 2.

Definitions of the concept

While interpersonal communication is a common concept across a variety of health disciplines, there is little agreement as to just how the concept should be defined. In the area of social psychology, interpersonal communication involves a process that

Table 2. Comparison of Traditional and Critical Literature Findings

Concept Analysis Component	Traditional Literature	Critical Literature
Definitions of the concept	• Understand patient concerns • Share health information • Promote shared decision making	• Self-serving paternalistic discourse • Cultural and institutional inequalities • Patients should be active participants
Defining attributes	Patient centeredness: • Partnerships between patients, families, and providers • Tailoring care to support decision making and engagement in care. Verbal and nonverbal communication: • Focuses on data gathering • Education and counseling • Use of medical jargon • Development of trust and rapport Communication styles: • Balance between psychosocial and biomedical information.	Patient-centeredness: • Should emphasize relational autonomy • Acknowledges the structures and social context that influence the patient-provider relationship. Verbal and nonverbal communication: • Focuses on partnership building • Emotionally responsive • Traditional medical jargon has imbedded values/inequalities. • Subtle communications of social power. Communication styles: • Do not properly address the needs of underrepresented groups • Influenced by gender and racial concordance
Antecedents	• Values, beliefs, principles, qualities, and communication skills of the patient and provider. • The emotions and needs of the provider and the patient	• Mediated by social status, gender, race or ethnicity, religion, and language. • Includes the social, cultural, legal, and physical aspects of the environment. • Provider implicit bias
Consequences	• Common outcomes of effective communication: ◦ patient satisfaction ◦ quality of health care ◦ adherence to medical treatment ◦ recall of medical information.	• Common outcomes of effective communication: ◦ Commonly used metrics may not accurately capture or reflect the experience of marginalized groups in regard to gender, social class, or race.

allows participants to simultaneously affect one another.[23] In philosophy, dialogue is one way of expressing the interpersonal nature of human existence.[24] An ethics perspective emphasizes the need to sustain and nurture dialogic interaction as a key component of communication, where both participants are considered worthy of respect and allowed to express their own points of view. In health sciences and health communication literature, interpersonal communication is commonly viewed as the ability of the provider to elicit and understand patient concerns, explain health information, and foster shared decision making.[25,26]

From a critical lens, alternative schools of thought suggest that interpersonal communication in health care can be a self-serving discourse and a paternalistic exercise involving a more powerful and knowledgeable informer (ie, the health care providers) and the less powerful message receiver (ie, the patient).[27] Similarly, the nurse philosopher, Sally Gadow, warns against paternalistic roles and encourages mutuality in the nurse-patient relationship, with an emphasis on the importance of the patient's own lived experiences, values, and expected outcomes in health care decision making.[28] Patients should be active participants who interpret, manage, and create the meaning of their health and illness based on their own experiences.[29] Adding a feminist perspective, interpersonal communication involves relationships that are influenced by gender, informed by patriarchal histories, and subject to cultural and institutional inequalities.[30]

Defining attributes

A key attribute of interpersonal communication is patient-centeredness. Commonly, health care providers are taught certain norms for communication, including verbal and nonverbal communication and communication styles that will promote patient-centered care. These norms often do not consider the diversity in communication preferences influenced by power differentiation, gender, race, and class.[27,31,32] This need for diversity presents a challenge for providers and a needed area for clarification as we begin to identify essential interpersonal skills for patient navigators who primarily serve marginalized individuals.

