

Episode – Ethics Talk: Trauma, Trust, and Pharmaceutical Marketing in Native American and First Nation Communities

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[mellow theme music]

TIM HOFF: Welcome to *Ethics Talk*, the *American Medical Association Journal of Ethics* podcast on ethics in health and health care. I'm your host, Tim Hoff. This month's issue of the journal explores transgenerational trauma. Also called intergenerational trauma, these terms describe how historical atrocities directly experienced by one's ancestors, such as slavery or forced migration, have legacies that affect the lives and health of those ancestors' descendants over time, up to and including the present day. Transgenerational trauma has received little attention in the clinical literature, though a range of cumulative embodied health consequences are documented in the public health and mental health literatures. Zoe Tao, the editorial fellow who helped develop this issue, explains how transgenerational trauma experiences can play out during clinical encounters.

ZOE TAO: It's something that very much plays into people's trust of the health care system, how safe they feel in medical encounters, and what decisions that they make, often like high-stakes decisions that they would make in a medical setting.

HOFF: So, how can learning about transgenerational trauma help clinicians motivate health equity and respond with care to patients who are members of historically traumatized communities?

TAO: I think it gives language to a lot of things that you see in your daily life and you see in your daily practice in medicine, but that don't, you don't necessarily have a way to describe. And so, maybe you've had an encounter with a patient, and you felt like you didn't have a very good relationship with them, but there wasn't a particular reason why. And then maybe you can situate that in a community or cultural context or even think about it in terms of transgenerational trauma and accumulated experiences with health care. And then you could come to a more nuanced understanding of maybe why it is that you don't have a very good relationship with this person. And that's just on an individual level.

HOFF: Appreciating the nature and scope of patients' and communities' experiences of transgenerational trauma can help clinicians reorient themselves to what it means for a patient to trust a clinician.

TAO: I think we, as medical professionals, are not entitled to other people's trust. We have to establish ourselves as trustworthy, and we have to make our spaces and direct our spaces so that people feel safe and people feel comfortable during what may be the worst times in their lives.

HOFF: Dr Michael Oldani is a medical anthropologist who's thought a lot about the specific roles pharmaceuticals play and how clinical encounters relate to colonial legacies in North America. He's a Professor of Pharmaceutical Sciences and Administration, as well as the Director of Interprofessional Practice and Education at Concordia University Wisconsin in

Mequon. He's worked with Aboriginal communities in Manitoba, Canada and in Wisconsin. And he's with us today to discuss Western allopathic pharmacopeia uses and marketing in Native American and First Nations communities. Dr Oldani, thank you very much for joining us. [music fades out]

DR MICHAEL OLDANI: Happy to be here. Appreciate the opportunity.

HOFF: The history of pharmacopeia in North America and around the world is strongly tied to Native American and First Nations healing. To begin with, what should our listeners know about the relationships between medicine, pharmacy, and caregiving among Indigenous communities?

OLDANI: Sure. I mean, there is a rich literature that any of the listeners can access. To just talk about the pharmacopeia, I would refer our listeners to Daniel Moerman's work. He's a pretty well-known medical anthropologist, and he meticulously has cataloged something like 5,000+ medicinal plants in the Indigenous communities throughout Native North America, South America, and Central America. I mean, it's just kind of an awesome project that he spent most of his career working on. He has also done interesting work in other areas, including the placebo effect.

When I think about this question, which I think is really an important one, I often think about some of the work I did in Canada in the early 2000s. I was there working in Winnipeg, Manitoba.

HOFF: Mmhmm.

OLDANI: And Winnipeg's kind of off of our mental map for a lot of people in America, in the United States, and it's a city similar in size to Milwaukee where I live now. Spent a couple years there. And there was, at the time, about 75,000 Aboriginal or First Nation Canadians living in the city.

HOFF: Hmm.

