

CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

How Should Clinicians Address a Patient's Experience of Transgenerational Trauma?

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Abstract

Establishing trust is essential to a healthy patient-surgeon relationship. Respecting patient autonomy while seeking to understand patients' unique perspectives can strengthen trust. This article discusses cultural mistrust, a response shaped by historical iatrogenic harm (ie, unintentional harm caused by health care professionals or the health care system) and transgenerational trauma (ie, the transfer of attitudes and behaviors from survivors of trauma to their children and subsequent generations) and the importance of recognizing how patients' life experiences impact their health decision making.

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Case

A retired veteran, Mr S enlisted in the US Army with hopes of giving his family a better life. He is an active Black elderly man with no significant illnesses or injuries before being brought to an emergency department (ED) after collapsing at home. Clinicians learn that, for about 3 months, Mr S has experienced early satiety (feeling full after consuming only a few bites of food), weight loss, and persistent fatigue. Following hospital admission, an endoscopic biopsy reveals localized gastric adenocarcinoma, and a surgical team, led by Dr D, evaluates Mr S for gastric resection.

Mr S's wife, children, and several grandchildren are present with him in the hospital. Dr D explains gastric resection to Mr S and his family, and Mr S clarifies that he does not want surgery because he is "unsure whether I would make it." Dr D asks him to say more about not wanting surgery. Mr S explains that, when he was young, his father had an operation for an infected foot ulcer. His father was discharged home the morning after his operation with minimal instruction on how to care for the wound and without any home resources to facilitate ongoing wound care. Despite the operation, the foot infection did not get better. Instead, the infection got much worse. His father's leg became rapidly necrotic after discharge home. The involved skin, fat, and muscles of his foot began to die as the infection spread rapidly up his father's leg. His father sought

care from multiple surgeons, and no one agreed to care for him. Mr S remembers waiting for hours and hours in numerous emergency rooms with his father as they sought treatment. He remembers his father being accused by one nurse in an examination room of “not taking care of himself.” Unfortunately, by the time his father was appropriately evaluated and able to be admitted to a hospital, the infection had spread all the way up to his thigh and hip. He was admitted to an intensive care unit and died the following day. Mr S explains that he worries this could happen to him, although times have changed. “Some things haven’t changed. It’s nothing personal against you, Doc. I just don’t want this surgery.” Dr D wonders how to respond.

Commentary

There are limits to what clinicians can accomplish with patients during a single interaction or clinical encounter. The ability of clinicians to anticipate what can be achieved in a clinical encounter is limited by their personal, social, cultural, and historical experiences. For many patient-clinician relationships, intentional consideration of potential interactions is just as important as a clinician’s technical skills and interpersonal aptitude in earning patients’ trust. As surgeons practicing at the complex intersection of health and inequality, our **ability to empathize** with patients’ unique life experiences is paramount to establishing a strong patient-surgeon relationship. Furthermore, we must acknowledge the long-standing institutional barriers to building trust that many of our patients (continue to) endure as they seek our care.¹ Surgical treatment for Black patients is rooted in **historical and contemporary mistrust** that cannot be ignored.^{2,3,4,5,6,7}

Health Discrimination

Black Americans have been disproportionately affected by health conditions for centuries in the United States as a result of racial discrimination. Systemic racism has led to a higher likelihood of denied access to health care and higher mortality rates for Black Americans compared to their White counterparts.^{8,9} The alarming rate at which Black patients with diabetes undergo amputation is one surgery-specific example of racial inequity in access to care in this country.¹⁰ The impacts of these health disparities are worsened by the unequal rate at which Black Americans are subjected to police brutality, mass imprisonment, and poverty.^{8,9} Additionally, despite some progress, much of the country remains racially segregated, and Black Americans continue to face discrimination in their efforts to secure safe housing, quality education, nutritious food sources, and reliable employment. Multigenerational discrimination and injustices affect not only the physical health but also the mental, spiritual, and emotional health of Black patients.^{11,12,13}

For the last 400 years, in an effort to survive under the dominant White culture in the United States, Black Americans have developed behaviors and beliefs about White people that were passed from generation to generation.^{11,12,13} Although these survival behaviors and beliefs historically provided protection, without properly addressing the continuous trauma Black patients experience, these behaviors and beliefs can result in harm.^{11,12,13}

Effects of Transgenerational Trauma

Understanding how cultural context can influence patients’ processing of past and present experiences of racial discrimination is key to establishing trust. Before his arrival in the ED, Mr S was a healthy, independently functioning man. He is a husband, a father, and a grandfather. He has not only served and protected this country but also worked

hard to provide for his family. We assume that because of Mr S's role as the patriarch, his family members are present not only to listen and learn about his diagnosis, but also to advocate for him. Before beginning our analysis of Mr S's case, we must pause to recognize the values that influence his family dynamics. Understanding these unique dynamics will assist us in framing our discussion of the case.

