On trust: a basic building block for healing doctor–patient interactions

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Keywords: trust; self regulation; community service; patient advocates; ethics

Introduction

I believe that the issue of trust in medicine and the doctors who deliver care to patients, what promotes and enhances that trust and what erodes or destroys it, should receive an intense and single-minded focus from those of us in medicine today. I say trust, naked and alone, because I believe that how it is established and preserved is the verity we seek. Ethics, the value systems we bring to doctoring, how these values are developed, shaped and applied, seem to me necessary process determinants of patient trust in what we are, or what we do. However, ethics are the means to that goal, not the end in itself. They are one step removed from what we wish to achieve.

The changing nature of patients' perceptions of medicine and doctors, so profoundly altered by new technological advances in biomedical science must be examined. The increasing importance patients attach to having direct, personal involvement in medical care decision-making, and maintaining control of their own destiny, must be discussed. The increasing commercialization of medicine and the injection of a whole series of jarring terms like market share, competition, managed care, productivity, providers and consumers (all terms borrowed from the culture of business which has very different values and objectives) must be explored. The emergence of consensus guidelines, designed to help physicians through an increasingly complicated clinical wilderness, but viewed by many physicians as insulting and destructive of their professional autonomy, must also get attention. All these topics, and a series of others, which bear on the issue of trust, should receive consideration.

I shall show you how seriously I regard the present, sorry state of trust in medicine, offer my thoughts about some of the historical happenings and decisions which have contributed to our plight, and make some suggestions about steps that we, as physicians, as a professional group, might take to see if we could regain that precious, ethereal relationship with those we serve.

Individual patient trust, confidence and comfort, with the medical profession and its doctors, have fallen to an alarming low in both the UK and the USA. The schizophrenia first noted in polls a number of years ago (i.e. that patients generally have considerable confidence in their own doctor, but a singular distrust of the profession as a whole) continues. However, even an individual patient's confidence in his or her own personal physician is now often more conditional and tenuous.

Until a few years ago, I regarded this as primarily an American problem and lauded my colleagues in the UK for the sensible retention of their autonomy and professionalism, and with these, patient trust. Now, to my dismay, I find that the UK is following in the footsteps of the USA in ways that seem to me unwise and ill-fated. Chris Fordham summed this up rather disarmingly in 1990:

> One cannot help but be impressed by the extent and dismaying nature of the problems we have in the United States and must conclude that we have no concrete proposal to deal with them . . . whereas our colleagues in the United Kingdom, with what most of us would construe to be probably the best system for delivery of modern health services at reasonable cost in the entire world, are preparing to make a sea change in the system without any assurance that it is going to work. They are going to 'fix' something that seems to work beautifully and we do not have anything to fix one that clearly does not work[1].

Lack of confidence

What has happened to create this troublesome state of affairs in which patient confidence in doctors and medicine has sagged so alarmingly? The reasons are complex and many but some can be dissected out readily. In the USA, the following seem to be central players.

First, America's 30-year failure to mute or dampen a consistently frightening rate of rise in health care costs has contributed to a darkening perception of physicians and medicine and what many regard as its failure to deal responsibly with the problems it has helped to create. Obviously, new technologies, an ageing population, inflation, and the costs of an increasing number of other health professionals now participating in the delivery of care services, have fuelled the cost bonfire. Physicians have been viewed as singularly unresponsive and disinterested in the control of those costs. This apparent lack of concern became quite evident during a period when there was a meteoric rise in physicians' incomes. Alas, this occurred at the very time when increasing numbers of American citizens, particularly children, moved into poverty. These polar events did not endear doctors to the nation.

The USA has just lived through a 12-year period in which selfishness was raised to new heights as an art form. Differences in income between those in the highest wage brackets and those in the lowest rose from twofold or threefold, to as much as 10-fold or 20-fold. Physicians, as a group, were generally near the top of that ladder.

