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Transgenerational Trauma

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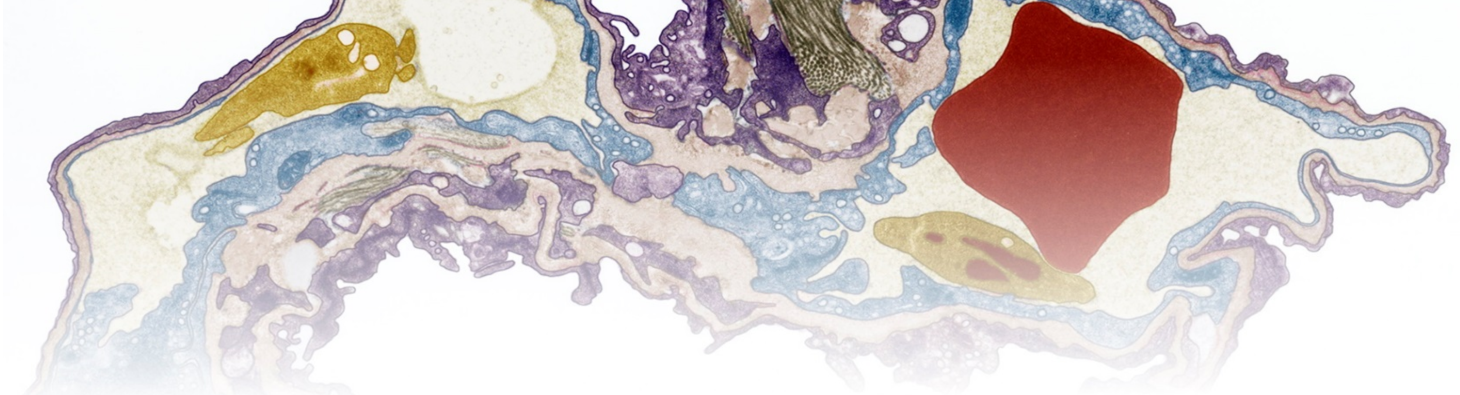

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FROM THE EDITOR

Transgenerational Trauma and Health Inequity Today

Zoe Tao, MD and Niki Kasumi Clements, PhD

In the history of the United States, we have long dehumanized, otherized, and exploited people in the name of Manifest Destiny.[1] Contemporary structural violence normalizes inequity in resource and opportunity allocations and in distributions of benefits and burdens. Such inequity propagates harms rooted in ancestral traumas of slavery, internment, and trafficking among contemporary individuals and communities.[2] Trauma events experienced by ancestors are widely documented in the public health literature as casting long shadows with measurable legacies of cumulative, embodied risk to descendants that undermine their and their children's health status.[3,4] Pervasive racial and ethnic health inequity is one consequence of exploitation perpetrated by individuals and institutions throughout several generations. Health equity research continues to reveal undertreatment of patients and populations with minoritized identities and inequity in their health outcomes.[5,6]

Improving individual and collective capacity to think powerfully about relationships among transgenerational trauma, social equity, and possibilities for healing, particularly in US health care, is key to promoting equity. Health care is a public investment and must be held to account for historical and present conditions that affect patients' abilities to heal and to live well.[7,8,9] This issue of the *AMA Journal of Ethics* offers personal, professional, and institutional perspectives on a range of topics in racial and ethnic transgenerational trauma. We have curated work that promotes an ethical shift toward accounting for how health inequity today is rooted in histories of trauma and violence. Discussions center on several minoritized racial and ethnic groups in the United States and evaluate influences of transgenerational trauma on the health care experiences of clinicians, patients, and communities.

The content in this issue aims to go beyond racial essentialism, which too often disregards human experiences in favor of reductionist understandings of illness manifestations and how disease or injury is experienced.[10] Key to these explorations is how mistrust, cycles of displacement and exploitation, and poor health outcomes are legacies of transgenerational trauma that are situated in our shared histories of advantage and disadvantage. Contributors offer recommendations for best practices in how to adjust health policy, health professions education, and clinical practice to recognize and respond to medicine's complicity in domestic and international histories of dehumanization. Our hope is for journal audiences to engage with, reflect on, and think about how to enrich our understandings of the ethical weight of transgenerational trauma and its legacies in clinical practice and research.

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CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

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

Ashley Suah, MD and Brian Williams, MD

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.

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 disproportionally 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.[1,2] 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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Brian Williams, MD is the co-director of the surgical intensive care unit and a professor of trauma at the University of Chicago in Illinois. A recognized expert in acute surgery and critical care, he is also a surgeon-activist who works fiercely to end racial inequities in health care and put a stop to the American epidemic of gun violence.

Editor's Note

The case to which this commentary is a response was developed by the editorial staff.

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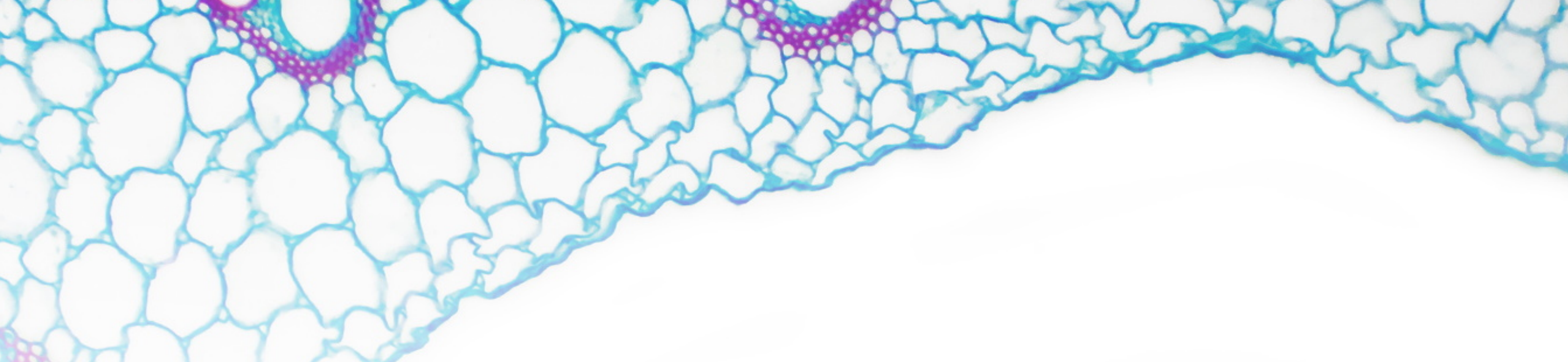

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CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

Trauma-Informed Caring for Native American Patients and Communities Prioritizes Healing, Not Management

Michael J. Oldani, PhD, MS and Deidre Prosen, MFA, MS

Abstract

Addressing intergenerational trauma remains a public health priority in Native American (NA) communities. Clinicians working with NA patients must express humility, understand local culture, collaborate, and develop an insider's perspective on NA past and present life in order to earn trust. This case considers an NA adolescent suffering from mental distress, possible substance use, and multiple traumas. The commentary argues that trauma-informed therapies are lacking in some current psychiatric and primary care practices in the Indian Health Service and that an interprofessional, trauma-informed approach that considers the interplay between relevant somatic and psychological factors can better motivate patient-centered care. Cultivating safe environments in which interventions are pursued within the patient-clinician therapeutic alliance is key to generating optimal outcomes and healing among NA patients.

Case

Dr L is a new attending physician in an Indian Health Service (IHS) facility on the Colorado River Indian Reservation who has an interest in serving minoritized communities with few resources in the United States. Dr L is introduced to JM, a 16-year-old who lives on the reservation. JM was brought to an emergency department (ED) last weekend after an apparent narcotic overdose and sees Dr L for follow-up. JM's blood pressure is slightly elevated at 145/90 mm Hg. Dr L asks about JM's family, with whom they interact only minimally.

Substance abuse on the reservation has resulted in many adolescents' deaths in recent years. Dr L observes that JM has developed dysfunctional ways of coping with abundant stress, sources of which include having few resources and enduring grief over ancestral losses of land, status, and sense of a future. She also worries that JM might have tried to commit suicide last weekend and might try again.

Dr L wonders how to follow up.

Commentary

Over the course of the last century, anthropologists and mental health experts have seen their roles evolve when working with and within First Nation communities (used interchangeably with all Indigenous peoples) in North America. Psychiatrists, who were initially part of the colonial apparatus and diagnosed mental illnesses using first Freudian and then Western-based biomedical categories, were often complicit in removing Native peoples from their homes and aiding in their institutionalization at boarding schools and asylums.[1,2]

During the early 1900s and into the 1960s, anthropologists in the United States engaged in "salvage ethnography,"[3] often treating Aboriginal communities as laboratories and as an opportunity "to study" non-Western forms of kinship, social structure, and healing or medical techniques. Native cultures were thought to be at risk of Westernization, forced assimilation, and ethnocide through missionary and government practices. Anthropologists framed Native life as a vanishing artifact that should be preserved through monographs and museum displays, rightly drawing the ire of Native American activists in the 1960s and 1970s,[4,5] which initiated a robust critique and reflexive examination of ethnographic practices that continue today.[6,7]

Fortunately, anthropology has a more recent tradition of engaging with mental health diagnosis and treatment cross-culturally[8,9,10,11,12] and examining the experience of trauma more critically.[13] During the last several decades, anthropologists and mental health experts have shifted from seeing Indigenous peoples as study subjects to seeing them as community partners and working collaboratively to ameliorate Indigenous people's mental distress and myriad traumas through innovative approaches and models of care.[14]

In the spirit of collaboration, we comment on this hypothetical case of JM and the mental well-being and treatment of Native North Americans more generally. We do this with the understanding that we have some knowledge, experience, and training in specific areas that might help Native peoples and the practitioners who work *with them* and care *for them.* Our goal is to help advance a Native-centered, collaborative ethos in the area of mental health and trauma-informed care (TIC).

Towards Clinical and Cultural Humility

Although JM's case scenario is hypothetical, it is unfortunately typical of both Native and non-Native communities, especially those with limited resources and that are more vulnerable to exploitation by opioid manufacturers.[15,16] The stakes are high for young patients and clinicians alike when clinical encounters see the convergence of addiction, mental illness, history of trauma, structural racism, implicit clinician bias, and dysfunctional family dynamics. We would start by suggesting that clinicians proceed with the following questions in mind:

- How should clinicians initiate conversations with traumatized and at-risk adolescent patients from vulnerable populations?
- How should historical trauma be accounted for in terms of treatment as well as building individual and community trust and a therapeutic alliance?
- What responsibility do clinicians and their teams have to navigate and understand history, culture, and context as these factors relate to everyday diagnosis and treatment of individuals under their care?

When working within a vulnerable community, all caregivers—especially those from outside that community or with little experience or ethnographic knowledge of that community—must take a deliberate step back and start to build their cultural competencies and knowledge, developing, as a first step, cultural humility (an ongoing, life-long process) based on cultural awareness.[17,18] Cultural humility toward the people we work with is always an unfinished project. However, the goals of cultural humility in the medical context are concrete in the sense that clinicians strive to emphasize and put into action concepts such as *diagnostic openness*.[19] Building cultural humility must be deliberate and can be difficult because of time constraints, yet it remains an essential responsibility.

The IHS facility described here, a tribal center or a local clinic, will have at least some people from the community working at various levels, from practitioners to staff. Assuming that Dr L is a non-Native clinician, we would ask: Has she worked to meet local people and sincerely introduce herself to the community and clinical staff prior to meeting a patient like JM? Has she made the effort to reach out to local leaders via letter or email to more formally introduce herself, outlining what kind of medicine she practices and, of particular importance, why she wants to work within this community? Has she pursued understanding of how local institutions, such as health care, tribal governance, schools, social services, and law enforcement, operate? Has she visited a local cultural or historical center while on rotation? Clinicians should also seriously consider attending community events and gatherings, eating at local restaurants, or attending public ceremonies, such as powwows, even as an unobtrusive observer or casual participant. Finally, where has Dr L decided to live—within or near the community?