Patient centeredness

Patient-centeredness is a defining attribute of interpersonal communication in health care and is defined as "health care that establishes a partnership among practitioners, patients and their families to ensure that decisions respect patients' wants, needs, and preferences and that patients have the education and support they need to make decisions and participate in their own care."[33(p181)] Patient-centeredness incorporates elements of tailoring information in response to a patient's concerns, beliefs, and expectations to improved health status and reduced medical costs.[34]

Nevertheless, Ells et al[35] offer a critique of patient-centered care, particularly in its conceptualization of patient autonomy and the assumptions that exist in clinical culture that may isolate patients in decision making. Ells et al[35] recognize the larger social context that influences an individual's ability to participate in their care. An individual's ability to participate in their care is intimately connected to economics, politics, race, ethnicity, gender, and culture.[35] The challenge to providers is to advocate for fair and supportive social contexts that allow patients to exercise their autonomy.[35] In a scoping review of barriers and facilitators of patient-centered care for immigrant and refugee women, breakdowns in communication typically resulted at the clinician level.[36] Providers found it difficult to accommodate specific cultural needs and time-consuming to utilize interpreters. This left the patients feeling that the providers were busy and rushed, offering little chance for patient-centered communication between the patient and the provider.[36] Facilitators of patient-centered care in this context included core attributes of

interpersonal communication related to verbal and nonverbal communication, such as focusing their attention on the patient and being friendly and caring, and communication styles, such as chatting informally.[36]

Verbal communication

Verbal communication is a key player in promoting patient-centered care between a clinician and a patient. There are some categories of verbal communication that are commonly utilized during a clinical assessment including data gathering, education, and counseling.[26,37,38] However, the clinical encounter can also be an opportunity for patients to relay their narrative and experience. A less commonly emphasized category of verbal communication is partnership building, in which providers promote patients being active participants in the encounter by seeking patient input, checking for provider understanding, and taking on a less-dominating role, such as being less verbally dominant.[26,37,38] Less emphasized, but equally powerful, is the role of emotionally responsive communication, which includes verbal behaviors that foster positive talk including agreements, approvals, compliments, and social talk to convey friendliness and personal regard.

Furthermore, medical language is not value-free and can be utilized to emphasize the perceived inferiority of another. The verbal communication utilized during the clinical encounter does not exist in isolation but is part of a broader social discourse and is reflective of microstructures and macrostructures in which they are embedded. For example, medical jargon contributes to perpetuating stereotypes by consistently applying a certain gender to certain body parts, such as breasts, or bodily functions, such as menstruation or pregnancy.[27] Another study found that non-Black providers with higher levels of racial bias in racially discordant clinical encounters tended to express more social dominance by utilizing more first-person plural pronouns (eg, we, us, our) and more negative emotion-related terms (eg, worry, nervous, tense).[32] It is critical to be aware of what meaning, values, and inequalities clinicians adopt during the clinical encounter through the use of descriptive language and traditional medical language that may not be culturally sensitive.

Nonverbal communication

Nonverbal communication typically revolves around facial expressions, gestures, posture, and physical barriers such as distance from the patient. Common expressions include eye contact and touch, which have been associated with the development of understanding, trust, empathy, and rapport.[39] However, nonverbal cues can also lead to feelings of not being accepted, a sense of insecurity for patients, and may impede further communication. In a study of hospital-based clinicians' communication with Black and White patients at the end of life, providers exhibited fewer positive, rapport-building nonverbal cues with Black patients.[40] Moreover, nonverbal communication may be seen as subtle communications of social power. In a study by Carney et al,[31] psychology students identified several nonverbal behaviors that differ between individuals based on their perceived level of social power. Some of these nonverbal behaviors for higher powered individuals included paying less attention to the less powerful person in the interaction, initiating more hand shaking, engaging in more invasive behavior, having less gaze aversion, expressing less fear or sadness, orienting the head toward the other, leaning forward more, and having an open body position.[31] In addition, persons with higher social power were more likely to express confidence, express intimacy in greeting, use fewer "um"s and "ah"s, and fewer pauses in speech.[31]

Communication styles

There are several types of health communication styles that have been identified that both promote and inhibit patient-centered

interpersonal communication during a clinical encounter. Communication styles that were the most highly associated with increased patient satisfaction are those that promote more of a balance between psychosocial and biomedical information; this includes less data gathering and information giving and more emotionally positive speech and social talk.[26,37,38,41] The utilization of different communication styles is influenced by provider type, years of experience, gender concordance of provider and patient, racial concordance of provider and patient, and the level of complexity of the visit.[26,37,38,41]

