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The Impact of Medical Injustice: Restoring Trust in Clinical Practice

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Introduction

Intergenerational trauma, defined as the impact of trauma on not only one generation but also the next generation, can adversely affect the integrity of patient-physician relationships [1, 2]. Racism and the structural inequity it perpetuates are one of many driving forces behind intergenerational trauma [3]. In children, families, and communities, its effects can be felt biologically, socially, and psychologically [1]. Such an effect extends itself into the cardiac health of African Americans and minority groups, resulting in disparities in most cardiac procedures and treatments, such as CABG and hypertension regulation [4]. To tailor care with a more compassionate view of Black experiences, clinicians must further their understanding of medical mistrust and its link to racial, historical, and intergenerational trauma.

The Link between Racial, Historical, and Intergenerational Trauma

Besides affecting a child's psychological well-being, intergenerational and historical trauma can negatively impact physical health by passing down biological memory [1, 5, 6]. Cumulatively and epigenetically, these stressors can affect the development of offspring independently of and in interaction with direct exposures to stress during perinatal and early childhood [7]. For instance, African American women who have continuous exposure to, and chronically internalize racial discrimination during their lifetime and pregnancy have been shown to suffer from preterm delivery and/or low birth weights [5, 8]. Furthermore, minority women are at a significantly greater risk of experiencing cardiac complications such as gestational hypertension, preeclampsia, peripartum cardiomyopathy, heart failure, and arrhythmias [9]. Racial trauma is at the root of intergenerational trauma [10]. This can manifest in the persistent denial of access to resources, opportunities, and the power to define reality, the normalization of which is defined as structural racism [10, 11]. In the face of such barriers, African Americans are susceptible to physiological decline, illness, and early mortality as a result of continuing stigmatization and disadvantages [5, 12]. Historical trauma is multigenerational trauma experienced by a specific cultural, racial, or ethnic group, such as slavery and forced migrations [1, 3]. It is even more important to recognize that post-slavery, discrimination preserved the subordinate relationship of African Americans through subjugation by Black Codes, Sundown Laws, and later segregation through Jim Crow [13, 14]. Even after the abolishment of such practices, the seemingly inescapable view of inferiority

persisted within the American landscape leading to feelings of social and political powerlessness, obvious wage gaps, educational deprivation, and high prison enrollment rates [14]. The effects were also perversely felt in medicine, where African Americans were reduced to experimental subjects instead of patients [2]. Byrd and Clayton noted that early colonial physicians laid the groundwork for enslaved Black patients to be experimented on and practiced upon, substantiating in their research the myth of racial inferiority that categorized blacks as subhuman things [2, 15]. These poisonous notions would later lead to the abuse and neglect of African Americans in the medical profession.

A History of Medical Injustice

It has been well established that medical mistrust undermines established patient-physician relationships, affecting patient-physician communication [16–18]. Among people of color, distrust is also associated with lower healthcare utilization and satisfaction and deterring preventative healthcare practices like colorectal cancer screening, obtaining a mammogram, and HPV vaccinations [19–21].

The most infamous example is the "Tuskegee Study of Untreated Syphilis in the Negro Male" which was known as the longest-running medical experiment in the United States [22, 23]. The study began in 1932 with the enrollment of a total of 600 impoverished African American sharecroppers from Macon County, Alabama. Of these men, 399 had latent syphilis, with a control group of 201 men who were not infected [24]. This study was designed to observe the effects of syphilis when left untreated, although, by the end of the study, medical advancements had made it completely treatable with penicillin [25]. The men were misled, unaware of their diagnosis, and left untreated for 40 years. More than 100 men had died from syphilis-related morbidity and mortality, while some of their wives had acquired the disease and some of their children developed congenital syphilis [22, 26]. The Tuskegee syphilis study has historically been regarded as a major cause of mistrust toward public health efforts and preventative care in the United States due to the extent of its deception and mistreatment [27, 28]. Even currently, the Tuskegee experiment has created a hesitation to get vaccinated against COVID-19 within the Black community [29].