Of particular importance would be to seek out and meet the known healers and other respected figures within the community or surrounding area. The case presented here is a good reminder of the complexity of Native populations. The Colorado River Indian Tribal (CRIT) Reservation has over 4000 members and 4 distinct Native tribes with unique histories and cultures: Mohave, Chemehuevi, Hopi, and Navajo. Which tribe does JM and his family identify with? There will definitely be elders, medicine persons, mentors, and peer support specialists within each group whom a clinician should work to connect with and *learn from*. How are these specialists engaging with people when treating trauma, substance use disorders, mental illness, and so on? What kinds of practices (eg, initiation rites, fasting, and sweats) have shown efficacy within the community as alternatives to, or in synergy with, prescription medication and Western forms of care? For example, it was not uncommon for elders in Manitoba, with whom the first author (M.J.O) worked, to recommend sweat lodge ceremonies (with Aboriginal naming rites) and psychiatric care with antidepressants for young persons in distress.[20] Has Dr L been able to observe and explore IHS clinic culture before entering practice, locating what some ethicists describe as “moral spaces” that are quiet and private and help to foster health agency for patients like JM who need to have sensitive conversations? These actions would create the kind of diagnostic openness that fosters trust with patients and the community, because other forms of knowing are actively being recognized and embraced.

Finally, we would stress how clinicians can develop a deeper understanding of Native life and culture by engaging with the literature. There is an emergent historiography of the River Basin[21] and the resources of the Human Relations Area Files[22] can be utilized to gain understanding of specific cultural practices and their history. Additionally, perhaps one of medical anthropology's most important contributions to clinical care is the reflexive awareness that poverty and pathological processes can be conflated (and confused) with culture.[23] For example, researchers have documented how entire communities can be categorized as "sick" by overemphasizing epidemiological data on particular diseases or disabilities like type 2 diabetes.[24] Clinicians then stress individual responsibility and medical compliance rather than stepping back to understand how dispossession of ancestral lands, economic factors, and structural violence have led to the lack of a healthy diet and reliance on processed foods.[25,26] Dr L's continuous learning would establish a baseline of cultural awareness of the CRIT community, thereby preventing her from pathologizing and racializing culture(s)[27] and enabling her to practice cultural humility during clinical exchanges.[28] As a result, Dr L would develop an ethnographic mindset, a cultural insider's perspective (in anthropological terms), or, in a clinical sense, epistemic humility in embracing different ways of knowing.[19]

Collaboration

In terms of the immediate care of a legal minor, Dr L must find a way of collaborating with him and his family that can ensure relationship building and trust. Older models, stressing medical compliance and mental health management by one clinician have been replaced with interprofessional models of Native care.[29,30] This model stresses a patient-centered approach wherein the patient or family is part of the team (both theoretically and in practice), helping to make care decisions with other health and social care specialists. The information a patient and family can provide is now considered essential for everything—from making a culturally informed diagnosis to understanding the impact of social determinants and adverse childhood experiences (ACEs) on morbidity and mortality—and, in particular, for making TIC decisions.

JM's perceived estrangement from his family and general sense of alienation will make establishing initial rapport a challenge, albeit a critically important one. Making JM feel comfortable during that first meeting is going to hinge on the answers to several questions: Is there *any* family member or trusted adult or guardian available whom JM wants (and should have) with him during the visit? Is language translation a factor in his care? Can Dr L (or a member of the clinic team) administer appropriate assessments during the initial visit and follow-up appointments in ways that are not overly stressful? It would be of the utmost importance for JM not to feel overwhelmed by the assessment process, and therefore only suicidal ideation would be assessed initially and an accompanying safety plan developed. Moreover, because of JM's complex history of possible drug overdose and the spike of adolescent deaths recently in his community, the team will need to determine if a higher, more immediate level of care is required (whether in-patient treatment or intensive day treatment). After the suicide assessment and JM's eventual stabilization, we would recommend that the clinic use the following types of tools administered ideally over the span of several sessions: a social determinants survey (with a family member),[31] the ACE survey,[32] Beck's Depression Inventory,[33] and clinic protocols for brief interventions, assessments, and referrals of adolescents with suspected opioid use disorder.[34]

Before these assessments can be made, however, Dr L essentially has one opportunity to build enough trust and rapport with JM to ensure productive and meaningful follow-up visits. First impressions matter in terms of compassion and showing one cares about *the person* (vs the data), with continuity of care a close second (ie, patients having one clinician or team and telling their story *only one time*). A study on vulnerable HIV patients in the United Kingdom found that trust was built and patient anxiety reduced at the first visit through 5 actions being taken: "1) provide reassurance to patients, 2) tell patients it's okay to ask questions, 3) show patients their lab [survey and assessment] results and explain what they mean, 4) avoid language and behaviors that are judgmental of patients, and 5) ask patients what they want (i.e., treatment goals and preferences)."[35] This kind of approach to JM would allow for the long-term work of healing to take place and help establish trust for a young patient who may be estranged from his family.

Trauma-Informed Healing

We argue that the practice of TIC by clinicians within First Nation communities should be guided by a deep understanding of embodied trauma. Embodiment as a concept has a long history in anthropology,[36,37] and contemporary TIC has worked to fully integrate the body into treatment planning, techniques, and psychotherapy.[38,39,40] The impact of intergenerational trauma is an everyday reality within Native communities.[27] First Nation families are often *one generation* away from the forced removal of children from homes to attend boarding schools in the United States and Canada (the last of which closed in Canada in 1996).[41,42] There are rich sources on TIC, and practicing clinicians should routinely review tools such as the "Trauma-Informed Care Fact Sheet" (TICFS) by the Substance Abuse and Mental Health Services Administration and National Indian Child Welfare Association, which are essential starting points.[43] JM may have embodied the convergence of all 4 forms of trauma outlined by the TICFS—cultural, historical, intergenerational, and current.

Peer support for JM and expertise in TIC are critically important to JM's healing. Dr L and the care team must be careful not to inadvertently retraumatize the patient in the first or subsequent interview sessions so that the chance of successful therapeutic alliance is enhanced instead of thwarted. TIC ethically mandates that individuals receive care in a safe, compassionate, and collaborative environment that seeks to build upon both the strengths and the resiliency of the individual seeking care. With this in mind, in subsequent treatment, it would be helpful to consider appropriating modalities used in psychotherapy, such as somatic and polyvagal strategies.[40] Somatic modalities (eg, Levin's body-oriented techniques and Dana's polyvagal exercises) help to calm and regulate the nervous system. Using basic techniques like "grounding" through simple breathing exercises (eg, box breathing), breath map exercises, and sensing the body-boundary or body as a container helps patients like JM feel safe and learn to self-regulate.[44,45,46] Nurturing a sense of calm and well-being helps create an environment and conditions that are less threatening and more receptive for treatment. Furthermore, any strategy should include a TIC treatment plan,[47] which aims to ensure that an individual has been able to establish basic coping skills that they can use in order to remain grounded and present when processing aspects of their traumatic experiences. Once coping skills are in place (eg, self-regulation) and somatic interventions are routinely practiced, a safe environment can be established so that an individual, such as JM, is able to accept and receive other forms of treatment necessary for the long-term processes of healing to occur.

Discussion

First Nation peoples, like other historically oppressed groups, such as African Americans, have experienced centuries of marginalization through the tactics and techniques of settler colonialism and exploitative and racialized capitalism. Native Americans continue to face some of the same problems, such as police violence[48] and gendered violence against women,[49] as other vulnerable communities. Nevertheless, Native Americans live, work, and continue to heal in vibrant communities that over the last several decades have witnessed a revitalization of culture and language. Psychotherapists and anthropologists often have the luxury of time when building rapport, trust, and long-term relationships with the people they work with. Clinical encounters today, where the stakes can be extremely high for patients like JM, are not structured for this kind of relationship building. However, there are novel, emergent, and historically sound ways to build healing relationships with communities in need of trauma-informed approaches to care that would benefit patients and clinicians alike.[50] Interprofessional collaboration with empathy and openness is foundational in this regard, with the patient, family, and caregiver being key members of and contributors to the team—their voice(s) and their ways of knowing must matter.[51,52]

We emphasize that clinicians must understand the body through a trauma-informed lens.[53] Clinical training and medical school teaching has begun to rethink the physical examination through this approach, while assessing its impact on practice and learning.[54] Moreover, we advocate for daily collaboration, whether in person or through the electronic medical record, between practicing primary care specialists and mental health experts, such as social workers, psychologists, addiction specialists, and clinical counselors, as well as peer supporters, all of whom are advancing TIC and body-informed healing ahead of medicinal practice.

Mental health care itself can be marginalized when the care of a patient is referred out to specialists, who in turn may not communicate with clinicians on a regular basis because of the logistics of modern medicine (eg, different electronic medical records or health organizations). There remains a curious siloing of mental health care,[55] wherein psychiatrists and primary care clinicians continue to prescribe robust levels of psychotropic medication while relegating more complex psychodynamic treatments for patients, such as TIC, to other specialists. Medical anthropologists, such as Kleinman, when assessing the state of global mental health resources, have noted the imbalance between overprescribing of psychotropics in White, wealthy countries and communities and the lack of care for serious mental health issues in poorer, more marginalized countries and communities.[8] Ironically, it is the nonpharmacologically based clinicians who have brought the traumatized body back into focus for biomedicine by listening to their patients and advancing TIC. Complex patients like JM, who embody and live with myriad forms of trauma, must receive safe, Native-centered care in a trauma-informed clinical environment with appropriate resources. Healing will depend on effective collaborations, diagnostic openness, and clinical humility that provide an opening (or opportunity) for patients to trust that the care they receive can lead to a more meaningful and healthy life.[56]

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CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

How Should Clinicians Help Patients Navigate "Model Minority" Demands?

Nellie Tran, PhD, Kevin Yabes, MS, and Arianne Miller, PhD

Abstract
The "model minority" myth (MMM) has far-reaching implications for Asian Americans in many settings, including medicine. For clinicians working with first-generation Asian American college students, this article considers 3 factors that affect how the MMM plays out in clinical care: clinicians' racial identity awareness, cross-racial dynamics, and the extent to which a patient has internalized racism or oppression.

Case

JJ is a student doing a rotation in a university clinic. JJ's patient introduces himself as "Todd" and is an 18-year-old Chinese American student who states that he hasn't been feeling well. As JJ talks with Todd, JJ learns that Todd studies electrical engineering and that his parents, brother, and sister run a restaurant in a neighboring state. JJ notices Todd's flat affect and difficulty maintaining eye contact[1] and asks Todd about his courses, part of a curriculum widely known for its rigor and intensity. As JJ leafs through Todd's health record, a clinic note from 3 months ago suggests Todd experienced suicidal ideation.[2,3]

JJ continues to try to engage Todd, who says, "Classes are fine. My engineering project group goes out for drinks without me, though, typically leaving me with group problem sets to do alone. I hate that."

JJ responds, "I see why you hate it: that's a lot of pressure."

Todd denies that this is the case. "Sorry," he says, "I shouldn't have brought it up. It doesn't matter. I just have to get this degree so I can help my family and make my parents happy we came to this country."

JJ wonders what to say next.

Commentary

Research on Asian American students overwhelmingly focuses on the existence and impact of the "model minority" myth (MMM), especially on academic performance. The myth suggests that Asian Americans work hard and are successful despite racial discrimination. It was originally introduced to undercut the civil rights movement by suggesting that racism can be overcome by hard work and achieving the American Dream.[4,5,6] Indeed, the MMM was one means of pitting Asian Americans against other racial groups—specifically, wedging them between White and Black Americans.[7] However, the MMM can itself lead to discrimination against Asian Americans across many settings, including medicine. Non-Asian Americans who endorse the MMM are more likely to perceive Asian Americans as psychologically healthy,[8] generally healthier overall, and the least likely racial group to suffer from any disease.[9] Thus, the MMM has contributed to the larger public belief that Asian Americans are healthier than other minoritized ethnic groups.[9] Belief in the MMM might contribute to clinician bias that in turn contributes to underscreening for cancer,[9] overlooking of mental health symptoms,[10] and mistrust of clinicians in Asian American patients.[10]

Researchers and scholars in education, psychology, and Asian American studies consistently agree that there is a lack of scientific evidence for the model minority image of Asian American students as intelligent overachievers.[11,12] A closer look at the data shows that Asian American students vary widely in their academic abilities and that racism and oppression have a deep impact on the psychological health and academic outcomes of these students,[11,12,13] especially Southeast Asian[14] and Pacific Islander students.[15] Despite being a gross oversimplification and overgeneralization, the MMM remains a firmly held belief within many Asian American communities[16] and among the broader US public. Asian Americans continue to report experiencing racism on a daily basis on multiple levels, including individually, interpersonally, institutionally, and societally.[17] Racial discrimination, in turn, has been consistently shown to be related to poor health and poorer mental health.[18] Consequently, it is important for clinicians to understand that stereotypes like the MMM are likely to affect the way they perceive their Asian American patients, the way they judge symptoms that are presented or absent, and the medical choices they offer and diagnoses they ascribe to Asian American patients.