OLDANI: So, it had this really robust, vibrant Native community, all kinds of interesting projects going on. That was right in the middle of the Royal Commission on Aboriginal Peoples. There was sort of a national reckoning with the residential school there in Canada, which a lot of people may not realize the United States ended a little more recently than in the US. So, there was a lot—

HOFF: Can you provide some context for our listeners about what that is?

OLDANI: Sure. So, when we look at North America in general, if we take Canada and the United States, the residential school era really started with missionary work and then government involvement and then actually kind of the synergy between religious institutions and the government, whether in Canada or the US. And unfortunately, it involved the forced removal of Native Americans and Aboriginals from their home, kind of in an assimilation process that was kind of the government take on it. But from the Aboriginal point of view, it was ethnocide genocide, a lot of generational trauma. And in fact, one of my really wonderful informants in Winnipeg, who I'll call Marie, she had been a residential school survivor. And we kind of partnered when I worked there when I was working on my doctoral research, and she kind of led me through her experiences, which were heartbreaking when you heard about being removed from your family, which was so

common, losing track of your siblings, sometimes never seeing them again. So, that era in Canada really sort of officially ended. The last school closed in 1996.

HOFF: Wow.

OLDANI: So, you can see how recent it is in terms of the generations.

HOFF: Yeah, absolutely.

OLDANI: But back to your question. So, this, the pharmacopeia in what I experienced in Canada was really interesting because there was, I would say, kind of this integrative approach to how the Native peoples I worked with looked at their medicinals, or their, what we might call traditional Native medicine, modern pharmaceutical treatments.

HOFF: Mmhmm.

OLDANI: What I was mostly interested in was sort of how they were thinking about stimulant medication, psychotropic medication, and then a really sort of reemergence, because I think it had been underground for a long time, of Aboriginal healing techniques.

HOFF: Mm.

OLDANI: So, in Canada in particular, there was a resurgence of the sweat lodge, even in urban setting, which was really sort of novel at the time. Now it's 20 years later, and [audio drops] that urban sweat lodge there in Winnipeg for about 20 years. So, I also think, and I think some of our listeners will be aware, that there's been a tremendous amount of borrowing from Western, especially traditional colonial powers, borrowing Native remedies. I think people are familiar with things like quinine or ipecac.

HOFF: Mm.

OLDANI: These were digitalis. These were all sort of Indigenous medicines that at various times have contact by Western colonial powers. The realization was that they had efficacy; they had pharmacological efficacy and eventually were isolated, became different types of pharmaceuticals or treatments for things like malaria, in the case of quinine. So, I think there's been a lot of borrowing. There's been a lot of exchange, which an interesting anthropological topic as well.

HOFF: You said there was sort of a resurgence of interest in Indigenous healing techniques. Was that resurgence more sort of public-facing, or did you see a resurgence in the medical community itself?

OLDANI: That's a great question. I think, you know, in the early 2000s, if we take the Canadian context or even in the United States, in various areas like in northern Wisconsin— And that's one thing to keep in mind, too. We have these sort of arbitrary borders, but if we look in Canada, where I was in Manitoba, where the Ojibway is a cultural group along with the Cree and the Oji-Cree, kind of a hybrid of the two communities when they were placed together during the colonial era, a lot of the people I met in Canada were coming into Wisconsin or traveling back and forth for some of these Native rituals like sweat lodges or fast, because the Chippewa in Wisconsin speak the same language; they're technically Ojibway.

HOFF: Hmm.

OLDANI: It's just a variation on how Ojibway was spelled, especially initially by the French. So, in the Canadian context, some of the things, like if I go back to the sweat lodge, I would say that was definitely local, very local and Indigenous based.

HOFF: Mmhmm.

OLDANI: I can give you an example. So, the Aboriginal Healing Foundation in Canada had supported a lot of neighborhoods in Winnipeg at their community center level to create healing circles.

HOFF: Mm.

