



Racism is Life-Threatening and Continues the Cycle of Racial Trauma: What Can Clinicians do to Interrupt This Cycle?

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Abstract

The COVID-19 pandemic drew attention to health disparities and racism in healthcare. The first step in addressing racial disparities in healthcare is acknowledgement that there is a problem. Palliative care teams have an obligation to recognize how racism shows up in healthcare and in turn how it affects racially marginalized patients. Clinicians must engage in self-reflection by assessing their own conscious and unconscious biases that impact the clinician/patient dyad, by understanding their social location, and by using assessments and interventions that are grounded in cultural humility and awareness of racial trauma. This paper examines racism in healthcare, the psychological impact of racism when working patients, techniques for clinicians in palliative care to address their own biases, and implications for clinical practice. It includes a composite case study of a patient navigating pain management, illustrating how racism can impact the care of BIPOC and AAPI patients.

Keywords Racial Trauma · Racism · Palliative care · Social Workers · BIPOC/AAPI

Introduction

In 2000 the U.S. Surgeon General reported that racial and ethnic health disparities were likely due to racism (U.S. Department of Health & Human Services, 2000). More than two decades later, racial disparities continue to exist in healthcare and have a significant impact on people of color (Johnson-Agbakwu, 2020). The year 2020 will be known in U.S. history as the time in which racial disparities in healthcare were brought to the forefront due to the COVID-19 pandemic, which became a public healthcare crisis (Bullcock et al., 2021). This paper will examine the history of racism in healthcare, the psychological impact of racism when working with Black, Indigenous, People of Color and Asian American Pacific Islanders (BIPOC/AAPI) patients, the importance of social location for clinicians to address their own biases, and implications for clinical practice. A case study involving a composite patient navigating pain management will be shared, illustrating how racism may impact the care of BIPOC and AAPI patients. Although the paper is geared to palliative care social workers, the concepts

and interventions noted can offer guidance to all clinicians in healthcare.

Key Concepts

Racism can be understood as racial prejudice plus social power, originally created by and for the elite, who were and still are White people (Chisom & Washington, 1997; Karenga, 2017). **Systemic racism** emphasizes the involvement of all systems in race-based discrimination (Bailey et al., 2017). **White privilege** refers to the unearned social advantages given to White people based solely on their race (DiAngelo, 2018). **Racial trauma** can be defined as the impact of historical and ongoing individual and collective race-based stress on BIPOC/AAPI people (Chavez-Dueflas et al., 2019; Comaz-Díaz et al., 2019; Williams et al., 2018). **Racial weathering** is the chronic experience of social and economic disadvantage that can lead to a decline in physical health and could explain racial disparities in an array of health conditions (Forde et al., 2019). **Cultural humility** refers to an awareness and respect of all cultures and individuality (Foronda, 2020). This term was coined by Tervalon and Murray-Garcia in 1998 and it requires a lifelong commitment to learning and self-evaluation to address the power imbalance that exists between BIPOC/AAPI patients

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and clinicians (Foronda, 2020). **Palliative care** services are specifically designed to address the quality-of-life concerns of patients diagnosed with a chronic or life-threatening illness. When integrated into routine clinical care, palliative support can improve symptom burden and quality of life, as well as increase patient and caregiver satisfaction, through early identification, assessment, and treatment of pain as well as psychosocial and spiritual concerns (Bosma et al., 2010; Sumser et al., 2019).