Below we present 3 considerations for clinicians and educator-clinicians to note while serving first-generation, Asian American college students presenting with depressive symptoms in the clinic and facing the model minority stereotype while navigating college life. Awareness of these factors, including the clinician's racial positionality, the role of cross-racial dynamics, and the extent of the patient's internalized oppression, are important to consider alongside the MMM and its negative outcomes (eg, exacerbated psychological distress and further health care disparities). In offering these considerations, we posit that understanding racial dynamics allows clinicians to more effectively navigate their interactions with the patient and amplifies clinicians' ability to advocate for the patient and address the patient's needs.

Racial Identity Awareness

The extent to which you, as a clinician, internalize a positive racial identity affects the way you interact with other people within and outside of your racial group. This process is referred to as racial and ethnic identity development.[19,20] In other words, how do you think about the concept of race and your personal race affiliation? Not thinking about one's race is also an identified stage in racial identity development and ought to be explored. By starting with the self, clinicians lower the chances of projecting their own unexamined issues onto the client. For example, college students sometimes experience emotional discomfort if attending a college with more racial diversity than their hometown.[11] Racially unaware clinicians might not understand how normal and difficult this experience might be if they themselves have not experienced it. In this way, clinicians might perpetuate implicit beliefs that are inherent to the MMM, such as the belief that Asian Americans will be academically successful if they just work at it. The clinician might downplay or normalize the stress and pressure that the patient feels and miss possible depressive symptoms such as fatigue, excessive guilt, low mood, and anhedonia. These symptoms might be ascribed to the student patient's academic workload rather than being appropriately assessed as an indication of depression. Two experimental studies found that, when exposed to the MMM, participants were significantly more likely to perceive Asian Americans as having better mental health functioning and fewer clinical symptoms[10] and were less likely to diagnose alcohol use disorders[21] than when not primed with the MMM.

Clinicians who do not acknowledge the importance of race and racial experiences might also believe that Asian Americans only experience mild racism or are not affected by the racism they do experience. Indeed, studies show that doctors and other practitioners hold cultural stereotypes about Asian Americans.[22] Consequently, these clinicians might decide that racial stereotypes of success are not stressful, oppressive, or harmful, as research on the underscreening of cancer in Asian Americans[9] might suggest that members of this group already have all the necessary medical resources and services. If this is the case, Asian Americans presenting with mental health concerns must not need resources or accommodations, either. As a result, clinicians might work with Asian American patients on internal regulation and control rather than on externalizing or minimizing self-blame, which has been shown to be most effective in coping with race-related stressors.[23] One strategy for regulating racial bias that clinicians could apply to themselves is simply being aware of and acknowledging their racial identity and possible racial biases.[24] Indeed, when clinicians, especially White clinicians, are aware of their racial biases or made aware of these biases, they are more likely to make adjustments and work harder to adjust their prejudicial behaviors.[25]

Cross-Racial Dynamics

Perception of others. After you understand your own racial identity, you can attend to the patient's understanding of race and the impact of the MMM on the patient. *Cross-racial dynamics*[26] refers to the relational pushes and pulls, norms, and standards that exist among individuals belonging to or identifying with different racial groups. In other words, how do you relate to members of other racial groups? What implicit biases do you hold, and how do they show up when you interact with other people? Research has consistently found that medical practitioners are biased in their treatment of patients of color generally[27] and Asian American patients in particular.[28,29] One study of Asian Americans found that experiences of language discrimination (ie, being treated unfairly or with disrespect due to lack of fluency in English) is more strongly associated with chronic health conditions for those who have lived in the United States for 10 or more years than for more recent arrivals.[30] It is possible that biased experiences with health care professionals lead Asian American patients to avoid returning for subsequent health issues. This behavior would then contribute to health care professionals believing that Asian American patients do not need their services, which aligns with the MMM beliefs discussed earlier.

Others' perception of self. It is also important for clinicians to understand how they are likely to be perceived by their Asian American patients. Racial dynamics comprise the perceptions of all individuals involved. Extant literature suggests that patients' mistrust in the therapeutic relationship frequently stems from clinicians' stereotype bias and lack of awareness of racialized power and privilege.[31,32] Therefore, clinicians whose racial identity might not be readily perceived by others (eg, mixed race, racially ambiguous) have the additional task of understanding how their racial appearance affects them personally and their therapeutic relationships. For example, racially mixed or racially ambiguous-appearing people who are denied their American or White identity experience greater stress and are more likely to react by verbally asserting their identity than those who experience an identity-irrelevant denial.[33] Clinicians should be aware of the potential for this scenario to arise and be mindful of the patient's perception of the clinician's race. An Asian American student with low English proficiency interacting with a White-presenting, Latinx clinician might not ask for a translator because they hope to be accepted as more "American." Asian Americans like this one are likely struggling with the MMM and have tended to assimilate English-language norms (ie, good Americans learn English and are not a burden to others). Had the student perceived the clinician to be Latinx, perhaps they would have felt more comfortable asking for a translator. Understanding one's personal racial identity and race relations will guide best practices for working with Asian American student patients.

Generational status. Asian American clinicians must consider possible biases attached to their patient's ethnicity and generational status, as well as their own. For example, US-born Asian Americans or even US-trained Asian American clinicians might approach physical and mental health in a more westernized way relative to first-generation Asian Americans. Accordingly, clinicians working with first-generation Asian Americans would benefit from considering Asian American indigenous healing practices, such as detoxing and use of medicinal herbs.[34,35] The integration of traditional healing practices with Western medicine allows for the strengthening of trust in the patient-clinician alliance and the development of culturally appropriate care.[16]

First-generation Asian immigrants often report different acculturation patterns than their US-born counterparts,[36,37] such that they anticipate the need to behave differently in non-Asian dominant spaces. Consequently, postmigration and adjustment issues may present as depressive symptoms in first-generation immigrants. Isolation and loneliness are common feelings for college students away from home for the first time and might be amplified for newly arrived international students. Note that international students are technically not considered immigrants. First-generation immigrants typically refer to green card holders, foreign-born US citizens, Deferred Action for Childhood Arrivals recipients, and other undocumented immigrants. Nevertheless, international students are likely to present at the clinic and have unique concerns. For example, international students and other students who have recently immigrated are likely to have a harder time adjusting to cultural differences and potentially the English language, depending on their country of origin (although some Asian countries are English fluent, such as India and the Philippines).

First-generation immigrants often have less US experience and historical knowledge to contextualize their experiences of discrimination. Having historical knowledge of US racial oppression and the minoritization of Asian Americans along with other people and communities of color allows these individuals to externalize their experiences of racial discrimination.[13] For example, if a first-generation immigrant student is asked to "Americanize" their name so English speakers will have an easier time saying it, they are likely to believe that they are at fault for having an unusually difficult name. A US-born student receiving a similar request to change their name to simplify their English-speaking clinician's or peer's life might be more able to externalize the incident, depending on their racial identity development. This individual might say, “This is a racist request that people of color often receive from people of European descent and stems from a history of colonizing both other people’s land and body.”

More recently arrived Asian Americans are also likely coming from a home country where they are part of the racial and ethnic majority group (eg, Thai person living in Thailand). This period of residence in the United States might be the first time in their life when they are part of the minority group. Immigrants who do not identify as bicultural—who are not able to fully engage in both their culture of origin and the new US culture—often report more depressive symptoms than bicultural immigrants.[38]

Ultimately, clinicians need to adjust their approach to their patient’s needs. For patients who are low in understanding societal-level oppression, be careful about pushing for work on internal processes alone and inadvertently suggesting that the individual is deficient. Instead, a more just approach would be to balance helping patients learn about the US racial historical context and the existence and history of the MMM with building their sense of agency to combat the effects of the MMM. For patients who are only focused on societal-level oppressive forces, understanding where their internal controls lie might be helpful.

Patients’ Internalization of the MMM

If we begin from the position of believing the science that suggests that the MMM is indeed a myth, then we can understand that Asian Americans’ endorsements of and belief in the MMM constitute internalized racism or oppression (ie, internalization of the MMM). Understanding the extent to which the patient has internalized the MMM is another means of considering the patient’s positionality within the racial dynamics of the therapeutic relationship.[39] The MMM plays out for Asian Americans in myriad ways.[40,41] On the one hand, Asian Americans sometimes play into the myth, believing that it helps them appear “good” and even smarter than other students. This stance, however, might contribute to a lack of confidence, chronic anxiety, and the development of *imposter syndrome* if they feel the MMM helps them appear smarter or better than they actually feel they are. Research suggests that Asian Americans who internalize the MMM show higher levels of psychological distress and more negative views of help-seeking behaviors.[42] On the other hand, the MMM relies on there being a racial hierarchy, with White Americans at the top as the dominant majority and Asian Americans at the top among racial minorities. Consequently, Asian Americans who uphold the MMM might work against their own best interest in order to maintain the racial hierarchy and their position above other racial minorities, such as by advocating for racially color-blind policies.

There are several ways for clinicians to support patients who have internalized the MMM. One way to minimize stereotyping and allow for a supportive and culturally informed program for navigating the MMM might be to build patient-support groups that are run by fellow Asian American patients. Clinicians might also consider developing support groups at university clinics to allow Asian American patients to work with one another. Meditation groups have been found to provide relief for Asian Americans dealing with racism-related stressors and presenting with depressive symptoms.[43] While this approach eliminates cross-racial dynamics, other in-group dynamics (eg, gender, immigration status, ethnic group affiliation) may be present; thus, practitioners must be cautious of presuming that this support group would be helpful to all Asian Americans.[44]

Conclusion

Best practices for working with first-generation Asian American college students entail cultural knowledge, empathic understanding, and a balanced approach to internal regulation and externalization of problems. To develop these resources and skills, clinicians need to be knowledgeable about their racial positionality, cross-racial dynamics, and the internalization of the MMM.

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The people and events in this case are fictional. Resemblance to real events or to names of people, living or dead, is entirely coincidental. The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.

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CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

How Should Clinicians Respond to Children in Transgenerationally Traumatized Families?

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Abstract

Pediatricians have obligations to respond with care to all children's clinical and social vulnerabilities. Finding and addressing causes of children's stress (ie, family separation, child abuse, and trauma) are also obligations. Preventive and rescue interventions should be implemented to address potential short- and long-term harms of toxic stress and their short- and long-term consequences.

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Case

Dr A practices primary care in a US plains state that is home to many recent Honduran refugees. HH is an 11-year-old patient brought to the free clinic by their mother for a routine check-up. Dr A greets HH and HH's mother and interviews HH, who does not make eye contact. Dr A confirms that HH doesn't hurt anywhere, is eating well, and attends school. "Are you sleeping all right?"

HH shrugs. HH's mother states, "It has been hard on my children," and explains why the family recently fled Honduras. HH's ancestors lived on land now known as Honduras for centuries until recent political upheaval made life there intolerable. HH's father was murdered near their home. This necessitated that the remaining family members leave Honduras on foot and seek asylum by crossing through Mexico and entering the United States. At the US border, they were separated and detained for several weeks. HH's family members were each granted asylum and have been staying with cousins.

HH's mother begins to cry after saying, "I don't know what would've happened to us if we didn't have any cousins here."

HH begins to cry, too, but does not want to speak with a counselor. Dr A wonders how to respond.