These experiments ultimately failed to improve the condition African Americans and medicine found itself in since the start of the 21st century was plagued with inequality, especially regarding cardiac health. In 2001, 15,400,000 African Americans perished from heart disease, hypertension, and other related cardiac complications, as opposed to the 8,040,000 white deaths [30]. They were less likely than whites to be referred for coronary artery bypass grafting, receive thrombolytics, and undergo coronary angiography [30]. Furthermore, the rate of heart failure is expected to increase by 46% in African Americans by 2030 [30]. The remnants of these inequalities have lingered and still greatly affect the quality of cardiac care that African Americans can receive. Such inequalities have torn African Americans from the medical community and instilled a sense of fear and mistrust.

Restoration of Trust in Clinical Practice

It has long been recognized that trust is fundamental to the physician-patient relationship [31, 32]. The failure of this bond should not be a surprise since the African American population has suffered a collective experience of intergenerational trauma as a result of medical violence [2]. In recent years, the lack of trust in health care has been attributed to the proliferation of managed care and for-profit health care, disclosures of past unethical research, and widespread publicity surrounding medical errors, malpractice, fraud, and abuse [31, 33, 34]. Considering the present situation of this relationship, Laura Specker Sullivan stated that "mistrust might well be rational" [2, 35].

It is vital for healthcare providers to understand and address the long-standing trauma affecting African American patients. As it relates to structural racism, it is also necessary to recognize the historical, cultural, institutional, and interpersonal aspects that result in inequity for African Americans [36]. The use of patient-centered communication (PCC), which has been described as the key to cultural competence, will allow physicians to prioritize patients' needs and preferences in care, allowing patients and providers to collaborate. Previous literature has shown that when treated as partners, patients are more likely to participate in their care and receive information about the treatment regimen they find useful [37–39]. Shared decision-making, a central component of PCC, has also been shown to improve

patient's understanding of treatment plans and their satisfaction with their clinicians [37, 40]. A trauma-informed approach and healing-centered engagement could also provide meaningful interactions with African American patients who have endured trauma and emotional harm [36].

Unique factors have been shown to influence trust and distrust in physicians among African American patients. For instance, trust was influenced by the perceived interpersonal and technical competence of physicians. During routine healthcare provision, distrust was influenced by a lack of interpersonal and technical competence, a sense of greed, and expectations of racism and experimentation, all drawing parallels to previous historical trauma of medical injustice [2, 41]. Physician-patient relationships built upon a foundation of reliability, advocacy, beneficence, and goodwill are also most likely to be credible and therefore, trustworthy [2, 42].

This distrust has extended into underrepresentation in cardiovascular clinical trials due to a significantly lower willingness to participate when compared to Caucasian [43]. Thus, impacting medical knowledge on the efficacy of medications and treatment plans for African Americans. For instance, The American College of Cardiology took until 2017 to declare that thiazide diuretics and calcium channel blockers are more effective in treating hypertension than ACE inhibitors and angiotensin II receptor blockers. Even more worrisome, is the nonadherence to medications. There is an estimated 51% compliance rate among hypertensive patients, and African Americans adhere to their treatment course 452% less often than whites [44, 45]. Clearly, such mistrust cannot be ignored and the relationship between African Americans and the healthcare system needs to be mended.

Conclusion

Evidently, trust, a vital component of the physician-patient relationship, has been undermined by racial, historical, and intergenerational trauma. In the past century, racial injustices have eroded Black patients' confidence in physicians and the medical establishment. It is impossible to resolve deep-rooted suspicions in a single patient-physician interaction since trust must be built and earned. We must continue to empower African American patients through active listening, patient-centered collaboration, and acknowledging the hardships of intergenerational trauma and medical injustice, in order to improve health outcomes.

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