I believe that if there had been a parallel improvement in the profession's ability to deliver care to all Americans, and an obvious improvement in their health, irrespective of socioeconomic status, trust in

the physician and his or her commitment to patient care would have been maintained despite these embarrassing inequities. However, this was not the case. First, an increasing number of Americans dropped out of the health care financing system, and, as inequalities in income, education, housing, and standard of living widened, the differences in mortality rates between the wealthy and the poor have widened (in some instances by sevenfold)[2]. Further, the fact that those who are poor are six, eight or 10 times more likely to be hospitalized, even for conditions viewed as amenable to simple, inexpensive ambulatory treatment such as asthma or diabetes, has deeply troubled the American public[3]. Doctors do not seem to be attempting to reduce these disparities.

Second, and also of great public concern, has been academic medicine's apparent disregard for the totally inappropriate fit between the kinds of physicians we *produce* in the USA, and what is generally regarded as the kind of doctors *needed* to care for Americans. A system which each year grinds out 80% specialists and 20% generalists, when all studies suggest precisely the reverse kind of mix would better serve the nation, has not evoked confidence in medicine in the hearts and minds of most thoughtful American citizens.

Third, and paradoxically, our breathtaking and triumphant technological revolution seems to have contributed to the trust problem. Our wondrous new technologies have clearly led us to much greater diagnostic accuracy and therapeutic effectiveness, but many are frightening, painful and impersonal in their application. The absence of the physician, and his or her reassurance, in many of those patient/technology transactions has put new strains on the relationship. Thus, technologies have often created an emotional 'moat' between doctor and patient.

Often the application of a powerful technology is all that is needed for a miracle to occur, and the kindly physician might seem to be redundant. A robot administering penicillin to a youthful patient with pneumococcal pneumonia can effect a swift biologic cure. Physicians know this, but patients do not. The confidence and comfort from the careful attention of a doctor to a patient's anxiety or downright terror are often missing at critical moments.

Fourthly, the decision of medical schools to go actively into the busy practice of medicine in the giant tertiary care units which we call Academic Medical Centers has contributed to a progressive failure to transmit those values which breed trust in those aspiring to be physicians. An often over-busy clinical faculty has too often given teaching and leisurely interactions with either patients or medical students a low priority. This has changed the ambience of medicine for the worse. Harried clinicians, often with too little time to spend with either patients or medical students, and often quite obviously failing to fulfil their patient care obligations (because they are elsewhere giving lectures as visiting professors, or attending conferences), has left few wise and gentle role models in continuing contact with our students.

Dr Walsh McDermott, the very model of the splendid teacher-physician, used to make the point that even the physical change in hospitals from the large public ward to single-patient rooms has contributed. He pointed out that in days of yore, as an attending physician made his rounds on an open ward with a retinue of young physicians in training in tow, he would often stop and sit down to discuss a difficult or sensitive issue with a patient in full view of those trainee doctors. While lacking in many graces, it did mean that sensitive problems of life, death and how a particular physician helped people cope with some of life's most tragic problems were there for all to see. Nowadays, when that same attending physician has a sensitive issue to discuss with his or her patient, he will often enter the patient's room alone. Thus the interaction which promotes trust is not witnessed by those in training.

Lastly, and to me the most destructive, has been the startling embrace of the belief that competition is what is needed in medicine to make us sharp, finely honed, on our toes and maximally productive. In my judgement, nothing has done more damage to the 'trust' part of medicine than the belief that the use of marketplace ethics and competition would improve medicine or make it less expensive. It borders on the obscene. As pointed out by Uwe Reinhardt, a fine satiric American health economist, competition, when stripped of all its niceties means, 'I am going to try and drive you out of business'. In a profession where cooperation, concerns with feelings, needs and the sensitivities of one's fellow man should be paramount, I have been absolutely bewildered by how many physicians seem to have accepted this philosophy.

In the USA, as costs began to rise and a concerned government began to try to deal with them, in part by suggesting that physicians face up to the problem, doctors begin to give away the most important part of their reason for existence. American medicine's insistence that it maintain an entrepreneurial 'fee for service' system, and its resistance to caps or restrictions on either personal income or resources devoted to medicine, meant we had to trade something in return. To preserve that *economic* autonomy, we gave away what I regard as doctoring's unique birthright - our *professional* autonomy. Thus, increasingly regulation and supervision of our professional actions has become our lot. Little wonder, as government and insurance companies supervised doctors more, and trusted them less, patient trust was one of the factors to suffer profoundly.