Commentary

Pediatricians have obligations to respond with care to all children's clinical and social vulnerabilities. Yet pediatricians might feel unprepared to deal with the complexity of care for refugees and immigrants. While providing care to HH, Dr A should address all their immediate medical needs while ensuring that all factors that affect well-being are taken into consideration, including the trauma that HH and their mother have experienced. The National Child Traumatic Stress Network (NCTSN) outlines 7 principles of trauma-informed care: (1) "Routinely screen for trauma exposure and related symptoms," given the high prevalence of trauma in children; (2) use evidence-based, culturally sensitive tools for assessment and treatment of traumatic stress and associated mental health symptoms; (3) "make resources available to children, families, and providers on trauma exposure, its impact, and treatment"; (4) "engage in efforts to strengthen the resilience and protective factors of children and families" that have been affected by trauma; (5) address trauma in both parents and caregivers and address its impact on the family; (6) "emphasize continuity of care and collaboration across child-service systems"; and (7) "maintain an environment of care for staff that addresses, minimizes, and treats secondary traumatic stress."[1] These principles are recommended as practical guidelines to ensure that clinicians recognize and respond to the impact of trauma. Discussion of this case considers how clinicians can recognize, assess, and respond to trauma.

Clinical Assessment

Trauma. Dr A is probably aware of the high prevalence of trauma in immigrants, refugees, and children who have experienced separation from their parents.[2] The case relates that HH is not making eye contact. Dr A should consider several reasons for HH's lack of eye contact, including trauma and conditions such as anxiety, depression, and posttraumatic stress disorder (PTSD). Dr A appropriately asks about HH's sleep as part of the routine interview but perhaps also as a way to start assessing for HH's experience of and response to trauma. Children with any of these conditions typically present with various sleep problems: difficulties in falling asleep, middle-of-the night awakenings, difficulty falling back asleep, disruption in sleeping patterns and schedules, or oversleeping.[3] Dr A also assessed the child's appetite and eating patterns, as many children with emotional distress, depression, anxiety, or PTSD will present with appetite changes or disruption in eating patterns.[4] Dr A confirms that HH is eating well. Identifying and addressing the causes of emotional distress is an obligation for any pediatrician. Different causes must be considered, including family separation, child abuse, and trauma. Often, the first sign of emotional distress, anxiety, depression, or PTSD is a change in school attendance or school performance. Although in this case vignette HH is attending school, the case does not include complete information pertaining to HH's school attendance and academic performance. Also important are HH's social interactions. Does HH have friends at school? Does HH see their friends outside of school? What do they do together in their free time inside or outside of school?

HH's mother describes several stressful events that the family has endured recently, including the violent loss of HH's father, family members' need to leave their home country and pursue asylum, and the separation and detention that they experienced at the border. HH's mother cries while describing these events. While her emotional reaction is appropriate, Dr A, as a pediatrician, has to wonder whether HH's mother herself is experiencing emotional distress, depression, anxiety, or PTSD. Dr A thus should also address HH's mother's experience of trauma when addressing HH's problems. If indicated, Dr A should refer HH's mother to a therapist and help her connect with resources that would help both her and HH. Studies have documented how the presence of trauma, emotional distress, anxiety, depression, or PTSD in parents affects the well-being of their children.[5] When left untreated, these conditions can undermine healthy parenting.[5]

Counseling referral. Although HH does not want to speak with a counselor, it is extremely important for the care of both HH and their mother to include behavioral support. HH might have feelings of guilt, shame, and avoidance that can make obtaining the history of trauma difficult.[6] HH's developmental stage and limitations in memory and language might also alter HH's capability to share details of past experiences and trauma from the death of their father, leaving their home country, crossing the border, being separated from their mother, and now adapting to a new home and a new country.[7] Dr A should refer HH to a therapist. Although many free clinics might not have therapists who provide counseling on-site, a reasonable recommendation is to have a list of potential local therapists who can offer services pro bono or on a sliding-scale fee. Some of these resources could be obtained through local colleges and universities or through federally qualified health centers. Therapists might employ different techniques to engage and elicit communication from children who have experienced trauma. These techniques might include play therapy, drawing, or reenacting. It is important to take into account that HH's distressing memories and emotions are likely to resurface when describing the traumatic events that they have endured.[8] Therapists and other members of the treating team should share the child's primary language or use linguistically appropriate resources (eg, certified interpreters) and developmentally appropriate techniques as well as show cultural awareness.

Child abuse. Consideration should always be given to the possibility of child abuse by any caregiver—in this case, by HH's mother or other adults that cared for HH while HH was separated from their mother, such as immigration officers. Red flags include, but are not limited to, lesions discovered upon physical examination, reports of physical or sexual abuse made by HH or their mother, or unexpected or unusual behaviors, such as hypersexual activity. All 50 states have laws requiring reporting of child abuse, and 46 states have criminal penalties for failure to report child abuse.[9]

Persecution or torture. Frequently, asylum cases require or include forensic evaluations.[10] A pediatrician can ethically undertake a forensic evaluation. Indeed, pediatricians are in a unique position to perform forensic asylum evaluations, as they know all the conditions of their patients and can be the best advocates for the well-being of their patients.

Long-Term Effects

HH's long-term health and cognitive and physical development might be hindered by their experiences following departure from their home country, especially the mutual separation that HH and their mother endured. During the time of their separation, probably neither HH nor their mother knew if or when they would be reunited and both suffered from toxic stress. It is well established that childhood stressors, including detention and family separation, are harmful to a child's well-being and development, putting the child at lifelong risk for negative physical and mental health consequences.[2,11,12,13] While experiencing toxic stress, both HH and their mother were, and might still be, in survival mode. Their brains and bodies are fixated on ensuring immediate survival. HH, as a child, is especially vulnerable to the effects of toxic stress because he is still undergoing major brain development. As HH experiences toxic stress, survival takes priority over other normal childhood activities, such as cognitive development and physical growth. The trauma that HH experienced while being separated from their mother most likely has neurodevelopmental sequelae. During toxic stress, stress hormones affect the development of critical synapses and neurological connections that are essential to child development, learning, academic performance, and emotional maturation. The neurodevelopmental sequelae of toxic stress have physical and mental health implications that might be lifelong.[11]

Conclusion

HH and their mother's situation is quite complex. Treating their basic medical and mental health needs requires triaging the appropriate resources. In assessing asylees' social environment, needs, and current support, clinicians must evaluate their trauma symptoms while taking into account their capacity for emotional regulation.[8] Dr A should consider involving an interdisciplinary or a multidisciplinary team to address HH's and HH's mother's needs. While the involvement of such a team is not necessarily an ethical obligation, it certainly helps in fulfilling the ethical obligation to promote the well-being and best possible care of the patient. An ideal team might include behavioral therapists, social workers, other mental health care professionals (eg, developmental behavioral pediatricians, child psychiatrists) as well as schoolteachers and counselors, community advocacy leaders, and immigration lawyers. In the case vignette, Dr A might believe that referral is necessary to address HH's and their mother's needs—in particular, those related to traumatic stress or its exacerbation by asylum interviews.[8] Dr A and all health care professionals, especially pediatricians caring for children and families who have experienced situations similar to those of HH and their mother, can access helpful information through the NCTSN.[14] Although pediatricians and other health care professionals might perceive themselves as ill prepared to address the unmet needs of immigrant families, they have the resources and they have the moral and ethical obligation to identify these needs and refer patients to the proper resources. Pediatricians and all health professionals also have obligations to advocate for their patients and encourage local, state, and federal appropriation of resources to improve conditions in care settings for immigrant and refugee patients.

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CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

Pharmacist and Prescriber Responsibilities for Avoiding Prescription Drug Misuse

Stephanie Sun, MD, MSc and Bruce D. White, DO, JD

Abstract

Pharmacists have the same duty as prescribers to prevent inappropriate use of dangerous drugs. Loperamide, for example, is an over-the-counter medication that has been reported to be potentially misused for euphoric effects. Pharmacists and prescribers alike face challenges in providing optimal care for patients and protecting communities from drug misuse. These challenges include cognitive bias, underdeveloped safety culture, and differing expectations of responsibilities of the other party in ensuring safe prescribing. This commentary explores legal, ethical, and practical considerations for pharmacists and prescribers working together to address uncertainty in drug prescribing.

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Case

Ms D is one of 2 pharmacists at an Indian Health Service (IHS) unit in Oklahoma. Familiarity with community members who recently died by prescription medication overdose has prompted Ms D to focus more on preventing misuse and abuse of prescription medications. She has, for example, recently reviewed the Indian Health Manual's pharmacy section, which outlines standards of practice and the mission to "ensure efficacious, safe, and cost-effective drug therapy."[1] Since her license to practice pharmacy is from the state of Ohio, Ms D also reviewed the Ohio Administrative Code's State Board of Pharmacy section about prescribers' and dispensing pharmacists' "corresponding responsibility"[2] to properly issue prescriptions to patients.

Ms D is processing a loperamide refill for Mr T, a 32-year-old Cherokee patient with chronic intermittent diarrhea. When viewing Mr T's electronic health record, Ms D notices his history of opioid use disorder. She also sees that Mr T's clinician, Dr O, has refilled the loperamide prescription 4 times over the last 3 months, and there was no documentation of symptom exacerbations during that time. Ms D wonders whether Mr T could be misusing loperamide to try to mimic effects of opioids.[3] Ms D calls Dr O to discuss this possibility.

According to Dr O, Mr T's history of substance use disorder is in the distant past. Dr O notes that it is also important for Mr T to have loperamide to manage his symptoms. Ms D is unconvinced, however, and states that dispensing loperamide could contravene Mr T's best interests and violate her duties to this patient as explicated in the Indian Health Manual and Ohio Administrative Code. Exasperated, Dr O reminds Ms D that Mr T has no supplemental insurance, that Mr T does not have access to a hospital or other clinic within 2 hours of his home, and that the IHS pharmacy is his only source for obtaining loperamide.

Ms D and Dr O remain on the telephone line and wonder how to resolve their disagreement about whether it is appropriate to refill Mr T's prescription.

Commentary

In *Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine*,[4] Jonsen, Siegler, and Winslade suggest tackling ethical dilemmas by first looking closely at facts that could help establish agreement about clinical indications for timely, specific interventions. Ms D is probably aware of published reports that persons who abuse opioids have attempted to use loperamide as an opioid substitute for euphoric effects.[3] Mr T has a history of substance use disorder. It is unclear whether the substance use disorder involved opioids. Although this is a reasonable possibility,[5] the details of Mr T's substance use disorder history, including whether he is an active user or in recovery, is insufficient to determine the appropriateness of prescribing loperamide. It is also inappropriate to suspect Mr T of prescription misuse on the sole basis of recent overdose deaths in the community (a cognitive bias that will be explored later).

The case as described leaves many reasonable questions unanswered regarding the appropriate use of loperamide by Mr T (see Supplementary Appendix Tables 1 and 2). Therefore, Ms D rightly contacted Dr O for clarification. This commentary explores legal, ethical, and practical considerations for pharmacists and prescribers working together to resolve uncertainty in drug prescribing.

Indian Health Service

Which regulatory body—state, federal, or tribal—holds jurisdiction over dispensing at this IHS site? As federally operated pharmacies, each IHS service unit is responsible for developing local policies and procedures that are in accordance with federal law, including US Drug Enforcement Administration (DEA) regulations[1] and state prescription drug monitoring program reporting.[6] IHS sites also maintain a pharmacy library that includes current federal and applicable state laws governing the practice of pharmacy.[1] Since IHS pharmacies are federally operated, IHS pharmacists do not need to be licensed in the state where they work. However, IHS pharmacists must comply with their state board regulations in order to maintain their licenses. An opinion from the Arizona Attorney General addressed this issue in the context of a question from the Arizona Board of Nursing and is helpful in explaining how state and federal legal jurisdictions are applied.[7] If there is ever a discrepancy between federal and state laws, pharmacists are to follow the more restrictive law, regardless of whether it is federal or state. Fortunately, federal, IHS, and state regulatory language on corresponding responsibility is consistent (see Supplementary Appendix Table 1).