OLDANI: And [inaudible] about trauma. And I know that's one of our topics in the podcast today. It was in direct response to trauma. And what Canada was good at, at the time, was listening to Aboriginal elders and medicine people and saying, what do you need? And they said, we need to be heard. We need these healing circles. We need the kind of rituals where people come together, and they can eventually create a comfort level to share their experiences. And I kind of was asked to participate in some of these healing circles, and it became really interesting because it is a sacred space. And I had to assure everyone I wasn't going to write necessarily about what went on in the healing circle.

HOFF: Mmhmm.

OLDANI: They would be against that, and so was I, ethically; however, they were very interested in pharmaceuticals, which is kind of a side story. So, I was invited in. And what was, what I thought was so interesting is that the process of healing that took place in group—and it was kind of like group therapy—always ended with a sweat lodge ceremony. And a lot of the Native people who were living in Winnipeg had never experienced a sweat. They had lived in the city all their lives.

HOFF: Mmhmm.

OLDANI: They hadn't, out on the reserve. So, it was sort of this kind of fascinating process where a lot of people were coming to the city, and Aboriginal Canadians could rediscover their culture in an urban setting because there were so many people coming together.

HOFF: That is interesting. Around when was that?

OLDANI: That was like 2000 to 2004.

HOFF: Okay, interesting.

OLDANI: Yeah, that was sort of a real important time in Canada, too, because of the kind of the process of reconciliation that was going on.

HOFF: One contributing factor to health inequity in Native American and First Nation communities is the lack of access to clinical specialists, and that includes pharmacists, obviously. That's slowly changing in some places. For example, as I'm sure you know, the Red Lake Indian Health Service in Minnesota is embedding pharmacists into primary care

teams. How might improving access help address the present-day health care needs of survivor descendants of genocide and its various traumas?

OLDANI: I think it's such a great question. As you know, trauma, in its treatment, is so complex, and I'm not a clinician. But from a medical anthropology point of view— And I happen to, at the School of Pharmacy, direct an interprofessional program here.

HOFF: Mmhmm.

OLDANI: And if your listeners aren't familiar with that, that's the collaborative care movement in medicine. And we could talk about this from a couple of angles: collaborative care in general, and you asked in your question about having a pharmacist on the team, for example.

HOFF: Sure.

OLDANI: You know, I just think it's so important that you have a medication expert at the clinic level, whether it's an ambulatory care clinic or even an urgent care clinic. And, of course, it's resource dependent.

HOFF: Mmhmm.

OLDANI: One of the most perfect scenarios could be could you have, let's say, in Ojibway, someone from the Chippewa community, let's say, in northern Wisconsin, and we're trying to create these pipelines to our school, pharmacy school or UW Madison, which has a pharmacy school. And there are. There's been kind of these amazing programs in the state of Wisconsin. There's something called GLNARCH, and that's the Great Lakes Native American Research Center for Health, where the sole mission is really getting Native students interested in sciences, which hopefully would pipeline them into health care careers.

HOFF: Mm.

OLDANI: And even if, and, you know, there are some limiting factors in terms of the numbers of peoples that maybe you could get back helping or living on their community. But from the interprofessional point of view, we're training students, just in general, in underserved pathways, rural northern communities in Wisconsin, for example. And we take kind of this global approach to the underserved, whether they happen to be in a predominantly White community, or maybe it overlaps with a Native reserve, say, Lac du Flambeau in northern Wisconsin. We really train our students for cultural awareness, cultural humility. But I also think you need to take it a step further, if we're talking a little bit more about policy. If you're going to have a clinic team working on or near reserves in Canada (reservations in the United States) you really need to have community members as part of that team.

HOFF: Mmhmm.

OLDANI: Now, you start with patients and family members. That's the core of the interprofessional movement, is that they're going to be essential members of the team meeting; their voice is going to be heard. So, from an anthropological point of view, that speaks to anthropology. We've advocated for that sort of insider perspective. But that's not always the case in clinical meetings or clinical encounters.

HOFF: Sure.