Historical Context of Racism in the Practice of Medicine

The history of systemic racism in medicine reveals a legacy of abuse of Black people in the name of science. By understanding the historical context, it will give clarity to the psychological impact of racism, how mistrust, fear, and ambivalence towards treatment occurs, which leaves BIPOC/AAPI in constant state of high-alert or makes them feel like they do not matter. Racism in healthcare dates to the 1600s, when the first enslaved people were brought to the United States (Nuriddin et al., 2020). Examples include the violent medical treatment and experimentation on Black enslaved women against their will to develop gynecological surgical techniques (Nuriddin et al., 2020). The horrific Tuskegee Syphilis Study of late-stage syphilis in Black men, which began in 1932 that continued until 1972 (Benton, 2021). As part of the study, researchers did not collect informed consent from participants and they did not offer penicillin treatment even after it was widely available (Benton, 2021; CDC, 2021). The most significant era of eugenic sterilization in the United States took place in the 20th century. The exact number of African American women is still unknown (Villarosa, 2022). An estimated 40% of Indigenous women and 10% men underwent sterilization in the 1970s (Amy & Rowlands, 2018). Within the Latinx community, one-third were sterilized between 1903 and 1970, and in 2020 Immigration and Customs Enforcement was accused of forcibly sterilizing detainees at the U.S./Mexico border, who were under their care (Mendosch, 2021; Novak et al., 2018).

Those seen as unwanted and/or unwelcomed including the poor, the disabled and various marginalized ethnic groups, were seen as targets of compulsory sterilization by the government (Villarosa, 2022). Benjamin Rush, the “Father of American Psychiatry,” supported the belief that Black people were inherently dangerous and needed to be controlled (Haeny et al., 2021). He believed that being Black was a mild form of leprosy and the only cure was to become White (Haeny et al., 2021). This was supported by Dr. Samuel Cartwright, who coined mental illness terms such as, “drapetomania” (slaves who wanted to flee and escape captivity) and “dysaesthesia aethiopica” as a disease of

‘rascality’, both cured by whipping (Shim, 2021). This was the beginning of pathologizing normal behavioral responses to racialized trauma. These are just a few examples of racism in healthcare as well, how BIPOC/AAPI patients continue to endure racism and remain affected by intergenerational racial trauma. Despite the ample evidence that supports the impact of racism in healthcare, many clinicians continue to believe in the concept of biological differences. Although these beliefs are false, they maintain its place in medical pedagogy and with the providers harboring these biases (Shim, 2021). This emphasizes the glaring reality that the institution of medicine continues to be White value-driven with much of its leadership, decision-making power, and influence remains in the hands of White and White-identified individuals (Bailey et al., 2017; Nuriddin et al., 2020).

The Role of the Palliative Care Social Worker

The role of palliative care social worker (PCSW) is to help alleviate suffering and improve the quality of living and dying by addressing physical, psychological, social, and spiritual concerns (Sumser et al., 2019). Social workers equipped with cultural awareness skills and knowledge, curiosity, and cultural humility can have a profound influence upon the way BIPOC/AAPI patients experience their care and the way other members of the palliative team view them as patients. Steps toward assessing the effects of racism require that clinicians avoid assumptions, comprehend through assessment how the consequences of racism can manifest in palliative treatment, and appreciate and respect why it is important for BIPOC/AAPI patients to be seen and heard as they receive medical care (Vo, 2020).

In June 2021, the National Association of Social Workers revised the Code of Ethics (Code), social workers are now mandated to take an active role against discrimination, oppression, inequities, and racism (NASW, 2021). Therefore, social workers are obligated to ground their interventions firmly in antiracist practice through demonstrating cultural humility by means of engaging in critical self-reflection (understanding their own biases and actively self-correcting) (NASW, 2021), having knowledge that racial disparities exist in healthcare, learning how racial trauma shows up, and implementing culturally appropriate clinical interventions, see Table 1, and will be explored further in this paper.

A first step towards an antiracist practice is for White and White-identified social workers to acknowledge their White privilege and power in clinical practice. This also requires a commitment by White and White-identified clinicians to give voice to BIPOC/AAPI patients experiences of racism and to understand how it influences the quality of the medical care provided and to acknowledge that racial disparities exist. As the Code emphasizes, social workers must recognize that BIPOC/AAPI patients are experts of