What about tribal jurisdiction over health care? As sovereign nations, federally recognized tribes can exercise their authority to pass laws to protect and promote the health of their citizens.[8] While jurisdictional issues of tribal, state, and federal laws can be complicated,[9] the development of tribal law is an important step in self-determination and tribal political sovereignty. An increasing number of tribes and tribal organizations have also been taking ownership of the design and management of health programs. Since the passage of the Indian Self-Determination and Education Assistance Act of 1975,[10] federally recognized tribes and tribal organizations can assume control of IHS funding to directly develop and manage programs, services, functions, and activities to meet the needs of their tribal communities. A tribe can choose to continue receiving health care services directly from the IHS, to contract with the IHS to administer individual services, or to compact on a nation-to-nation basis with the IHS to control health care programs the IHS would otherwise provide. The decision to move from direct IHS services to contracting or compacting is a tribally driven initiative informed by the tribe's determination of its unique needs and circumstances.

Physician and Pharmacist Responsibilities

In entering discussions of physician and pharmacist responsibilities, all parties must share 3 key understandings: first, that pharmacists have a corresponding responsibility to ensure the medical appropriateness of dispensed medications; second, that all are doing their best for the patient within their capabilities; and third, that clinical judgment will always involve some degree of uncertainty.

Medical appropriateness. Often when those familiar with pharmacy law and ethics topics read the phrase *corresponding responsibility*, they immediately think of the DEA regulation on prescribing that charges pharmacists with the equivalent duty as prescribers to ensure that controlled substances prescriptions are written and dispensed "for a legitimate medical purpose … in the usual course of … professional practice."[11] The Department of Justice (DOJ) and the DEA wanted to make it crystal clear that pharmacists have a corollary duty with physicians, dentists, veterinarians, and other practitioners to prevent inappropriate use of dangerous drugs and opioids. This rule helps eliminate an irresponsible defense (ie, "I don't write prescriptions; I just 'fill them'"), as implied by Elvis Presley's pharmacist defense of his dispensing over 5600 controlled substances doses during the 6 months before Presley's death.[12,13]

Why should Ms D be worried about any corresponding responsibility with a nonprescription over-the-counter drug, such as noncontrolled loperamide?[14] According to the State of Ohio Board of Pharmacy rule, all prescriptions—not just controlled substances prescriptions—are dispensed under the same standard as federal law.[2,15] One might reasonably argue that this may be the standard of care expressly[16,17] or implicitly in all US jurisdictions, since pharmacists are ethically obliged to act in patients' best interests and "assist individuals in making the best use of medications."[18]

One should note, however, that Dr O and Ms D might feel differently about following the letter of the law. Abood and Burns write in their textbook, *Pharmacy Practice and the Law*:

> Pharmacists are highly regulated as health professionals because the slightest misstep in drug distribution or pharmaceutical care could cost a life. As custodians of the nation's drug supply, pharmacists are subjected to extensive regulation because the products pharmacists control are held to the most exacting standards of any consumer product. Pharmacists study the law because, through the law, society has described what is considered acceptable conduct for pharmacists, and pharmacists who fail to meet this level of acceptability will be held accountable for their failure.[19]

Unlike physicians and other health care professionals, pharmacists are trained extensively in the law. In pharmacy school, pharmacists take a pharmacy law course (or some series of required law lectures); they all sit for and must pass a state-specific pharmacy jurisprudence examination as part of the licensure process; and many are required to take a required pharmacy law refresher course periodically as part of their mandatory continuing education requirements for relicensure.[20] Regrettably, many of the laws and regulations that govern pharmacy operation and practice appear ridiculously detailed and have little to do with meeting practice obligations to patients. To name a few such regulations: the minimum pharmacy square footage of floor space and uncluttered prescription counter area required per pharmacist available for filling prescriptions, the titles and types of books necessary for a pharmacy reference library, the equipment necessary to compound prescriptions, and unique requirements for a pharmacy operating within a larger mercantile or grocery store.[21,22,23,24,25]

Patients' best interests. The second shared understanding in interprofessional discussions is that all parties are doing the best they can within their capacity to help the patient. Ms D has not only a legal obligation to understand Dr O's clinical rationale for prescribing loperamide to better ensure compliance with regulations, but also an ethical obligation to provide the best care for the patient. Additional conversation is an opportunity for Ms D to provide Dr O with suggestions for other antidiarrheal substitutes that do not carry the same misuse potential as loperamide. The frequency of loperamide prescriptions for Mr T may have passed under Dr O's radar, especially if more critical patient-driven issues were the focus of visits or if there has been a lack of patient-clinician continuity. Concerns about the risk of drug misuse aside, the loperamide refills may be a clue to an underlying chronic diarrheal condition that has not yet undergone full workup or treatment. When brought to Dr O's attention, this issue can be the means to move care forward for the patient's benefit.

Regarding the financial issues the "exasperated" Dr O advances for prescribing loperamide, one might challenge these as potentially immaterial justifications and caution Dr O and Ms D not to chase them too far down the rabbit hole. As health care professionals, both Dr O and Ms D are ethically obligated to help Mr T compassionately and cost effectively.[18,26] Both should be making decisions in Mr T's best interests. Without appearing too callous or flippant, one might agree with Ms D that access to care and cost issues should only be taken into consideration once the physician and pharmacist resolve the issue of clinical indications: if loperamide is not the optimal drug at this time for Mr T, other considerations are probably irrelevant.[4]

Pharmacists often see themselves as having little discretion in providing optimal pharmaceutical care to patients. In contrast, physicians, in exercising professional judgement, see themselves as having more options when making decisions in patients' best interests. In reading the facts of this case, one might wonder how much of Ms D's decision making may be driven by a compulsion not to deviate in any way from what she considers to be her legal duty. Should this be the case, Ms D might reflect on the prime question: Is she making decisions out of fear of criticism or sanction for allegedly violating a law or in the patient's best interests?

Uncertainty in clinical judgment. The third shared understanding of pharmacists' and clinicians' job duties is that uncertainty is inherent in clinical decision making. Heuristics—cognitive short cuts used to come to a decision quickly—are common and put professionals at risk for cognitive biases. Heuristics and cognitive biases have been discussed widely in the literature,[27,28] and some examples are seen in this case. Ms D could be expressing *availability bias*, wherein the probability of an event (eg, recent overdose deaths) might seem higher than it is due to instances being easily recalled. Ms D could also be expressing *representativeness bias* if she bases the likelihood of Mr T's loperamide misuse on how similar Mr T appears to a stereotypical representation of someone who is actively misusing prescriptions, despite her lack of knowledge regarding Mr T's substance use recovery status. And Dr O could be prey to *diagnostic momentum* by continuing an already initiated clinical course of action (eg, refilling Mr T's loperamide prescription) without considering possible reasons for changing the treatment plan. Time constraints, lack of clinical support, or the presence of demands can exacerbate cognitive biases.

Culture of Collegiality and Communication

What should clinicians and teams do to help mitigate cognitive bias? Anti-bias training is a start but does not address how a busy clinic environment can contribute to cognitive bias. Ms D's reaching out to Dr O to ask questions and considering alternatives are 2 strategies listed in Table 1.

Table 1. Possible Responses to Cognitive Bias

- Slow down.
- Ask questions.
- Consider alternatives.
- Use checklists.
- Solicit peer and committee input to improve practice consistency.
- Use validated screening tools, such as the National Institute on Drug Abuse's "Clinician's Screening Tool for Drug Use in General Medical Settings."[29]

Health care professionals' defensiveness about perceived challenges to their decision making is one barrier to addressing cognitive biases, which can be addressed by cultivating a workplace culture centered on mutual respect,[30] transparency, and nonpunitive approaches to learning, wherein the system's vulnerabilities are addressed proactively and prioritized for improvement. This environment is known as a safety culture and is recognized by the Joint Commission as supportive of high-quality health care.[31] A safety culture is built through facility leadership modeling appropriate behaviors and eradicating intimidating or disruptive behaviors.[32] Focusing on the systems, the facts, and the acts, rather than on assumptions about employees' intentions, is vital to building an organizational safety culture.

Suppose Dr O has reasonable answers to Ms D's proffered questions. Ms D should be satisfied that this particular refill is for a legitimate medical purpose prescribed "in the usual course of … professional practice."[11] Careful documentation of this conversation with certification by both Ms D and Dr O further validates for the record that both the physician and the pharmacist acted prudently, in the patient's best interests, and according to accepted medical and pharmacy practice standards of care. One should recall that just because the answers are satisfactory at this point does not obligate Ms D to fill or refill any future loperamide prescriptions.

Should Dr O not have reasonable responses to the questions Ms D poses, one might reasonably infer that Ms D—in the proper exercise of her professional judgment—has a valid reason for refusing to refill the loperamide prescription for Mr T.[33] In this case, Mr T would not have a way to obtain loperamide without pharmacist approval. Although loperamide is available for purchase over the counter without prescription, IHS pharmacies are often the sole source of over-the-counter or prescription medications for patients in rural reservation communities. As illustrated in Mr T's case, this IHS pharmacy is his only viable option to obtain medications due to the vast distance to the next health care facility and his lack of insurance. Further steps Dr O might take if Ms D still refuses to refill the loperamide prescription after a conversation are outlined in Table 2.

Table 2. Steps Dr O Might Take if Ms D Refuses to Refill the Loperamide Prescription

- Dr O might ask to speak with the second pharmacist who works at the Oklahoma Indian Health Service unit. The second pharmacist may not be licensed in the state of Ohio, as is Ms D, and thus may not feel obliged to refuse to refill the loperamide prescription for the same legal reason, although the second pharmacist should use good professional judgment in filling the prescription "for a legitimate medical purpose … in the usual course of … professional practice."[11]
- Should Ms D and the second pharmacist who works at the Indian Health Service unit both refuse to refill the prescription, Dr O could talk with their supervisor about the issue.
- Should Dr O exhaust the chain of command, he could have a conversation with the relevant boards of pharmacy about best practices regarding this problem.
- If more pharmacists refuse to refill the prescription after hearing Dr O's explanation of the clinical indications, Dr O might reconsider and plan another course of action.

Assuming that all pharmacists who would refuse to refill Mr T's prescription would be acting in good faith and exercising independent professional judgment in the patient's best interests and that pharmacists' judgments are supported by a chain-of-command and relevant boards of pharmacy, Dr O's position would become less tenable because it would appear very likely that the pharmacists are acting reasonably, as any prudent pharmacist should do in similar circumstances, and meeting their ethical and legal standard of care to Mr T.[34]

Conclusion

Prescription drug misuse is a challenging problem for which both prescribers and pharmacists have legal and ethical obligations to act in patients' best interests. Pharmacists' corresponding responsibility includes reviewing all relevant information in order to determine the safety of dispensing a medication—including discussing concerns further with prescribers. Multiple factors impede the ability of health care professionals to provide the best care for patients. Two major factors are inappropriate use of heuristics during periods of stress and time constraints and a lack of workplace safety culture. Cognitive biases can be addressed by restructuring behaviors to allow deliberate, standardized pharmacy processes that ensure practice consistency and utilize evidence-based tools. Safety culture involves building a workplace culture centered on mutual respect, transparency, and nonpunitive approaches to identifying and fixing system vulnerabilities. Everyone, from health care facility leaders to frontline staff, has an essential part to play in mitigating cognitive bias and building safety culture. In addressing these issues, not only will the health care community fulfill its ethical and legal responsibilities to provide the best care to patients, but we will be one step closer to a more humane and just world.