OLDANI: So, I think there's a variety of ways you can approach it. The other is through community health workers where those can be members of the community that are trained, and even two-year Associate degrees, where they can integrate themselves with pharmacists and doctors who may not be in the area full-time or may be doing telepharm or telepsych or telemedicine, which has become more popular and also kind of necessary during the pandemic.

HOFF: Sure.

OLDANI: So, it's an amazingly great question. And I guess to summarize, I would say we need to pipeline more Indigenous young people into these careers. There was a bit of a stereotype and a cliché, I think, with Indigenous schools and training, where often, they were nudged into social science or case management, which is totally important, and I would still advocate for that. But we have like the Menominee Tribal College in Wisconsin, where they have a pre-medicine, or at least they did as of a few years ago, pre-nursing programs where they're training Native young people on the reserve to go into these health careers. And we just have to help them and support them with resources once they leave their communities to complete their training.

HOFF: In the US, the Cherokee Nation's attempt to sue drug distributors and pharmacies was unsuccessful because of a cited lack of jurisdiction. And other Indigenous groups have brought similar suits against pharmaceutical companies, and essentially what they argue is that they've had poor stewardship of opioids that exacerbated opioid use disorder and overdose death in Indigenous communities. So, what role do cases like this have in helping those who live on tribal land assert tribal sovereignty, and what role does tribal sovereignty have in promoting tribal health interests?

OLDANI: Yeah, another great question. You know, the opioid crisis has, I think a lot of our listeners and you know, affected everyone. It caught the attention of government leaders. Unfortunately, once it kind of went through that white-ification where White young people when, once they became victims and entered the criminal justice system, I don't think it's any surprise drug treatment course increased. It became a bipartisan issue, so to speak.

HOFF: Right.

OLDANI: But vulnerable groups knew what they were dealing with way ahead of that curve. And if we look at people in our population, people of the BIPOC kind of populations, yeah, they were disproportionately affected. If I took this in two parts, this question, one, these cases, opioid case, one, it's just important to understand from the pharmaceutical industry point of view. And I'm a critic of the industry in this regard: They were complete opportunists. So, they went to where the easy prescriptions were, and whether that was primary care doctors that didn't quite understand how addiction worked with these compounds. You know, the industry crafted an incredible narrative of almost zero or no addiction that it promoted through sort of pseudo-theory in their package insert or through the literature in a way that didn't allow doctors to really understand the data but told this really compelling narrative. And they were able to do that, I believe, for six to eight years in the marketplace and dealing with the aftermath of that, this sort of non-addiction idea behind opioids. Now, obviously, that's not true.

HOFF: Right.

OLDANI: We're in sort of this next phase. You know, when I think about tribal sovereignty or tribal health interests, I think it's really important, and I'm sure there are many initiatives afoot for these local communities. And every community's going to be a little bit different, how they were affected by. One community might've had a prescription situation with prescribed opioids. Another, maybe it was black tar heroin. You know, it could be Fentanyl or Carfentanil, more of the synthetic opioids. I think that's where I hope tribes have the resources to look really local at what the situation is: What are the demographics, what impacted us, what kind of opioids were being prescribed, and who are the high prescribers? And it almost requires sort of a root cause analysis, which is sort of common practice in interprofessional work, right, in an institution?

HOFF: Mmhmm.

OLDANI: But it has to be really local where you traced out, you know, why were we so vulnerable, and why were we impacted to a greater degree? I also think when you think about tribal sovereignty and health interests, that's such a complex question, because, again, at a local level like here in Wisconsin, we still have disparities between the tribes in terms of the level of resources they have.

HOFF: Right.