These commonly accepted communication styles have limitations, specifically addressing underrepresented populations, such as the acknowledgment and tailoring of communication to women. This is compounded by the lack of current literature that incorporates discussions of gendered communication patterns in health care. Tailoring communication styles to women would emphasize the use of social talk as a primary way to create and maintain relationships.[42] Thus, if a provider is sending signals, both verbal and nonverbal, that he or she is not interested in talking with a patient, such as avoiding eye contact or remaining standing, this may impede the interpersonal communication between the patient and the provider and erode trust. Tailoring communication styles to women would also emphasize the need for hopeful and encouraging messages and showing empathy both verbally and nonverbally (eg, facial expressions and touch). Equality is also important in these communication styles as it lends itself to a more participatory method of interaction through being encouraged to ask questions, share personal experiences, and bringing up new topics.[42]

Antecedents

Interpersonal communication is highly influenced by the context surrounding the interaction. This social context of interpersonal communication is a combination of both the patient's and provider's characteristics and experiences as well as the social, cultural, legal, and physical aspects of the environment.[43] The provider-patient encounter is commonly described by marginalized patients as discriminatory and mirroring the social stratifications of society at large.[33] These experiences of discrimination and poor communication are frequently noted by economically disadvantaged individuals and women and can be further mediated by race or ethnicity, religion, and fluency in English.[33,44,45] For example, racial discordance between the provider and the patient may produce lower levels of trust, participation in care, and positive affect.[45,46] Patient markers of social class, including education and income, can also affect communication. There are several common characteristics related to poor communication received by people of color, persons with lower education, or individuals living in poverty. These include using dominant communication patterns where providers did not explain information in a way they could understand, showing less respect for the things told to them by the patient and the family members, expressing fewer positive emotions, and allowing less input on treatment decisions.[33,45,46]

It is important to discuss the role of provider bias in interpersonal communication.[47] Implicit bias involves unconscious associations that may lead to negative assumptions or evaluations of an individual based on irrelevant characteristics, such as race or gender.[47] Implicit bias among providers impacts specific aspects of communication, including having slower and less patient-centered speech, more verbal dominance, less clinician and patient-positive affect, and fewer rapport-building nonverbal cues.[40,46] These implicit biases may also influence providers' interpretation of symptoms, clinical decision making, interpersonal behavior, and treatments prescribed for racial and ethnic minorities.[45,46] These biases are not only limited to race and ethnicity but also extend to other social categories as well including gender, age, socioeconomic status, and illness.[48]

Consequences

Improved patient outcomes are a common metric in assessing the quality of interpersonal communication between providers and patients. Common outcomes of effective interpersonal communication are improved patient satisfaction, quality of health care, adherence to medical treatment, and recall of medical information.[11,23,26,37,38,41-44] However, the conceptualizations of common metrics, such as patient satisfaction, may not accurately capture the experience of certain groups or allow for differences in gender, social class, or race. Because of the lack of current literature critically evaluating patient satisfaction, it is important for future research to critically analyze our current measurements and ensure that it captures the many ways underserved groups conceptualize patient satisfaction in the context of interpersonal communication.

Implications for practice

Providers may find themselves wondering how the conceptualization and critical analysis of interpersonal communication in health translates into practice. Thus, the following exemplar is provided to model 2 cases that illustrate effective and less effective interpersonal communication in the context of oncology patient navigation.

The scenario revolves around Ms Janet Smith, an African American patient who is suffering from neuropathy as a side effect of her breast cancer treatment. Her nurse navigator, Sharon, a White female, comes to speak with her. In the first scenario, Sharon enters the room and says, "Hi Janet, Dr. Green sent me in here to discuss your prescription for your neuropathy." As Sharon remains standing with her clipboard to her chest, she quickly mentions that the provider noted that she was not taking her neuropathy medication because she could not afford it. As Sharon continues to ask a few questions, she remains standing and glances down at her watch frequently. She hands Ms Smith some information with numbers of organizations that provide financial assistance to help pay for medications and says, "You could try calling one of these organization. Is there anything else I can help you with today?". Ms Smith says "no" and then Sharon leaves.