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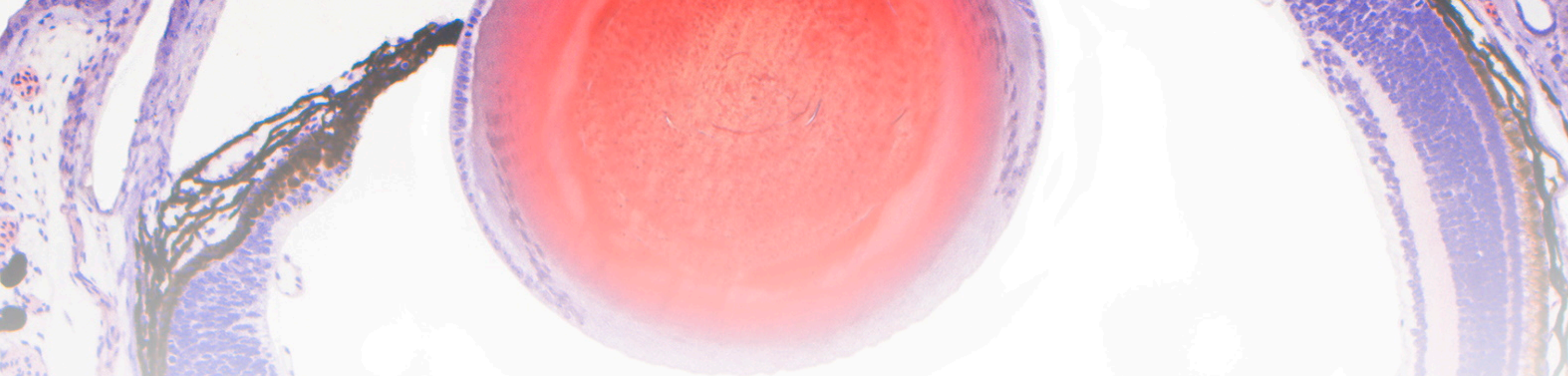

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MEDICAL EDUCATION: PEER-REVIEWED ARTICLE

Transgenerational Trauma and Trust Restoration

Fiona Miller and Pringl Miller, MD

Abstract

Transgenerational trauma is a potential barrier to achieving a healthy and holistic patient-physician relationship, particularly for Black Americans. Examination of deeply rooted historical injustices that Black patients suffer in health care and how they undermine trust can help clarify connections between historical trauma, distrust, and health outcomes. Furthering clinicians' understanding of how daily practice can respond to Black patients' experiences can help restore trust and mitigate racial and ethnic health inequity.

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Serena Williams

In 2011, Serena Williams was diagnosed with her first pulmonary embolism (PE) after incurring laceration injuries to both feet.[1] She subsequently underwent an emergency cesarean section in 2017 to deliver her daughter, during which time her maintenance anticoagulation therapy was temporarily suspended. On postoperative day one, Ms Williams felt short of breath and suspected she was experiencing a recurrent PE. She communicated her concerns to her treatment team and requested a computed tomography (CT) scan and heparin infusion.[2] Ms Williams' treatment team did not listen to her, despite her known history of PE and the temporary suspension of her anticoagulation therapy. Eventually, a CT scan confirmed Ms Williams' recurrent PE diagnosis and a heparin infusion was initiated. Although a patient under the care of medical professionals, Ms Williams was forced to act as her own physician in making the correct diagnosis and recommending the correct treatment. Had she not been in the position to strongly advocate for herself, the outcome could have been catastrophic.

Ms Williams's experience is neither strictly contemporary nor unique. Physicians in America have been quite literally mistreating Black people for centuries within a health care system that has promoted and reinforced the delusion of racial inferiority from its very beginnings.[3] One result of this mistreatment is embodied in Black patients' transgenerational trauma, which understandably fosters their distrust of physicians and of the health care system. Distrust, in turn, undermines patient-physician relationships.

This discussion focuses on historical injustices endured by Black patients and how they have eroded trust, ultimately compromising patient-physician relationships and leading to worse health outcomes for Black patients. Furthering clinicians' understanding of how daily practice can respond to Black patients' experiences can help restore trust and mitigate racial and ethnic health inequity.

Historical Injustices in Medicine

Physicians might be aware of some of the most egregious examples of clinical mistreatment of Black people in the United States: J. Marion Sims' serial surgical experimentation on enslaved Black women[4]; the Eugenics Board of North Carolina's forced sterilization program, which disproportionately targeted Black women[5]; the use of Henrietta Lacks' cancer cells, which gave rise to the immortal HeLa cell line, for decades in medical research without her or her family's knowledge or consent[6]; and the now-infamous US Public Health Service Syphilis Study at Tuskegee, in which hundreds of Black men infected with syphilis were left untreated, even after penicillin became the standard of care.[7] In looking back on this history, it is noteworthy that the majority of these well-known cases of abuse were perpetrated against Black women specifically, underscoring the appallingly unexceptional circumstance of Serena Williams' experience. But it is crucial that physicians understand that historical trauma inflicted on Black persons by the medical establishment extends well beyond these incidents. When it comes to the history of the American medical system, harm inflicted on Black patients is not the exception but the rule.

As physicians W. Michael Byrd and Linda A. Clayton demonstrate in their meticulously researched treatise, "An American Health Dilemma: A History of Blacks in the Health System," Black people have been subject to inferior health care access and delivery and have consequently experienced worse health outcomes since the inception of slavery in the American colonies.[8] Moreover, these injustices did not occur incidentally but instead were executed with careful intention in service of the medical establishment's best interests. While physicians in the early colonial period rarely treated enslaved Africans as patients, Byrd and Clayton note that over the course of the 17th and 18th centuries, American physicians developed a myth of racial inferiority—preserved in their research and writings—that "categorized blacks as subhuman 'things.'"[8] This view of the enslaved Black population as less than human laid the groundwork for the conscription of Black people as experimental specimens on which medical students practiced. This systematic exploitation "added another dimension to the already flawed white physician-black patient relationship," Byrd and Clayton write, which "matured into a defective relationship steeped in racial inferiority—an upside-down convenience based on doctor needs … instead of the usual patient needs."[8]

Byrd and Clayton further argue that, well into the 19th century, "most doctors did not follow the ethical codes of the profession" with regard to their Black, Native, and impoverished patients and continued to advance the campaign of scientific racism in medical education, research, and practice.[8] It was during this period that the decidedly unscientific "Negro Diseases,"[8] including Cachexia Africana ("dirt eating"[8]) and drapetomania (hypothesized by physician Samuel Cartwright to be the cause of enslaved Africans fleeing captivity[9]), were invented. Despite the passage of the Freedmen's Bureau legislation during the Reconstruction period following the Civil War, American health care remained willfully segregated for another century, with Black patients "locked … out of mainstream medical systems."[8] Even with the passage of the Civil Rights Act of 1964, the passage of Medicare and Medicaid legislation in 1965, and ensuing hospital desegregation, all of which were intended to increase health care access and quality for all Americans, Black health outcomes remained dismal—a disparity that persists to this day.[10] As Byrd and Clayton grimly observe, "organized medicine … has either fought against black health interests or based health policy on its own needs at every opportunity since its beginnings."[8]

Trust Restoration in Daily Practice

This critical historical account of Black health in the United States shines a spotlight on the dark truth that racial disparities in health care delivery and health outcomes between White and Black Americans are neither a recent development nor a product of Black people's choices. These racial disparities instead reflect the injustice of calculated and cumulative violence (both structural and physical) inflicted by physicians and the medical establishment on Black patients, embodied in the racial inferiority myth, scientific racism, systematic exploitation, and willful exclusion. The legacy of this violence has led to a collective experience of transgenerational trauma within the Black population. It should not be surprising, then, that trust between Black patients and physicians is fundamentally undermined. As bioethicist Laura Specker Sullivan has written about the state of this relationship, "mistrust might well be rational."[11]

Multiple studies have documented higher levels of distrust in physicians among Black patients than White patients.[12,13,14] Other research has attempted to explore what this distrust means. In her concept analysis study, "Trust in African Americans' Healthcare Experiences," nurse Traci Murray identifies the defining attributes of trust as dependence (of the patient on the physician), willingness (to enter into the patient-physician relationship), and met expectations (the mechanism by which trust is maintained).[15] In Murray's view, the barriers to trust are so great that the dependent nature of the patient-physician relationship is a sufficient deterrent for many Black patients, who would rather "risk the unpredictability of possible illness in the future" than voluntarily enter into that relationship dynamic. As we have seen, the historical forced dependence of Black Americans on White physicians, and the consequent abuse Black patients have endured, serve as a stark disincentive.

Furthermore, in a qualitative study designed to better understand this same question, Elizabeth Jacobs et al found that Black patients' "expectations of racism and experimentation" in routine care, as well as their perceptions of physician profit seeking, contributed to their distrust of physicians.[16] On the other hand, Black patients' trust in physicians was influenced by perceptions of "technical and interpersonal competence as demonstrated by compassion, reliability and dependability, communication skills and evidence that the best interests of the patient were at the forefront of physician-patient interactions."[16] More generally, Susan Goold and Mack Lipkin, Jr have proposed that trust between patient and physician is "most realistic when a relationship has a history of reliability, advocacy, beneficence, and goodwill."[17] Black patients are caught in a vicious cycle in this regard, wherein rational distrust is a deterrent from engaging in the patient-physician relationship in the first place, further diminishing the opportunity for such a history of reliability and goodwill to be established.

Features of trusting relationships between Black patients and physicians that arise from these analyses—reliability and dependability, benevolence, and patients' best interests—are instructive, particularly given that the concept of trust is often not well-defined in clinical medical ethics education. Strikingly, the 4 fundamental bioethical principles of autonomy, beneficence, nonmaleficence, and justice that govern our contemporary approach to clinical ethical standards do not explicitly incorporate the significance of trust in the patient-physician relationship[18]; nevertheless, trust is championed as an imperative of ethical clinical care. In its treatment of the patient-physician relationship, for example, the AMA *Code of Medical Ethics* declares: "Building relationships of trust with patients is fundamental to ethical practice in medicine."[19] The AMA *Code* reinforces the notion of trust in Opinion 1.1.1,[20] affirming that "the relationship between a patient and a physician is based on trust, which gives rise to physicians' ethical responsibility to place patients' welfare above the physician's own self-interest or obligations to others, to use sound medical judgment on patients' behalf, and to advocate for their patients' welfare." There seems to be broad recognition among researchers and professional organizations that trust is a fundamental component in patient-physician relationships, but this understanding is accompanied by little guidance on how physicians might go about building or restoring "relationships of trust."[19] What's more, contemporary professional standards (as represented in the AMA *Code*) do not acknowledge that, for certain patient populations, achieving trust might not be so straightforward.

Given the historical basis for and rationality of Black patients' distrust, physicians cannot assume that trust will proceed automatically from a demonstration of the traits of dependability, advocacy, and prioritization of the patient's best interests above all else. Instead, we propose that trust building with Black patients is physicians' burden to bear and is achieved through a dynamic, iterative, and intentional process of listening to and learning from them and acting on those lessons. One way that physicians can attend to this distrust is by understanding their personal biases and behaviors in the context of a Black patient's preexisting history with medical racism. Additionally, physicians can explicitly acknowledge this preexisting history and affirm the rationality of the distrust it has generated. Exhibiting vulnerability by leaning into the discomfort of discussing medical racism during patient encounters is a risky proposition for the physician, but it might lay the groundwork for restoring trust by equalizing the playing field with Black patients.[11] Finally, organizations can leverage accountability to encourage physicians to prioritize proactive trust building. For example, physician trustworthiness could be incentivized alongside clinical productivity.

Most importantly, physicians should ask Black patients what they need to achieve trust. By continuously practicing what Black patients teach them about how to restore trust in the patient-physician relationship, physicians can hope to break the cycle of transgenerational trauma that has so deeply undermined the relationship between Black patients and physicians. Indeed, when Dorr Goold and Lipkin write that "continuity [of care] encourages trust,"[17] we take the broad view that the concept of *continuity* applies not only to the patient-physician relationship itself, but also to the intentional practice of building trust within it.

Conclusion

Trust in the patient-physician relationship is vital to ethical clinical care. This is especially true for Black patients, for whom distrust in physicians and the medical system has been linked to inferior health outcomes.[21,22,23] When it comes to Black patients, physicians must recognize that due to a long legacy of racial injustices, the patient-physician relationship is not starting from a neutral baseline. Black patients' trust in physicians and in the medical establishment in general has been eroded over centuries—a loss broader and deeper than what might be attributed to any one physician's individual behavior—and likewise cannot be restored during any single patient-physician encounter. We physicians must own the impact of transgenerational trauma and enthusiastically accept that trust building must go beyond the individual patient encounter to an everyday, living practice of listening to our patients, honoring their rights, respecting their dignity, and serving as their fiercest advocates. Only by shifting power back to Black patients do we stand a chance of restoring trust in the patient-physician relationship and, by extension, improving Black health outcomes.[24,25] This transformative investment in the patient-physician relationship is an ethical imperative if we are to make strides towards eradicating Black health disparities and achieving health justice for Black patients.