OLDANI: During the pandemic, the Pottawatomie were just an amazing case study of going from one of the poorest tribes 25, 30 years ago to one of the most resource-heavy, thanks to the way they worked gaming in the city of Milwaukee and throughout the state. And they were able to deploy those resources in, right away, two areas, and it tells you what's going on: education and health care infrastructure. And they could be held up as a model about how kind of a philosophy of a healthy population is going to lead to a healthy tribal nation. And I think they're a great example of that are, as are, I would say, the Lac du Flambeau and some of the other groups in northern Wisconsin. But it's so resource dependent. So, if they're not able to kind of generate their own resources—and you have some tribes that aren't able to maximize, say, gaming revenue. They're just in a particularly odd location, maybe, that's not near a tourist center—how do we find the resources for them? And Wisconsin's, I think, a state, especially now with the current administration, that really is working with the tribes when it comes to twin areas that you, I think, are really smart of you to point out, you know, tribal sovereignty and health care and how they work together.

HOFF: It does sound like it's very sort of location and resource dependent. Does the IHS have any role in sort of coordinating resources across communities, or is that not really something that they would take on?

OLDANI: That's a good question. I would say that's not in my, that policy part, is not in my wheelhouse. I know where I've worked a little bit is with the Lac du Flambeau, a Chippewa community in northern Wisconsin, where they've been able to use gaming revenue to build—maybe I shouldn't say build—but create sort of a resurgence of their health infrastructure, an infrastructure: a full clinic, case management, social services. Now, whether or not that was independent of Indian Health Services, I'm not sure. But I know they work together with them, and I know we send our students up there. I should know a little more of the particulars [audio drops] through those programs.

But to me, what was interesting, like, for example, if I compare the Canadian experience to the US experience, a lot of people living in the United States may not realize that many Canadian reserves are inaccessible. Maybe they're accessible by winter road, or they're fly-in communities. You can't drive to those communities. Or the way Canada is set up, Americans don't quite realize this. You know, there's a few main highways, east and west. And if you're a reserve that is near one of those highways, you may be able to increase some of your revenue through gaming. Often the government controls the gaming more in Canada than the reserves. Where in the States, it's a different situation, especially in a state like Wisconsin or out west or even in parts of Michigan, where the nature of tourism and where these casinos are located and the fact that tribes can have sovereign control over that revenue to a certain extent [inaudible] and so on to the state. It's just a different situation. So, a lot of the Canadian reserves weren't able to tap into that resource, and they were sort of fully dependent on sort of government intervention, where I think here, we have more of a hybrid model depending on access to resources.

HOFF: Earlier this year, the American Psychiatric Association published an apology to Black, Indigenous, and other communities of color. The apology doesn't specifically call out transgenerational trauma by name, but it does acknowledge the role of medicine in centuries of dehumanization and trauma to multiple generations of individuals and communities. So, in your view, does the specific language of transgenerational trauma help promote health equity for present-day survivor descendants? Or is it just a matter of getting the right message out there, regardless necessarily of what you call it?

OLDANI: Yeah, I think it's getting the right message out there. I mean, "transgenerational trauma" is an important term. I think it's an important medical term, psychiatric term. My wife, my partner, is a psychotherapist who does trauma-informed care. But I kept thinking about that question and that term on a local level.

HOFF: Mmhmm.

OLDANI: I think the more it's in use, the more people are going to understand what it means. And there's such a great literature. I would point listeners to like Laurence Kirmayer's work out of McGill and a lot of the work he's done with transcultural psychiatry on trauma, for example. It's so multifaceted. There's historical, there's familial, cultural. There's all these different traumas coming together. And kind of to pick that question apart a little bit, you know, let me put it this way: I think, let me give you a story from Canada.

So, when I was in Canada, I interviewed a lot of older psychiatrists, and there was always this interesting juxtaposition with them. A lot of them had no problem talking about Winnipeg. There's a small city north of Winnipeg called Selkirk, where there was an asylum—which they called an asylum. It was a mental health institution—with a large population of Aboriginals. And to my ear, it sounds like a lot of Aboriginal men especially were hospitalized and institutionalized with things like schizophrenia, psychosis, heavily medicated. And this is '60s, '70s, into the early '80s that these psychiatrists worked, and they were using methods that we would deem now very traumatic, you know.

HOFF: True.