In the second scenario, Sharon enters the room, greets Ms Smith with a smile and says, "Hi Ms. Smith, it's nice to see you again." Sharon sits down next to Ms Smith and says, "Dr Green mentioned to me that you are struggling to pay for your medicine that helps with your leg pain." Ms Smith nods in agreement. Sharon goes on to mention, "I'm sorry, a lot of people have a hard time paying for medication. What do you think would be the best way I could help you?" Ms Smith mentions, "It's the copay, it's just too high." Sharon informs Ms Smith that she'll talk with the pharmacist and the nurse practitioner to see what options there are for getting a generic version of the medication or see whether there is some financial assistance. Sharon observes Ms Smith's closed posture and sad facial expression and says, "Ms. Smith are you in pain now?" Ms Smith responds, "Yes, I am. I hurt all of the time and it is getting to me, mentally. I don't get much sleep." Sharon asks a few follow-up questions regarding her pain and loss of sleep and Ms Smith thanks Sharon for her concern. As they wrap up their conversation, Sharon asks Ms Smith about her new granddaughter and mentions that she will follow up with Ms Smith tomorrow to let her know what she learns about generic options for her medication.

In evaluating these scenarios, it is important to point out that the second scenario provides a more emotionally responsive and patient-centered example of interpersonal communication between the patient navigator, Sharon, and the patient, Ms Smith. In the first scenario, Sharon expresses her social power by using Ms Smith's first name but in the second scenario, she shows respect to the patient by greeting her in a more formal way. In the second scenario, Sharon promoted equality in the relationship by sitting at the patient's level, not rushing the conversation, avoiding medical jargon, and empowering

Ms Smith to play a role in the decision-making process. Sharon's use of social talk as well as her friendly and caring demeanor in the second scenario demonstrated how she was able to tailor her communication style and allowed her to be more patient-centered. In the first scenario, Sharon does not provide Ms Smith an opportunity to explain the trouble she is having paying for her medication and does not address Ms Smith's closed posture and sad expression. In contrast, in the second scenario, Sharon seeks assurance from the patient that she understands the situation and encourages Ms Smith to ask questions. In addition, Sharon recognized the patient's closed posture and sad facial expression and offered her an opportunity to express how she is feeling.

Overall, there are many ways in which the interpersonal interactions between patients and providers may unfold. Therefore, taking the time to critically analyze how the interpersonal context is more than words and kind gestures and is a place where power dynamics can subtly place a barrier to communication between patients and providers is important to continually challenging ourselves to provide the best care possible to patients.

CONCLUSION

This analysis of the concept of interpersonal communication in health has provided a broad overview of some of the conceptualizations of interpersonal communication from a critical lens. Interpersonal communication is a complex phenomenon, but this analysis has highlighted some of the issues that can arise in our traditional conceptualizations of interpersonal communication that may leave patients feeling marginalized and worsen experiences of inequality in our health care systems. This work has also identified the need for a new measurement paradigm that incorporates power dynamics from the patient's perspective into measuring outcomes of interpersonal communication. Interpersonal communication is a commonly discussed competency for health care providers, but there is still much work to do in expanding and strengthening our conceptualization and operationalization of interpersonal communication in health care to reflect the voices of commonly underrepresented groups. Nurse philosophers and leaders have always been at the forefront of promoting mutuality between clinicians and patients and we will need to continue to operationalize interpersonal communication skills that will resonate with today's clinical environment and marginalized communities to provide more meaningful patient-centered care.[49]

This analysis also provides a critical perspective at a crucial time in patient navigation's ongoing development, understanding, and conceptualizations of interpersonal skills and communication as key competencies for patient navigators. As the field of patient navigation continues to grow and expand, it is important to take this opportunity to intentionally bring to the forefront the voices of underserved groups and apply a critical lens to ambiguous definitions and widely accepted key components of interpersonal communication in the health care context.

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