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MEDICINE AND SOCIETY: PEER-REVIEWED ARTICLE

Historical Trauma and Descendants' Well-Being

Reeya A. Patel, MS and Donna K. Nagata, PhD

Abstract

Because multiple Asian American and Pacific Islander (AAPI) communities in the United States have experienced historical trauma (HT), it is important to understand HT's impact on the well-being of members of subsequent generations. This article addresses intergenerational trauma transmission, focusing primarily on Japanese American and Southeast Asian American communities. Research on these groups illuminates strategies for future empirical investigations of intergenerational trauma in other AAPI populations and suggests implications for care.

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Historical Trauma and Health

Historical trauma (HT) is characterized as a traumatic event shared by a group of people that contributes to an increased prevalence of negative physical health outcomes, impaired parenting, distrust, and mental illness in subsequent generations.[1] HT research has utilized both qualitative and quantitative methodology and began with a focus on the offspring of Nazi Holocaust survivors. Several of these earlier studies relied on clinical samples of survivors' children, leading to the impression that their mental and behavioral health problems (eg, depression, anxiety, and disruptive behavior) stemmed from their parents' Holocaust trauma.[2,3,4] However, additional studies that utilized nonclinical samples and compared offspring whose parents did and did not experience the Holocaust failed to find increased pathology in survivors' offspring.[5,6,7] Investigators have also noted the importance of studying general resilience and specific vulnerabilities in families of Holocaust descendants.[8] Although there is limited research on HT in Asian American and Pacific Islander (AAPI) communities, this paper highlights findings on this topic related to Japanese Americans and Southeast Asian Americans, the AAPI groups for which there is the most published research on this topic. Because there is a dearth of research examining the physical ramifications of HT in both these groups, we focus here on the psychological impacts. Our review elucidates subtle factors related to HT that can influence the well-being of AAPI patients and suggests that ethical treatment of patient needs can benefit from assessing possible factors related to HT beyond general family background. Although not discussed in this article, recent pandemic-related instances of anti-Asian harassment, discrimination, and violence have negatively targeted AAPI individuals. The increased sense of vulnerability and race-related stress associated with these events have the potential to retraumatize the AAPI community and can be included among these factors as well.

Japanese Americans

Soon after the Japanese military attacked Pearl Harbor, Hawaii, in 1941, the United States ordered all persons of Japanese ancestry from Western portions of the country to live in internment camps in remote areas.[9] Falsely portrayed as potentially disloyal, men, women, and children—two-thirds of whom were US citizens—were interned for up to 4 years.[9] Four decades later, the US government admitted this policy was based on false pretenses of national security and racial prejudice[9] and paid reparations of $20 000 to surviving internees.[10]

These actions, however, did not address the impacts of HT on postwar third-generation Japanese American (Sansei) internee offspring. Lost businesses, land, and livelihoods during internment left few economic resources for Sansei to inherit.[11] Some were deprived of a healthy parent. Survey data indicated that “former internees had a 2.1 greater risk of cardiovascular disease” than their noninternee counterparts,[12] and a study of Sansei found that twice as many formerly interned fathers as noninterned fathers died before the age of 60.[13] Large-scale surveys and in-depth interviews with Sansei also reveal the impacts of HT on family dynamics and parenting.[13] Despite the trauma associated with internment, several researchers have observed that most Japanese American families were silent about what happened.[13] In one study, many Sansei reported having had approximately 10 brief conversations in their lifetime with their parents about the “camps.”[13] Parents avoided the topic altogether or spoke of it in curt or evasive ways. Some only discussed the internment to help their child do a school project.[13] Attempting to protect their Sansei children from further targeting, former internees minimized or omitted the teaching of Japanese language and culture and urged their children to blend into mainstream American culture and achieve scholastically.[13] In turn, Sansei experienced a loss of identity, family history, and a self-consciousness about their ethnicity.[11,13,14,15,16] This struggle was exacerbated by insufficient coverage of the trauma in the broader society. For example, 2 analyses of history books published between 1988 and 1992 and between 2002 and 2003 that were used in public high school curricula found that the internment was justified solely in terms of national security with no mention of racism or discrimination,[17] and, in the media in the 1960s, Japanese Americans were portrayed as a “model minority” that overcame the wartime experience.[18]

Over time, most Sansei learned on their own about the trauma through books, ethnic studies courses, and films.[13,15] While the information helped close the gap in information that Sansei experienced growing up, survey data indicate that increased knowledge about the hardships suffered by their own parents and grandparents is associated with greater levels of sadness and anger.[13,14] Knowledge about the internment also engenders distrust of the government: those who have a parent who had been interned are less confident about their rights in the United States than those for whom neither parent had been interned.[13,14] Sansei are also, however, positively inspired by viewing their parents as role models of resilience. Some have been motivated to fulfill their parents’ lost dreams by pursuing the degree or career a parent had missed or by entering a legal career or community activism to prevent future injustices.[12,13,14]

Southeast Asian Americans

The severe traumas experienced by Southeast Asian (SEA) groups are also linked to HT transmission. Starting in 1975, the Pol Pot regime implemented the Cambodian genocide, which resulted in the deaths of 1.5 million individuals and over 100 000 US refugees.[19] Life under the regime included starvation, forced labor, executions, destruction of property, and separation of families.[19] In the same year, North Vietnam's capture of Saigon signaled the end of the Vietnam war and the first surge of the Vietnamese refugee exodus to the United States.[20] The ending of war was not the end of trauma for Vietnamese families, however; political repression, economic hardships, and warfare with other countries continued.[20] By 1996, over 700 000 refugees had escaped to the United States.[20] SEA refugees' experiences in refugee camps prior to arriving in the United States also became a source of trauma.[19,20]

Findings are mixed regarding whether refugee parents' exposure to trauma or symptoms of posttraumatic stress directly affect their children's mental health and behavioral functioning.[21,22,23] However, parents' experience does seem to exert an indirect effect on their children's health through various components of family dynamics, including parenting style, family functioning, parent-child engagement, and intergenerational communication.[21,22,23] One study, for example, noted that observed patterns of severe anger episodes among Cambodian Americans receiving psychiatric treatment at a clinic were frequently directed toward children and associated with intergenerational conflicts that had elicited parents' somatic trauma recall.[24] As with Sansei, intergenerational communication about families' trauma is a critical component of SEA youths' experience of HT. Findings among young adults in Cambodian refugee families indicate that communication patterns vary widely—from complete silence, to partial avoidance, to open communication.[25,26] These patterns could both positively and negatively affect (1) connectedness between offspring and parents and (2) offspring's emotions. For example, open communication could either engender positive emotions in children in response to learning more about family history or emotionally overwhelm them.[25,26] Like Sansei's parents, sometimes SEA parents have only been willing to talk about their trauma with their children if it was needed for a school project.[25,26] Also similar to the Sansei, SEA children face societal silence about their group's HT, although they have had increased access to information via the internet.[20,25,26]

Similar to Japanese Americans, an emphasis on academic achievement and professional success as a means to security has been one impact of HT in SEA refugee families.[20,27] However, both the Sansei offspring of internees and their internee parents were US-born, whereas immigrant SEA parents encountered posttrauma challenges of adjusting to the United States due to limited English facility and job opportunities, which contributed to low income, living in disadvantaged neighborhoods, and hardships in navigating American life.[20,28,29,30] Unsurprisingly, then, their offspring have lower rates of educational attainment compared to other Asian groups and the general US population.[27,31] Such findings caution against perceiving Asian American youth as a model minority generally and in the context of HT.

Future Research and Care

This brief review suggests the benefits of considering the impacts of HT in order to provide ethical assessment of and care for AAPI individuals and to promote future research. An understanding of the trauma that patients' families and communities have experienced can help contextualize patients' health problems and inform efforts to improve their health. Both clinicians and researchers are urged to:

- Investigate patients' unique histories and characteristics related to HT when assessing the impacts of HT on well-being by adopting a historical perspective that considers when and where the group trauma occurred; the potential existence of multiple and varying types of trauma linked to historical events; the amount of time since the group trauma took place; and the developmental and social context of subsequent generations. Such a perspective can give researchers a more complete picture of the context of and factors contributing to HT.
- Assess the role of acculturation and cultural gaps in HT transmission, especially among children of immigrants. Such gaps have contributed to maladaptive mental and behavioral outcomes for children and poorer parent-child relationship quality,[24,32,33] suggesting that they warrant consideration as potential mechanisms of HT.
- Consider the effect of mainstream society's lack of awareness of AAPI traumas on patients' ability to process their HT. Intrafamilial silence, combined with societal silence, may increase hesitancy to share concerns related to HT with health care professionals and may inhibit service utilization and treatment.
- Assess potential protective factors associated with HT, including the degree to which patients view the trauma and parents' or ancestors' resilience as a source of positive inspiration. Community-level factors might also facilitate resilience. For example, part of some Sansei's resilience is attributable to being actively involved in the reparations movement, a form of collective activism comprising multiple generations and organizations.[13]

Researchers can also take the following steps:

- Take a developmental approach—particularly by including younger children, since studies including this group are lacking—to prospectively examine variation in HT effects across developmental stages.
- Investigate potential biological mechanisms of HT transmission in light of emerging findings on the role of epigenetic transmission of stress in Holocaust survivor families.[34] Although previous studies have found that those who directly experienced the trauma (such as parents of Sansei,[13,14] SEA refugee parents[28]) suffered physiological consequences, there is a dearth of literature examining the physical ramifications of HT on subsequent generations.
- Emphasize qualitative methodology. Prior AAPI studies have included quantitative measures (eg, the Harvard Trauma Questionnaire), but the research discussed in this review on Sansei and Southeast Asians indicates that qualitative methodology—specifically, in-depth interviews and open-ended questions—are beneficial in discerning nuanced impacts of HT not revealed by quantitative measures.

- Expand research on other AAPI groups' experiences of HT. Preliminary research among Native Hawaiians and Sikh Americans exists,[35,36] but more studies on these and other under-researched AAPI groups is needed.

Conclusion

Research on Japanese Americans and Southeast Asians has assessed potential impacts of HT on well-being and care considerations. Future investigations on this topic are needed to expand the depth and breadth of this work. These efforts should be undertaken bearing in mind the unique nature of trauma faced by different AAPI groups.

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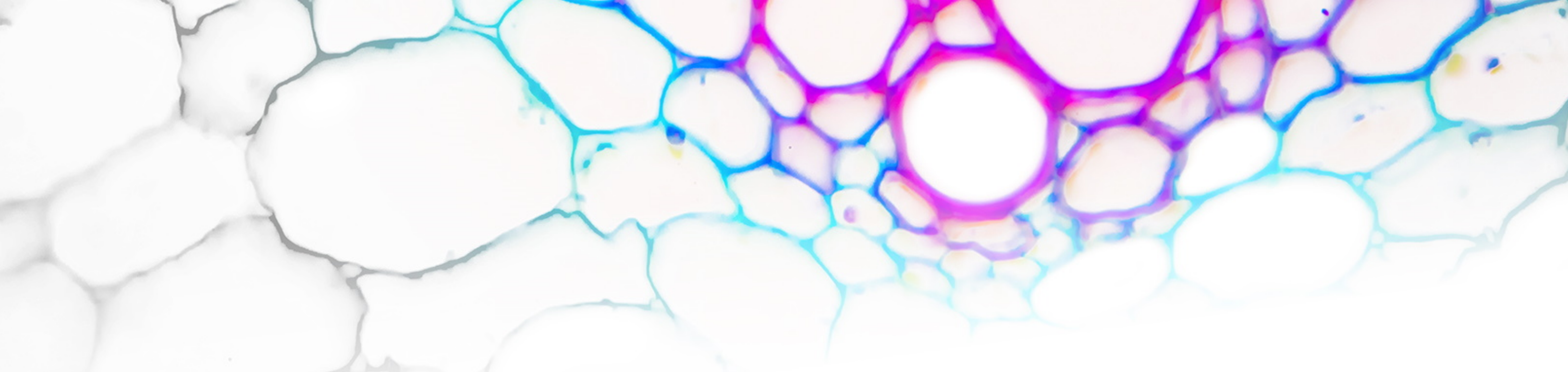

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What Does It Mean to Heal From Historical Trauma?

Natalie Avalos, PhD

Abstract
Native American peoples' health is impacted by structural legacies of settler colonialism, including land dispossession, racism, and poverty. Responding with care to individuals and communities experiencing past and present traumatic stress from genocide and deeply entrenched structural violence means navigating ongoing grief, restoring self-community and human-ecological relationships, and generating cultural vibrancy.