Table 1 Cultural assessment questions and guidelines

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| <p>Clinicians</p> <ul style="list-style-type: none"> · Cultural safety training also involves personal reflection of one's social location, as well as personal assumptions and biases related to health services · Location of self (clinicians self-reflection of their various identities) that may impact the therapeutic alliance. · Awareness of clinician's privilege and positionality. · Education of racial disparities in healthcare and how it impacts care. · Be aware of the differences between you and your patient (race, religion, spirituality, socio-economic status, sex, sexual identity, gender). · Educate oneself on how social and racial determinants of health impact BIPOC/AAPI patients. · Be cognizant of the impact of racism and racial trauma on BIPOC/AAPI patients and how it exist in healthcare. · Explore interventions as there is no one-size fits all. · Culturally appropriate interventions include an awareness of culture. · Gain understanding about cultural aspects (such as norms, customs, language, lifestyle, etc.) · Have knowledge and judgement to distinguish between culture and mental health disorder · Integrate these aspects into the intervention. · Cultural safety training involves intellectual, emotional, spiritual, and relational learning related to allyship · Obtain clinical supervision from culturally safe clinicians (e.g., religious leaders, Indigenous healers) to deepen your practice of cultural humility <p>Therapeutic Relationship</p> <ul style="list-style-type: none"> · Conduct culturally appropriate assessments that include learning about the cultural background of you patient, religions/spiritual beliefs, gender identity, sexual identity, cultural values, and beliefs. · Explore what identities are important, least important, how do these identities impact how the navigate healthcare. · Assess generational racial trauma and how this increases anxiety and fear in healthcare. · Assess anxiety, depression, and hypervigilance symptoms due to racism and racial trauma. · Provide interventions in patient's preferred language, · Modify the length/frequency of appointments, · Utilize culturally congruent terminology and concepts · Involve family members or friends · Give space for the lived experience of patients. |
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their own culture, and clinicians must commit to lifelong learning (NASW, 2021). It is imperative for clinicians to have self-awareness and knowledge of one's own cultural background and the power, privilege and subjugation associated with their identities as they develop an antiracist clinical practice (Watts-Jones, 2010). Yet little time is spent reflecting on our own biases and prejudices that can appear in our assessments, interventions, and interactions with BIPOC/AAPI patients (Hook et al., 2016). If not addressed, these biases and prejudices can reinforce a racist narrative that is too often made by clinicians and has the potential to dismiss medical concerns voiced by BIPOC/AAPI patients (Cohen 2016; Johnson, 2020).

When BIPOC/AAPI patients are seen in outpatient clinics or admitted to hospitals, they may be subjected to

microaggressions, labeling, and covert or overt racism (Hook et al., 2016). This conscious or unconscious characterization or misinterpretation leads to inadequate attention, inaccurate assessment, and insufficient treatment (Johnson, 2013). BIPOC patients are unjustly labeled as “non-compliant” or “drug-seeking” about two-thirds more often than their White counterparts (Baldwin, 2018; Washington, 2020). These biases have real impact on medical care and the lived experience of BIPOC/AAPI patients and can cause harm or perpetuate trauma (Algu, 2021; Johnson, 2013; Vo, 2020). When a BIPOC patient reports pain and requests medication, members of the palliative team may question or dismiss the patient's claim as not being legitimate (Algu, 2021; Maybank et al., 2020; Meints et al., 2019). This dismissal results in BIPOC patients being consistently undertreated, untreated or mistreated for pain (Bullock et al., 2021; Johnson, 2013; Maybank et al., 2020). The pattern of palliative care clinicians dismissing and misunderstanding pain in BIPOC patients is well documented; for example, it has been reported that BIPOC patients are less likely to receive analgesics (i.e., Tylenol or opioids) in the emergency room (57% compared to Whites at 74%), specifically to relieve pain (Benton, 2021; Hoffman et al., 2016), which is reinforced by the false narrative that Black bodies feel less pain than White bodies (Algu, 2021). These examples of racial discrimination are pervasive due to the racist ideologies that continue to exist in medical pedagogy as well as, physicians who use debased science to try to subjugate black and brown bodies (Murray-Lichtman et al., 2022). This fear and mistrust of the medical system, at times leads to mental health concerns. For example, depression among BIPOC/AAPI patients is vastly underrated and are less likely to receive treatment compared to White patients (Hankerson et al., 2022). These racial inequities are associated with lack of mental health treatment, being underinsured, unreliable mental health settings and the perception that the services are punitive and biased.

