



AMA Journal of Ethics®

June 2021, Volume 23, Number 6: E480-486

MEDICAL EDUCATION: PEER-REVIEWED ARTICLE

Transgenerational Trauma and Trust Restoration

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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 women⁴; the Eugenics Board of North Carolina's **forced sterilization** program, which disproportionately targeted Black women⁵; 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 consent⁶; 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 captivity⁹), 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 relationship¹⁸; 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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Citation

AMA J Ethics. 2021;23(6):E480-486.

DOI

10.1001/amajethics.2021.480.

Conflict of Interest Disclosure

The author(s) had no conflicts of interest to disclose.

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