Historical Trauma

In the last 2 decades, research on trauma has helped illuminate that trauma is relational because humans are social, so it operates on the level of relationships in multiple ways.[1] Trauma is sometimes understood as a response to discrete events; however, it can also develop as a result of a set of events, such as acts of genocide, in concert with structural violence.[2] While historical trauma has become as a term more commonly associated with Native American peoples,[3] it now functions as a public narrative for entire communities that have been psychologically affected by legacies of colonialism and their attendant forms of structural violence over time.[4] Since racism stigmatizes those who are racialized, the everyday interactions of those who racialize with those who are treated with hostility or demeaned as a result of stigma is one example of how racism's effects are cumulative.[5] In this sense, the racialized are permanently "othered" in a society that relies on racism to determine who has access to resources. The nervous system imprints these experiences of marginalization epigenetically, passing on their effects from one generation to the next, making trauma intergenerational.[6]

The concept of *historical trauma* was initially developed through clinical observation with Holocaust survivors whose adverse psychological effects—such as depression, self-destructive behavior, psychic numbing, anger, and elevated mortality rates from suicide—appeared to endure among their descendants.[7] Historical trauma was introduced in a Native American context in the 1990s by Debruyn and Brave Heart[3] and Duran and Duran,[8] who described this kind of trauma as historical unresolved grief or even a "soul wound," a concept resonant with Native American worldviews. As a narrative linked to colonial violence, historical trauma enabled researchers to understand why Native Americans suffer from disproportionately high rates of psychological distress.[9] Brave Heart characterizes this particular kind of trauma response as "*transposition* where one lives simultaneously in the past and the present with the ancestral suffering as the main organizing principal in one's life."[7]

Colonial Injury

While some researchers have framed historical trauma as a response to a "big event"—for instance, an act of physical genocide, such as a full-scale massacre of thousands of peoples by US troops or the Nazi regime—researchers working with Native American populations soon found that trauma resulted from both the big event and the enduring forces of structural violence that have remained for centuries.[10] Structural violence is a form of violence wherein social structures, such as ideologies like racism or institutions like laws, can harm people by preventing them from meeting their basic needs.[11] Settler colonialism is a distinct expression of colonialism that uses such structures to eliminate Indigenous populations in order to replace them with settler societies.[12] In the United States and Canada, federal Indian policy enacted both extermination and assimilation—in essence, genocide and ethnocide—to permanently subjugate and eliminate Native Americans as a political threat.[13] Historical trauma provides a framework for understanding the ways in which these policies—such as forced removal from Native lands, compulsory boarding schools, and coerced conversion through missionization—put Native American populations at higher intergenerational risk for poor mental health.[9]

The latest research on specifically Indigenous historical trauma finds that its effects are wide-ranging—from historical loss that brings feelings of shame and anger as well as drug and alcohol use to suicidality, sexual abuse, and depression among residential school survivors.[14] Historical loss is complex because it denotes the loss of land in addition to loss of culture. For Native Americans, lands are not objects; they are relatives, replete with plants, animals, and waters that are understood to be members of the larger other-than-human community. Researchers have found that the loss of sacred lands is a major source of grief.[3]

Federal boarding schools were developed in the United States and Canada in the late 19th century, and enrollment in the United States peaked in the 1970s before passage of the 1975 Indian Self-Determination and Education Assistance Act, which gave Native nations control of their own education systems.[15] In the late 19th century, federal agents were ordered to collect all Native children for compulsory schooling, where they lived away from their families for years, forbidden to speak their language or practice their customs.[3] Many died in custody from homesickness and disease.[3] Missionization began earlier through East Coast Mission schools and the California Mission system in the 1700s.[3] At the end of the Indian wars in the 1880s, Native American religious traditions were banned.[13] Mission representatives often lived on reservations and worked with federal agents to enforce this ban against ceremonial life, often imprisoning Native American religious leaders due to their political and philosophical influence.[13] Settler colonial violence continues to affect Native American well-being—for instance, through predatory forms of resource extraction like the Dakota Access Pipeline that was redirected from a predominately White city (Bismarck, North Dakota) to Standing Rock Sioux territory in 2016-2017, threatening not only Sioux waterways but also tribal sovereignty.[16]

Healing Arc

Native American researchers, in particular, have tried to understand historical trauma and how healing might operate in Native-specific contexts.[17] From a Native American point of view, historical trauma has been described as a soul wound because it is experienced as a wounding down to the level of being.[18] Systematic violence dehumanizes others, compounding the effects of historical trauma. Racism compromises Native Americans' self-image, leading to feelings of lesser self-worth, anxiety, and depression.[5] However, historical trauma is more comprehensive than that; it is instigated by a total loss of lifeways, producing deep philosophical disorientation.[7] Native American clinical researchers have also explored culturally relevant approaches to treatment, such as traditional grief ceremonies, as well as culturally specific definitions of healing. In particular, they have developed treatment protocols that draw from traditional values and ceremonial life in order to restore healthy relationships to one's self and members of the larger social body.[9] This social body includes the natural world and all living within it, human and other-than-human, such as plants and animals, but also one's ancestors.[19] When these relationships of reciprocity and stewardship are restored, so are general feelings of well-being and cultural vibrancy.

In a Native American context, then, healing is relational, meaning it cannot be facilitated solely through cognitive methods; it must be facilitated in and through not only relationships with others, but also one's relationship with one's own wound.[18] This kind of healing invites the process of feeling once again and is supported by being witnessed, having one's humanness and pain acknowledged by others. When feeling returns to the body, it enables empathy for self and others. This empathy reduces both the effects of othering and its perpetuation.

One study examined how historical trauma was experienced by Native Americans and could be effectively treated using culturally relevant concepts and worldviews related to 4 themes: recognizing emotional burdens; cathartic disclosure; self-as-project reflexivity; and recognizing the impact of colonization.[9] These 4 themes in total describe a healing arc. Initially, patients worked to recognize that a wound or emotional burden was carried in order to then name and disclose the wound to others, such as a counselor. These first 2 steps became a template for coping with these wounds over the course of one's life, making introspection a healthy habit. The final theme describes how contextualizing language and culture loss—or even abuse experienced at boarding school—within the historical facts of colonization can provide profound psychological relief. For Native American patients, understanding that colonial structures catalyzed high levels of interpersonal violence and addiction in their communities helped them make sense of their lives and, ultimately, find solace in their own cultural traditions. Conversely, it is now clear that the lack of public and collective acknowledgement of Native American genocide and its effects actively contribute to historical trauma.[3]

Regeneration

These articulations of healing resonate with the work of other Native researchers like Lakota clinical social worker Brave Heart, who, along with a core group of facilitators, developed a Native-centered healing model and workshop in 1992 called the Takini Network.[20] This workshop entails a community presentation and 4-day retreat that is adapted to specific tribal contexts. The general aim is to regenerate not only healthy human-to-human relationships but also healthy human-to-environment relationships. Healing these relationships reinforces trust and affinity in the community, which is critical to well-being, since higher levels of interpersonal violence, alcoholism, and depression strain community relations.[19] These workshops often end with a Lakota grief ceremony, which traditionally acted as a means to process major life events—in particular, individual and collective loss.[19] Ceremony provides a culturally relevant space for the process of healing to take place collectively, reflecting Native American worldviews of interconnectedness—among self, others, and the spirit world. It operates to remind Native peoples that they are part of larger whole, returning to them a sense of identity and positive orientation in the universe.

Conclusion

Native American and non-Native clinical researchers who have worked closely with Native American clients have come to understand historical trauma as not just an outcome of historical acts of genocide but as actively aggravated by ongoing forms of structural violence. These researchers found that treatment using culturally relevant concepts and worldviews, such as interrelatedness, have made Native clientele more receptive to treatment. Some of the most effective features of treatment include ceremonial protocols to restore self-community and human-ecological relationships, as well as the general acknowledgment of colonialism's impact on Native populations, which serves to rehumanize Native Americans and their experiences of devastating loss.

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ART OF MEDICINE

Drowning Outside the Insurance Pool

Ayanna Guzman and Kaitlin R. Weed

Abstract
This graphic narrative explores struggles with underinsurance, compromised access to indicated care, and intergenerational health inequity.

Figure. Detail from *Drowning*

Media
Procreate® for iPad.

Caption
For many, access to health care is a lifelong struggle. Systemic social and economic inequalities have intergenerational health consequences, affecting not only who can access care, but how long care is accessible. This comic tells Guzman's personal story of underinsurance both visually and narratively.

Ayanna Guzman is a student at the University of Illinois-Chicago majoring in psychology. Their other interests include literature and music.

Kaitlin R. Weed completed a bachelor of fine arts and writing degree at the School of the Art Institute of Chicago (SAIC) in 2020. They also pursued an interest in graphic medicine and disability as a 2020 SAIC Art of Medicine Intern with the *AMA Journal of Ethics*.

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VIEWPOINT

Knowledge Is Power

Audiey C. Kao, MD, PhD

If knowledge is power, scholarly journals as information gatekeepers play a potent role in promulgating it. For health-oriented journals, decisions on what is published and promoted profoundly influence humanity's well-being across time and place.[1,2,3] During the COVID-19 pandemic, we have borne witness to deadly harms inflicted on communities of color. Despite these harms, journals continue disseminating content, including a recent *JAMA* podcast,[4] that fails to recognize racism as a transgenerational source of health inequity.[5,6] The existence of racism in health care is "not opinion or conjecture," and its denial must be refuted.[7]

Contrary to ideals espoused in its founding, America was launched as a political and economic nation wherein Africans were enslaved and Indigenous peoples were herded. Given that pursuit of knowledge is a sociohistorical enterprise,[8] the medical literature unsurprisingly has long reflected and served prevailing powers.[9] Scientific racism based on reductionist and ahistorical premises justified White supremacy.[9] Samuel Morton, who has been called America's founding father of scientific racism,[10] touted phrenology or study of human skulls as indicators of intelligence and character.[11] Morton's comparative measurements of cranial volumes from racial groups he recognized (Ethiopian or African, Native American, Caucasian, Malay, and Mongolian)[12] lent pseudoscientific cover for White supremacy,[13,14] manifest destiny,[15] and Black slavery.[16,17] Morton's cranial findings fueled an onslaught of racist science that lingers, for example, in contemporary contestations about sociobiology.[18,19]

Yet there existed almost from scientific racism's beginnings knowledge challenging the ideological basis of White supremacy.[9] A notable contributor to antiracist knowledge was James Smith, the first African American university-educated physician.[20] Denied opportunity to train in America, Smith earned his medical degree from the University of Glasgow. The author of the first case report by an African American physician, Smith was not permitted to present his case at the New York Medical and Surgical Society.[21] He was also denied membership in the American Medical Association.[22] Through public lectures, Smith exposed and refuted phrenology's racist claims that human intellectual capacities were determined by skull sizes, shapes, and contours.[23] In 1844, he became the first African American physician to pen a scientific paper in an American medical journal.[24] Publishing "counter stories" like Smith's is vital reparative justice work.[25]

If scholarly journals are to be trusted gatekeepers of knowledge, what more should we expect of them as intellectual platforms for antiracist scholarship? Recently, journal publishing standards on racial health inequities were put forth and demand adoption.[5] To socially amplify and historically ground these standards, we must recognize that journals require editorial independence from their publishers, of which many are learned societies with racist histories.[26,27,28] The ability to publish ideas and evidence free from undue influence and pressure cannot be undermined. That said, editorial independence should never be leveraged to excuse bad content, such as works using race as a crude proxy for ancestry, genetics, and biology.[29] Care should also be taken to ensure that editorial independence does not manifest as editorial insularity and maintain White privilege.[30,31,32]

Knowledge that aims to promote human flourishing should be a public good and accessible to all. In March, the University of California (UC) struck a landmark deal with Elsevier, the world's largest scientific publisher, specifying that all research (much of it publicly funded) with a UC lead author will be free to read for everyone.[33] For the good of humanity, we should eliminate barriers to journal content and open access to antiracist science and health justice scholarship everywhere.

Stewarding knowledge, scholarly journals harnessed to right harms and advance good must rise to the moment, as justice delayed is justice denied.

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