Clinicians need to have a certain degree of comfort to talk about race to have a more meaningful opportunity with BIPOC/AAPI patients to explore, process and address the implications of racism, while enabling an opportunity to receive appropriate care. PCSWs should advocate for anti-racism practice in all areas, including the clinical assessment, giving voice to BIPOC/AAPI patients who are not heard, and to speak up where they see covert or overt racial disparities.

The Impact of Racism on Palliative Care

The following clinical case example is based on a real patient, “Maya.” Some details have been modified to protect her confidentiality. This case will illustrate how racial trauma manifests due to intergenerational experiences of

racism and in turn can affect palliative care for BIPOC or AAPI patients.

Maya is a 38-year-old Black woman who is a professional in the finance industry. She was diagnosed with metastatic ovarian cancer. Maya was recently hospitalized due to an increase in bone pain. During one of the morning rounds, a nurse practitioner requested a palliative care consult because Maya was “disruptive” during the night shift. The palliative care fellow (PCF) who evaluated her stated that he was “suspicious of Maya’s concerns regarding pain and believed that she was drug-seeking because her bone pain should have been manageable with the IV Tylenol that she was receiving”. The PCF reiterated that there was no substantiated evidence to prove that Maya was experiencing increased pain even though Maya’s medication list did not previously include the use of any analgesics. Regrettably, without fully appreciating her medical history, the inpatient medical team discontinued the IV Tylenol and discharged Maya with a prescription for Tylenol with codeine.

A few days later Maya returned to urgent care (UC) in excruciating pain, unable to stand, having difficulty breathing and extremely distressed. Fortunately, a BIPOC palliative physician who was on-call in the UC met with Maya. She took the time to hear her concerns regarding the level of pain Maya was experiencing, reviewed her medical record, and validated her experience. The palliative physician recommended a CT scan to rule out progression of disease before making any decisions about next steps. She also noted that Maya was extremely anxious and appeared fearful about sharing any medical information prior to this encounter. A consult with the PCSW to assess for anxiety and gather collateral information about Maya’s medical concerns. Maya acknowledged her fears of being dismissed as she recalled her cry being ignored during her last admission. She also feared being discharged to a detox facility because the PCF had identified her as drug-seeking. During the clinical assessment, the PCSW explored if there were other times in which Maya felt unheard or not seen in a medical setting. The PCSW reassured Maya by providing education about her role on the team and that her intentions are to better understand the patient’s needs. The PCSW initial goal was for Maya to feel like she was cared for and to help ease her distress, but the PCSW immediately realized that trust would have to be earned due to Maya’s fears associated with her past admission. The PCSW was aware of her own positionality as a healthcare provider and was worried about doing more harm and the mistrust she represented. She decided to let Maya lead the narrative, as she leaned in with curiosity.

The next day, the palliative care physician shared with Maya that her pain was substantiated as the CT scan revealed significant bone metastases, and they started Maya on analgesics. The medical team reviewed the next steps in alleviating the pain and how the palliative care physician plans

to closely monitor Maya as she begins a new form of treatment. During clinical rounds, the PCSW provided education about the importance of a trauma-informed assessment that included exploring racial trauma and how this can impact a patient’s medical care and their ability to trust proper and fair medical treatment.

The PCSW and Maya continued to meet for weekly counseling, where Maya revealed significant distress and fear as she shared her traumatic experiences of frequent visits to a local emergency room and subsequently being misdiagnosed for several years prior to her diagnosis with metastatic ovarian cancer last year. Maya recalls experiencing poor medical care growing up due to inadequate health coverage and being unable to find in-network providers. She thought that would change after obtaining private insurance and having access to quality medical care. She acknowledged being extremely accommodating to scheduling appointments that was convenient for the medical team. She recollected stories of her mother and grandmother receiving inadequate medical care, dismissed reports of pain, and being diagnosed with late-stage cancer as well, prior to their deaths.