OLDANI: Routine ECT, lobotomies, insulin shock, things they were telling me. It was important for me to hear their stories, but also for me to realize, coming right out of that American Psychiatric Association apology like, yes, how necessary it was.

HOFF: Mmhmm.

OLDANI: And then some of these same psychiatrists would reflect back on how wonderful it was to work with Aboriginal children who would, who they might see for psychotherapy. And I would ask them, "Well, why did you enjoy it so much?" They said, "Well, here's a culture that still values dreams." So, then they would kind of put on their Freudian hat and they would [audio drops] about, I think, how they felt almost like they had one foot deeper in the Native community because of their interest in interpreting the dreams of their Aboriginal clients that came in for psychotherapy. So, I guess I tell you this story because it was a complex way that psychiatry engaged, at least in Canada, in these older psychiatrists that I interviewed, with the Aboriginal community, on the one hand, very interested in helping them, helping young children work through whatever issues they might have from a psychotherapeutic point of view, then using other coercive methods within the institutional setting that are since not happening in Canada, part of the kind of intergenerational or transgenerational trauma that you're talking about.

HOFF: Yeah, that's interesting. Yeah, this question mainly was written, so I was talking to some other folks in sort of building the idea for this podcast, and one of the things that somebody said was that folks from communities that the conversation of transgenerational trauma is relevant to already know what it is.

OLDANI: Mmhmm.

HOFF: And I guess the question is, is it helpful to have a common vocabulary for it, or does it need to be necessarily broken out individually into various communities, and to have community-specific language around whatever it is that the trauma, however the trauma was expressed?

OLDANI: Yeah, I think that's a great question. I don't have a solid answer for it, but I could respond with, you know, if we think about a language, I look at it more like from an anthropological point of view. The hardest work that an anthropologist does is similar to a psychotherapist or a good clinician, I think, is to be a good listener. But you've brought up issues here already about trust and rapport, and how do you build that with individuals that either need to be heard because of the traumatic situations they come from, or they need to be heard because they're really suffering.

HOFF: Mmhmm.

OLDANI: Like, they're exhibiting symptoms that we might quantify or categorize as post-traumatic stress disorder, for example. If I take another story that I stopped probably working with this person around, we met in 2002 in Canada, and then they would travel to Wisconsin, and we would talk off and on. And probably the last time we talked was probably 2012. But if we look at her—and let's call her Sally—I got to know her because of family connections, but she was a Cree woman from northern Manitoba. And we probably talked, and I listened to her, and she wasn't a very talkative person, maybe 10 or 20 times through different events and things where we came together. And then finally, in one of our last visits in the backyard of an aunt of mine, she talked about her aunt and her aunt having two or three sisters that had been put in a mental health institution and branded.

HOFF: Hmm.

OLDANI: This was all related to residential schools and how the family was traumatized. And she told me the story, and I listened. And the family lost track of those three, two or three daughters. And I'm sorry, but I'm not remembering the exact number. I don't have the case in front of me that I wrote up. But they've never found the bodies. They know they died in the institution at some point. One may have died from tuberculosis. And even her description of the case was fuzzy in her own mind. It had kind of been handed down through the family. But to me, that's like the example of transgenerational trauma. Here, this person carries these stories her whole life. And she felt comfortable sharing with me because we were talking about her other work, which was working at a treatment center in northern Manitoba for Native kids. And here at this treatment center, she was a case manager, and a lot of these kids suffered from fetal alcohol spectrum disorder. And she knew I was interested in that because of the pharmaceutical management of those kids.

HOFF: Mmhmm.

OLDANI: So, you know, it's such a complex milieu for a lot of Native people, especially those living on or living in the communities and helping to treat people where they themselves come out of a family history of trauma, like this Sally individual that I got to know. But at the same time, she's working with the community. So, the long and short of it for me, and I think it's a tough answer for me to, or a tough question for me to answer is, I think there does have to be a common language. There has to be best practices.

HOFF: Sure.