After disclosing Mr S's diagnosis of localized gastric cancer and sharing her recommendation for resection, Dr D learns about the trauma Mr S experienced as a child in watching his father die from a treatable surgical infection and about Mr S's mistrust of surgeons. From the tone of the conversation and what we have learned thus far about Mr S, it appears that his father's death might have been related to his being a Black man. While these are difficult and uncomfortable discussions to have, it is important for us as surgeons to engage in conversation when patients extend an invitation.¹¹ Acknowledging vulnerability with positive feedback is essential. For example, Dr D might respond: "Thank you so much for sharing your experience with me, Mr S. That helps me to better understand where you are coming from." When an invitation to discuss past trauma is not offered (for example, if Mr S had *not* decided to share his experiences about his father), we should ask our patients if they would like to discuss their decision-making processes with us further. Possible questions are these: "Can you please tell me more about your decision?" "What questions about my impression and recommendations may I answer for you?" "Would it be helpful for me to include any other team members in our discussion?" It is our responsibility to address all aspects of health that affect our patients' well-being, including **past traumas related to structural racism**. In order to properly inform Mr S about his disease and to empower him to make the best decision about how his disease is to be managed, Dr D should attempt to delve deeper into his past experiences. Such historical events, especially those involving trauma, shape how patients navigate the world today.

We must also be sure our patients have a detailed understanding of their diseases and how we, as clinicians, come to specific conclusions regarding the management of their health. While cancer diagnoses typically do not warrant emergency operations, we want to be clear about the urgency of gastric resection in the setting of gastrointestinal bleeding and to avoid any progression of disease. When patients do not agree with our recommendations, we must check our own biases and sense of professional privilege as possible factors contributing to discord in the patient-surgeon relationship. While we are trained to consider our own biases when caring for patients with different values, we must also understand our own biases as they relate to our sense of professional privilege. Recognizing that our **biases towards our patients** can be shaped by differences in gender roles, race or culture, level of education, surgical familiarity, and understanding of complex disease processes and their treatments is helpful in identifying the basis of our privilege as surgeons. Even the most empathetic surgeon can make the grave error of not truly considering their own privilege during patient interactions. Privilege equates to power in patient-surgeon relationships; therefore, when surgeons do not consider their privilege, they may not recognize the power they hold.

Dr D must realize that, as an expert in gastric cancer, she has power over Mr S. Dr D should provide Mr S and his family time together to consider and discuss her recommendations in her absence. She should also offer additional resources such as drawings, videos, or other images to provide a visual adjunct to her explanations. Additional patient and family support in the form of pastoral care, social assistance, and

psychological consultation should also be offered to Mr S. Dr D should return when Mr S is ready to continue the conversation. Establishing trust takes time; thus, diagnosis of acute surgical problems requiring urgent or emergency intervention can pose a challenge to building trust.² Communicating respectfully and honestly, making decisions *with* patients and their families, and advocating for patients are important ways to gain and maintain trust.^{4,2} Trust that has been lost through multigenerational trauma can be reestablished through an understanding of the complexities of diversity, historical and modern-day experiences of social injustice, and our own biases and personal life experiences.¹¹ It is important to consider the cultural lens through which we look in our clinical practice.

Mitigating Effects of Transgenerational Trauma

As surgeons, we are closely tied to institutions that contribute to the ongoing oppression of Black Americans. Thus, addressing racism and its sequelae is a responsibility that we must own. We need to be familiar with race relations in our country and have an understanding of the **historical discrimination** our patients have faced for generations. Lack of knowledge may result in additional harm and reinforcement of cultural mistrust. Inadequate attention to a patient's concerns and reluctance to acknowledge that potential barriers even exist reinforces mistrust. It is not enough to know that cultural mistrust exists; we must understand *why* it exists. It is also important to understand our actions within the context of social justice dynamics in order to avoid subjecting our patients to the same injustices in the hospital that they face in their day-to-day lives.

Rather than dismiss the pain patients carry from their families because of trauma that occurred years ago, we need to listen and learn.¹³ Listening affords us opportunities to recognize connections between survival behaviors learned during traumatic events and current behaviors demonstrated by our patients. Fear-based survival messages shared with children and grandchildren may propagate mistrust in the health system. Ideas such as “do not go to the doctor” or “do not ask for help” may have intentionally helped people stay alive in the past; presently, however, they may result in delayed diagnoses and treatments. Recognizing these connections may allow us to intervene in the progression of transgenerational trauma.

Motivating Change

As surgeons, we must support the recruitment and promotion of underrepresented minorities in medicine to ensure that surgeons reflect the diversity of the communities they serve. We must work harder to eliminate implicit bias from the care of our patients. Building meaningful relationships with community leaders and investing resources in the communities we serve facilitates partnership with those most affected by structural racism—we cannot solve the issues of inequality without their input. We must continue to advocate for equitable health care, social justice, and transformative change. By listening to and amplifying the voices of our marginalized patients, we can begin the healing process.

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Editor's Note

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