The PCSW acknowledged Maya’s significant traumatic history and provided education about the concept of racial weathering and trauma. When the PCSW validated Maya’s experiences and used the word racism, she began to sob and said, “I finally feel heard, and seen.” The PCSW provided education about the responses to racial trauma (fight, flight, or freeze) and explored if this resonated with Maya’s experience. Maya expressed feeling a sense of relief that this was not her fault because she made choices to not seek medical care due systemic racism. This awareness opened the door for the PCSW and Maya to explore her experience and how racial trauma has impacted her medical care. The PCSW created a trusting therapeutic alliance with Maya, and it revealed a lifetime of experiences of racism in the medical setting. Counseling helped Maya acknowledge that she carried this significant generational trauma for a long time and never had an opportunity to share it or to receive mental health support. The PCSW asked questions around her experience in a medical setting, such as, have you experienced racism in the medical setting? Can you share what happened and how you felt? How did those experiences shape your beliefs about medical care? To assess and fully appreciate Maya’s experience, the PCSW reviewed past experiences of racism and how that shaped Maya’s beliefs and mistrust of medical care. The PCSW acknowledged her past racial trauma, including her mother and grandmother. The PCSW approached Maya with cultural humility and curiosity about her experiences and how they impacted her health care choices and current situation. The PCSW used supervision to reflect on her own biases, her social location and how her position could have negatively impacted Maya’s medical care, if she was not

educated in racial inequities that persist in healthcare. The PCSW explored how one can be unconsciously impacted by our interactions with patients if we have the same skin color.

The clinical case described above illustrates how recurring racism affects BIPOC patients and how it can lead to mistrust in medical care. In addition, it validates research that confirms that Black patients are less likely to report pain compared with White patients (Hoffman et al., 2016; Meints et al., 2019; Samuel et al., 2018). BIPOC/AAPI patients are also less likely than White patients to have access to quality care, including but not limited to standard medical and mental health treatment, clinical trials, and palliative care (Cain et al., 2018; Hankerson et al., 2022). The reality of systemic racism as a major cause of health-related disparities is clear as is the need for a framework to address the problem. Systemic racism that creates health disparities also affects other social determinants of health (e.g., poverty, poor public education outcomes, and food scarcity) (Bailey et al., 2017; Davis, 2020). Systemic racism takes a mental toll on BIPOC/AAPI patients and contributes to racial trauma.

Racism can be life-threatening for BIPOC/AAPI patients due to vicarious racism and the historical abuse in medicine (Comas-Díaz et al., 2019; Helms et al., 2012). Systemic racism affects BIPOC/AAPI patients in numerous ways that may include higher rates of health concerns (e.g., die prematurely to hypertension, diabetes, cancer) (Benton, 2021); social issues (e.g., Black men are five times more likely to be incarcerated) (Villarosa, 2022); and psychological problems (e.g., higher rates of depression, anxiety, post-traumatic stress disorder, racial trauma) (Hankerson et al., 2022). Systemic racism can lead to racial trauma, and it does not have to be a direct experience for this to occur (Comas-Díaz et al., 2019; National Institute for the Clinical Application of Behavioral Medicine [NICABM], 2019). Therefore, many BIPOC/AAPI patients may live for years with untreated and repeated trauma due to racism and/or live in a constant state of high alert when seeking medical care (i.e., addressing pain management, or obtaining mental health support) (Comas-Díaz et al., 2019; NICABM, 2019; Williams et al., 2021). PCSWs when working with BIPOC/AAPI patients who are diagnosed with chronic or life-threatening disease should incorporate into their assessment questions that explore how intergenerational racial trauma has impacted BIPOC/AAPI patients and how they process their diagnosis or prognosis. It is critical that PCSWs learn how to examine the impact of racism because research shows that racism is related to traumatic stress, depression, anxiety, suicidal ideation, and substance abuse (Williams et al., 2021). Disrupting racism by changing the structures in which we treat patients is the most effective way we can reduce the impact of racism, so that racial trauma is not perpetuated.