OLDANI: With people like my wife, a psychotherapist, what she's engaged in and really committed to best practices for survivors of trauma. But there also has to be a robust way of letting people tell their stories and engaging locally in ritual, whether those are healing circles or group therapy, and then allowing those rituals to flourish and kind of take on their own flavor within the community. So, I think it's a very complex question. And I had to read that APA apology again.

HOFF: Mmhmm.

OLDANI: And it's always striking. I think if they were guilty of one main thing, it was silence and not being advocates during this era until now.

HOFF: Sure.

OLDANI: And now you can see what they're advocating for. So, that was sort of striking to me.

HOFF: Hmm. So, to wrap up, what three things should clinicians who are working with Native and First Nation patients and communities know about the past, and perhaps transgenerational trauma in general, in order to care well for patients in the present?

OLDANI: Yeah, you know, that's again, that's a great question. I'm going to try and summarize. We have a piece coming out in the *AMA Journal of Ethics* where this comes up a little bit. My wife and I had sort of a response to a hypothetical case of a young boy brought into a clinic with some mental health, maybe some substance use issues, three things, and I jotted down some notes. But I would say definitely one is, anybody who works with Indigenous communities, you know, there's a lot of talk about trauma, ACEs, social determinants of health, and these kinds of things, super important. We have to be

cognizant of it. We have to bring cultural humility. And I think part of that is not equating poverty or social determinants with Indigenous culture. And I think sometimes that can happen, and it doesn't happen on purpose. But we have to look at their culture as something that's vibrant, living. That's a real fear right now during the pandemic. I know in northern Wisconsin, there just was an article today that in Wisconsin, the initial response was really positive for tribal communities. But now they're starting to lose, especially elderly tribal members at a higher rate than the general population. They're very concerned about that cultural knowledge.

HOFF: Sure.

OLDANI: So, kind of point number one is that, you know, is the history and culture is living. It's an everyday reality for Native communities, and it's part of their life, like any other cultural group. And I think that's really important. And I would stress not conflating socioeconomic conditions with their cultural life.

And I think we've covered this pretty well, that sometimes the idea of trauma is sort of like post-traumatic stress disorder, that there's sort of this it's happened in the past or that it was fixed at some point, and now the person's trying to move on. Which, of course, many people are. They're trying to deal with it. They're trying to get help. But that these things kind of can recur, and they can have kind of this ever-present quality in one's life until they get effective treatment. And we talked a little bit about that today. One thing we stress in the piece we put together for the *AMA Journal* was kind of a collaborative approach where members of the community are part of the team somehow, whether a clinician, a pharmacist, a community health worker. But those traumas are sort of ever-present.

You know, when I worked in Canada and I went to clinic appointments with that informant I mentioned, Marie, every appointment went, the first question—and of course, this was now almost two decades ago—but the first question out of the box always was related to alcohol, you know. And it was such a fixed thing in that particular time in Winnipeg because fetal alcohol spectrum disorder was on everyone's sort of mental map, both in the community and with clinicians. But it was so offensive to her. You know, she wasn't a drinker. She'd spent her life helping people with alcoholism. So, but that was like a microaggression and a trauma she dealt with a lot of humility herself, but she had to deal with on almost every appointment. So, that just reminded me. That's just the ever-present reminders that people have.

HOFF: Hmm, mmhmm.

OLDANI: And you asked for three.

HOFF: [chuckles]

OLDANI: So basically, my third point would be that I really think collaboration is key. And I mean, that's what we stressed in our article where, I think historically, especially from the point of anthropology or even some health professionals, Native Americans and how we worked with them, it wasn't really a partnership. They were treated more as research subjects, and there was kind of that laboratory metaphor that we're studying this uninterrupted group, which, of course, is not true. All groups live in and throughout history. But I guess today I would stress that partnerships are key. So, whether it was like the work I did in Canada or you're thinking of work at a clinic, if you're going to do patient-centered

care or Native-centered care, there has to be good buy-in; there has to be trust built. And I think that's built through collaboration, and that's not often easy to do.

