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Trust, Risk, and Race.
By Laura Specker Sullivan, Hastings Center Report, 2020[1]

Short summary: Lack of trust in American medicine is an issue for many patients who have experienced or been faced with discrimination and/or exploitation in their encounters with individual physicians, the medical profession in general, or with medical institutions. In this article, Laura Specker Sullivan explores different theories of trust, identifies responsibilities of medical professionals related to trust, and identifies approaches for addressing medical mistrust among patients.

Introduction

Evidence is showing that lack trust in the American medical system among patients is, to some extent, linked to communal and individual experiences of racism, stigmatization and prejudice in interactions with the health care system. Although mistrust may be directed primarily at health care institutions, it can also affect interpersonal relations. While patients have the right to choose their medical care, they often rely on physicians to help them make the best choices about their care. Mistrust in the medical profession and/or medical institutions may therefore compromise medical care. The author argues that it is essential for individual health care providers to signal trustworthiness. Different theories of trust and trustworthiness along with the responsibility of individual medical professionals to establish trust within a general atmosphere of mistrust are considered:

Key arguments:

Studies conducted in the late 1990s and early 2000s found that physicians' interpersonal skills and competencies, such as carefully listening, making eye contact, effectively communicating, and conveying empathy around patient experiences play a central role for developing trust. Studies also found that mistrust is higher among minority populations and that mistrust and perceived racism decrease satisfaction with care. The author highlights that most studies into satisfactory scales of trust were developed and primarily validated by white patients, mostly from privileged socioeconomic backgrounds, and may therefore not provide a good insight into what individual physicians do to demonstrate trustworthiness to patients from minority populations.

The author refers to theories by Annette Baier and Karen Jones, who focus on goodwill as a criterion for trust. Trust involves entrusting someone with something. Decisions as to whether to trust someone involve the expectation of goodwill, i.e., that the trustee has the truster's interests at heart. The perception of something or someone being trustworthy is individual and subjective. To show or signal trustworthiness the trustee would need to demonstrate *competence* and *caring* – two of three key

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[1] Specker Sullivan, L. (2020). Trust, Risk, and Race. *Hastings Center Report* 50(1): 18-26.

elements of trust. *Competence* refers to the physician's clinical and diagnostic skills, and as distinct from *caring*, which, in a trust-theory context, is described as a responsiveness to dependency.

Comprehension of the patient's and family's experiences as another key element of trust along with caring and competence. *Comprehension* is the ability to understand why someone acts in a certain way or expresses certain attitudes. In care settings, mistrust can manifest as refusal to make a decision. The author provides a case example where a family mistrusted the clinical team and refused to accept care for the patient on basis thereof. Exploring the family's past experiences with another family member's care helped the medical team identify the family's expectations to care in the current situation, and on basis of that they were able to establish trust and collaboration.

Differences in cultural backgrounds, as well as active mistrust and suspicion from the truster challenges the ability to establish trust. The author refers to Margaret Urban Walker and Trudy Govier's articles on trust and distrust as examples of theories attempting to address trustworthiness and trust in challenging circumstances. Challenges associated with building trust in interpersonal relations under circumstances where active mistrust is present are identified, and how a truster's expectations of disappointment may become a self-fulling prophesy is highlighted.

Next, Specker Sullivan considers trustworthiness and risk taking, arguing that it is not uncommon to experience anxiety in response to being met with suspicion and mistrust, and that medical professionals tend to respond to such anxiety by focusing on benefitting the patient and reassuring them of their qualifications. However, if there is no acknowledgement of the sources of the family's mistrust - whether this is mistrust in the institution where the patient is being treated or in the medical profession treating the patient - there is a risk that the health care provider may come across as disingenuous if they overstress their ability to care for the patient. The author argues that to prevent this from happening it is important that health care providers acknowledge the atmosphere of mistrust by voicing it. Only by acknowledging the sense of mistrust can the health care provider be certain that mistrust is present. This may, at the same time, demonstrate the provider's ability to understand the situation from the patient or family's perspective, and as such it can play an important role in establishing trustworthiness.

Finally, the author considers the responsibility of medical institutions and individual health care providers to rectify mistrust. Specker Sullivan argues that when mistrust in the medical institution becomes a barrier to the development of trust in an individual provider-patient relationship, it is necessary that the individual provider takes on the burden of building trust within the greater atmosphere of mistrust.

Conclusion

The general atmosphere of mistrust among those faced with discrimination or exploitation in their encounters with the medical system tends to be directed at the American medicine and medical institutions. While it is the responsibility of medical institutions to address medical mistrust generated by discrimination and exploitation of specific patient groups, it is important that individual health care providers work to establish interpersonal trust within the greater atmosphere of mistrust. Empirical

work is required to understand elements of mistrust and to collaboratively reflect on what a trustworthy system could look like.