Psychological Impacts of Racism

Understanding the psychological impact of racism will give clarity to how BIPOC and AAPI patients may mistrust, fear, and feel ambivalence towards treatment. These sentiments can leave patients hypervigilant or invisible. The National Institute of Clinical Application of Behavioral Medicine describes three ways in which BIPOC/AAPI patients may respond to racism: fight, flight, freeze and fawn (NICABM, 2019). It is essential for clinicians to understand these responses and examine it with BIPOC/AAPI patients, so they better understand their own reactions to racism. Examining these trauma responses, BIPOC/AAPI patients either react (fight) to the racist remarks, flee from the encounter, shut down (freeze) because they fear retribution if they advocate for themselves and/or fawn is when the body stress response is to please others to avoid conflict (NICABM, 2019). As illustrated in the case above with *Maya*, her fight response was illustrated in her wailing and determination for pain management. *Maya's* flight response showed up when she did not want to return to the hospital, and she became extremely distressed and anxious about returning to the UC. Her freeze response was in her acknowledgement of how she disassociated from the systemic racism by putting the blame on her lack of proper health insurance. And *Maya's* fawn response was seen when she accommodated the medical team's needs before her own. Social workers can help patients understand these common reactions through a trauma informed lens, so they are better equipped with how to manage racial stress and to alleviate self-blame for what happened or from experiencing shame or additional trauma. Trauma informed care explores emotional reactions to negative experiences that have the potential to cause serious health problems (Ricks-Aherne et al., 2020).

It remains challenging for BIPOC/AAPI patients to heal from racial trauma because these wounds occur unceasingly, in every level of society (Hardy, 2013), and the last place they expect to endure it is in their medical care where the consequences can lead to suboptimal care and hastened death. To explore these responses and the psychological impact of racism on BIPOC/AAPI patients, it requires clinicians to acknowledge their own social location, positionality, and patience to step into difficult conversations. As clinicians begin understanding the impact of racism and trauma in healthcare and mental health, it is imperative to keep in mind that BIPOC/AAPI patients are the experts in their culture and experiences, and this can lead to an open dialogue without the fear of being labelled or mistreated.

Approaches for Working with BIPOC/AAPI Patients

Left untreated and unacknowledged, racism can leave scars for those who have been impacted. If BIPOC/AAPI patients

who have experienced racism compounded by chronic or a life-threatening illness in a medical system where there are racial inequities and treatment is delivered by predominantly White clinicians, it is imperative that the medical team ground their clinical discussions with BIPOC/AAPI patients in cultural humility. A few culturally appropriate interventions clinicians want to consider are the services provided in patients' preferred language, modify the length/frequency of appointments, utilize culturally congruent language, and involve family members or friends. For example, integrating healing practices when caring for Indigenous patients (Beaulieu & Reeves, 2022) or being aware of 'familismo' when working with Latino families) (Chavez-Dueñas et al., 2019; Floríndez et al., 2020). In addition, interventions include an awareness of diverse cultures, gaining understanding about cultural aspects (such as norms, customs, language, lifestyle, values, beliefs), give space for the lived experience of BIPOC/AAPI patients, and the ability to integrate these aspects into the intervention.

Clinicians enter a relationship with BIPOC/AAPI patients with the intention of honoring their beliefs, customs, and values. Cultural humility raises awareness of clinicians to address both institutional as well as individual behavior that perpetuates the power imbalance, the marginalization of communities, and contributions to disparities in health access and outcomes. Clinicians, specifically PCSWs, ought to approach BIPOC/AAPI patients with curiosity about any experiences that may negatively impact their health care, who must be involved in the treatment plan, and how their religious beliefs affect their medical care. Cultural humility requires each member of the interdisciplinary team to examine their social location and their own biases to bring awareness to how they may subconsciously impact their interactions with BIPOC/AAPI patients (Makoff, 2020, Watt-Jones, 2010).

Given that BIPOC/AAPI patients do not identify solely based on their race, it is the obligation of clinicians to acknowledge the intersecting identities of BIPOC/AAPI patients who they engage with, which is another important skill in culturally appropriate care. Social location is a self-reflective process in which one names their various identities that impact all interpersonal interactions (Watts-Jones, 2010). Clinicians who engage in self-reflection will have a better understanding of what aspects of their own identity that may influence the clinical interaction. Exploring social location, gives BIPOC/AAPI patients an opportunity to share their own experiences that have impacted their lives (Watts-Jones, 2010). Both the clinician and the patient bring unique experiences, backgrounds, and aspects of their identities to the clinical encounter, shaping how they view conflicts, communication and understand the world around them (Watts-Jones, 2010). This impacts the relationship with BIPOC/AAPI patients but can be mitigated by bringing it to