But for example, in our article, we highlighted the idea of, especially if you're working in a clinic that's on or near a Native community, there are going to be people from the community available and present. And somehow you have to work to ally them with your team or your patients or your clients to build trust and rapport. So, I think collaboration's really important.

And a side corollary to that would be the reason I stress partnerships or collaboration when we're thinking about working with Native Americans, especially in the health care field, is that if we take a concept that's an interesting concept in anthropology like efficacy, clinicians would think of that as drug efficacy. Or if we have a specialist, how rehab science can be efficacious in terms of improving functionality of muscles and so forth. But in anthropology, you can think of cultural efficacy and pharmacological efficacy, for that matter, within Native American communities. They have efficacious forms of treatment. They have rituals and what we might call local kinds of healing that are very efficacious that I think have to be incorporated into the mindset of clinicians.

So, the example I like to use is, and I may have talked about it already on the podcast, but when I worked in Canada, there was like a weekly meeting of elders and medicine people that you could kind of sit in on. It was open to the community at a place called the Thunderbird House in Winnipeg, which is a really unique, kind of amazing architectural structure, community gathering place. And so, you could go in on like Thursday nights. And often, it was just a listening session: You'd listen to the elder. But they would talk about different kinds of healing mechanisms for the community.

So, for example, in the area I was interested in—disturbed children in the sense that they might have had behavioral issues or mental health problems, and they were struggling in school, or they could've had symptoms of fetal alcohol spectrum disorder—these leaders in the community would talk about things like, well, let's get them involved in perhaps a sweat lodge ceremony or a naming ceremony. Maybe I could meet with them weekly, and we could talk about what kinds of medication they are on. But then how, in this case, the Ojibway think about these issues within the community. And there are, and they really stress different kinds of techniques within the Ojibway community that would be really synergistic with a young person, say, meeting with a psychiatrist or meeting with a behavioral specialist.

But my point is collaboration is complex, but the partnerships are available. Even in the adult community in Winnipeg, those that had gone to residential schools or maybe were a second-generation survivor, maybe one of their parents had gone to a school, and there was trauma within the family, the healing circle was so important. And some clinicians clearly knew about those, especially doctors that had worked on or near Native communities. Others had no idea that these kinds of healing circles were going on, and they didn't ask questions. So, I guess that's my larger point to end on, is being really, kind of having a clinical openness and the kind of humility where whether you're an anthropologist or a clinician, you're not afraid to ask certain questions to build really productive collaborations and partnerships.

HOFF: Great. Thank you. And for our listeners who are interested, that article will be appearing alongside this podcast on our June issue. [mellow music slowly fades in] It's titled *Trauma-Informed Caring for Native American Patients and Communities Prioritizes*

Healing, Not Management. That was Dr Michael Oldani, a medical anthropologist and Professor of Pharmaceutical Sciences and Administration, as well as the Director of Interprofessional Practice and Education at Concordia University Wisconsin in Mequon. Dr Oldani, thank you so much for taking the time today.

OLDANI: Yeah, I appreciate the opportunity to share a few of my thoughts, and I really appreciate the drive of the *AMA Journal* and what they're trying to accomplish with a lot of the recent issues and articles. I just think it's a great, great journal, a great mission, and the information you're putting together for clinicians and others is really terrific. Thank you.

HOFF: Thank you, and thank you for your contributions to that effort. Hopefully, we'll talk to you again soon.

OLDANI: Yeah, that sounds great.

HOFF: That's our episode for this month. Thanks to Zoe Tao and Dr Michael Oldani for joining us. Music was by the Blue Dot Sessions. To read our entire issue on transgenerational trauma, visit our website, JournalOfEthics.org. For all of our latest news and updates, follow us on [Twitter](https://twitter.com/JournalOfEthics) and Facebook [@JournalOfEthics](https://www.facebook.com/JournalOfEthics). And we'll be back next month with an episode exploring visibility and measurability in health care. Talk to you then.