consciousness within an antiracist lens (Watts-Jones, 2010), even when the patient and social worker are of the same race (Vo, 2020). Questions to think about before exploring social location with BIPOC/AAPI patients: What influence might this have on our effectiveness in working with BIPOC/AAPI patients? When we consider one or more of our current patients, how complete or incomplete is our awareness of their personal cultural identities? And the racial trauma that they hold? How might this tendency toward a lack of cultural awareness in some areas influence how we view the world or how we view our patients? (Cénat, 2020; NICABM, 2019). Understanding social location is beneficial, as it allows the clinician to notice ways in which they may be privileged or oppressed, understand potential triggers that can impact the clinical encounter and identify common factors between the clinician and patient to build an alliance. This is an opportunity for clinicians to be curious and openly address racial trauma and systemic racism, which is essential for a patient's well-being.

Working with BIPOC/AAPI patients first begins with those on the medical team who identify as White or white passing to gain an understanding of their White privilege. White social workers are the largest race of mental health providers (58.5%), followed by Black or African American (19.9%), Hispanic or Latino (12.3%) and Unknown (5.4%) (Zippia, 2022). To understand their privilege, White clinicians must (i) learn to recognize that they are part of the system that benefits them while causing others harm or trauma (DiAngelo, 2018; Watts-Jones, 2010); (ii) be cognizant of the history of racism in medicine that perpetuates mistrust in healthcare; and (iii) recognize the differences between patient and the clinician (race, gender, gender identity, sexual orientation and religion) as this gives space to appreciate the diversity and uniqueness in the relationship (Cénat, 2020; Watts-Jones, 2010); and (iv) be cognizant of their own social location, in which the clinician self-discloses their identity (race, gender, gender identity, sexual orientation, religion) and how that may or may not impact the relationship with BIPOC/AAPI patients (Watts-Jones, 2010).

Clinicians, specifically PCSW competence surrounding discussions of race, ethnicity, power, and privilege are fundamental components in developing trust in the patient/clinician relationship. Self-disclosure gives an acknowledgement to the patient that they are seen, it gives permission for an open dialogue about how power, privilege and trust impact the interpersonal relationship (Cénat, 2020; Watts-Jones, 2010). PCSWs must have a familiarity with cultural humility and should commit to engage in on-going self-examination of their own attitudes and beliefs related to race and culture throughout their career. This commitment to challenge implicit biases and confront racism needs to be applied consciously by all healthcare providers on a medical team, no matter their own racial or ethnic identification.

Guide To Assessing Racial Trauma

Assessment must include being curious about racial trauma that BIPOC/AAPI patients may have experienced (past or present), and directly asking if they have experienced racism in the healthcare setting. For example, in the case of Maya, the PCSW, explored her past experiences and provided validation. Here are few questions to consider when assessing for racism or racial trauma: Can you recall an experience where you or your family member experienced anything hurtful, alarming, or traumatic while receiving medical or mental health support? Did you notice how you were treated because of your ethnic/cultural background, religious background, sexual orientation, or gender identity? Would you feel comfortable sharing? If it took place in a medical setting, did you feel safe sharing your experience with a social worker? How did they respond? As your clinician, I would like to create a space for you to discuss key life experiences that have caused trauma and contribute to your mental and physical health. Would you be comfortable talking with me about some of your experiences? Would you be open to discussing situations where you were treated with less respect than other people? What happened when you shared your experience with your medical provider? (Cénat, 2020; NICABM, 2019). Clinicians have an opportunity to explore the full humanity of BIPOC/AAPI patients, if we dismiss a patient's experience of racism or how racial trauma has impacted their life, this can minimize and invalidate their experience of therapy. Racial trauma is not a mental health diagnosis - it is an emotional and psychological wound that can be intergenerational and can manifest in physical ways (NICABM, 2019). Be aware of health disparities and the impact they have on racism and racial trauma. Do not forget that open conversations about race, culture and spirituality can help build a strong therapeutic alliance. It is also important to assess anxiety or depressive symptoms that might be related to their experience of racism (Benton, 2021). Clinical tests and interventions are not universal. Talking about race will involve the interdisciplinary team not knowing certain things and encouraging BIPOC/AAPI patients to let them know when a mistake has occurred. Acknowledge that mistakes will be made and that they are inevitable (Cénat, 2020; NICABM, 2019).

Keep in mind that communication is not just verbal but involves nonverbal cues such as eye contact, body positioning, and touch. Nonverbal communication is related to the interpretation of verbal messages, which directly impacts patient's trust, compliance, rapport, and long-term health concerns (Haeny et al., 2021). Take time to learn more about the cultural background of all patients, including ethnic identity, religion, gender identity, beliefs, and cultural values as this can build a strong therapeutic alliance (Cénat, 2020). When BIPOC/AAPI patient share their experience of

racism, they do not need a White clinician to analyze it or rationalize what transpired. Assess intergenerational, historical, and individual racial trauma. Validation and support are crucial and can lead to trust (NICABM, 2019). Explore with patients what can be done to improve the quality of their care, including using culturally appropriate interventions (Cénat, 2020). Talking about racism and racial trauma can be uncomfortable, difficult, and painful. If we, as clinicians, are not prepared to talk about it, we will fail our patients and can cause continued racial trauma to exist and be transferred intergenerationally.

Conclusion

The reality is that racism exist within medical and mental healthcare institutions and services in the United States. When BIPOC/AAPI patients navigate healthcare services, specifically palliative care, they should expect to receive culturally informed and safe palliative care practices. Yet many BIPOC/AAPI patients continue to suffer from racism at the hands of healthcare providers and are affected by intergenerational racial trauma. For there to be real change, clinicians need to first acknowledge that racism manifests in multiple forms. Racial trauma is transferred from generation to generation, through storytelling, negative health outcomes and witnessing of poor treatment in their communities. We must acknowledge that race is a social construct that does not create disparities; racism does. Race was a legally constructed to systemically disfavor racial minorities (Marcewicz et al., 2022; Nuriddin et al., 2020). Clinicians bring inherent assumptions about race into their work, which may have immense impacts on the care provided (Hoffman et al., 2016; Shim, 2021). These prejudices can be conscious or unconscious and frequently go unrecognized. To heal the wounds of racism, it requires a readiness from clinicians to see racial trauma and to acknowledge it beyond individual bias but also structural, systemic, and institutional oppression that is both deliberate and vicarious.

To move towards an antiracist practice, an important first step is to have a healthcare workforce that represents the communities it services, as it relates to race/ethnicity, gender, sexual orientation, immigration status, physical disability status, and spirituality to render the best possible care. Representation amongst healthcare professionals can help ease patient anxieties, increase compliance, increase trust, and improve outcomes as well. The more healthcare providers can reflect the demographics and diversity of their community, the more patients will feel represented and understood. Another step to dismantling racism requires empirical research and documentation of the impact of racism on health. Next, the medical health community needs to examine themselves (both individual and institutional) at

the ways in which medicine has participated and continues to perpetuate racist practices that cause harm. And the availability of data that includes diversity must increase.

As the field moves towards an antiracist practice, social work pedagogy is an area that requires special attention. A future paper will focus on the Council of Social Work Education's revised policy that requires social work education to integrate antiracism pedagogies and methods into the curriculum (CSWE, 2022). This revised policy is a step towards intentionally moving social work beyond being performative and embracing the necessary arduous work of active antiracism in the field (Murray-Lichtman et al., 2022). This new perspective must include diverse perspectives, theories, and approaches, such as abolitionists, indigenous to name a few. These approaches need to be grounded in antiracism, inclusivity, and collectivity (CSWE, 2022). To shift education, it requires social work educators to immerse themselves in antiracism trainings so that they do not perpetuate harm in the classroom.

Every patient is different; they are not homogenous. So, the specific needs and concerns of BIPOC/AAPI patients need to be assessed within the context of cultural humility.

Declarations

Conflict of interest The author declares that there is no conflict of interest.

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