Changes in the UK

What of the UK, that bastion of professionalism with all that went with it? The 1948 manifesto which established the National Health Service (NHS) was not only a blueprint for a delivery system, it was also a remarkably enlightened social contract. In it, the state achieved budgetary control at the price of leaving to physicians the decisions about how the resources were to be used at the point of service delivery. It was a remarkably trusting and intelligent arrangement. However, in recent years, although the economic reasons for the changes now threatening medicine in the UK were precisely the opposite from those of the USA, the same bureaucratic tangles which are now plaguing the USA have begun to be seen in the UK.

In the UK, as criticism of the serious underfunding of the health system began to reach an alarming decibel level, a 'conservative' government decided that rather than providing more generous funding, it would bring the health service to heel by imposing stricter management systems, thus increasing medical productivity and the units of care rendered per hours served. In 1990 Dr Klein gave an excellent summary

of how this had come to pass and how the physician-government relationship had shifted[1]. He suggested that in the UK the relationship had moved from 'status' to 'contract', from 'self regulation' to 'public regulation', from 'autonomy' to 'accountability', from 'peer relationships' to 'hierarchical control', and most important, from 'trust' to 'outside review'. The UK is now beginning to face the same problems that have bedevilled American doctoring.

Obviously, there is no question that a laissez-faire system (a professional system, if you will) in which trust is bestowed by society on a particular group to do the right thing is always, and will forever be, open to inefficiency and is potentially risky. Granting such trust has its hazards. There are few objective ways to determine whether the group so entrusted is really functioning as effectively as one would wish. Responsibilities for quality and accountability are internal and difficult to measure, but that personal accountability is what we must try to inculcate into all doctors. I have always maintained that our only excuse for taking 4-10 years of a young person's life in order to make him or her a doctor is to build into their souls an absolutely sacred feeling of responsibility for patient welfare which will serve as their unswerving internal compass for the remainder of their lives. That compass will guide them not only in the glass-house of the hospital ward, but also in the absolute privacy of the consulting room. I think that there is no other way for the uniquely human transaction of medical care to function properly. This highly internalized set of ground rules however, is not easily understood by others and very difficult to review from without.

So, an outsider's instincts as he or she looks at this kind of arrangement is one of unease. They are tempted to tidy it up, put someone in charge, check up on what individuals in the system are doing and get some order into it. The tragedy - and this is perhaps my central point - is, alas, that imposing regulation from without on such a system *simply does not work*. There is now a body of literature (psychological and sociological) which shows that as you impose managerial controls, regulations and hierarchical chains of command on well-educated, highly motivated groups of people, you quite predictably get increasingly troublesome negative results. The worst of the tragedy is whatever belief you hold about how human beings function best is self-fulfilling and self-reinforcing.

If one believes that basically human beings are socially responsible and can usually be trusted to do the right thing if given freedom to choose their objectives, almost all of one's life experiences reinforce this point of view. However, if one fundamentally believes that human beings are basically lazy, that they require goads, fear of punishment, and strict and explicit ground rules to do the right thing, the same reinforcement from life experiences occurs. Human beings governed by those who hold this latter philosophy quite predictably behave in ways that reinforce this sour view of mankind. Most in positions of governmental responsibility come from this philosophic camp. Thus, those who are basically trusting and permissive, and those who are distrustful and regulatory, have two completely different realities, communicate poorly, and, indeed, view each other as creatures from different planets.

Let me illustrate this with a small vignette. In the mid-1950s, as a young naval officer I was sent to a Navy research unit. Although it was a naval facility, it was staffed almost exclusively by a cadre of brilliant university-based biomedical scientists. The naval officer who commanded the unit was old enough and wise enough to recognize that his authority was limited, that the creative group in his charge, while seemingly chaotic, were highly motivated and highly productive. He was supportive, permissive and ignored appalling breaches in naval etiquette. This group of scientists worked 10-12 h days, snatched a few moments for lunch, and in general felt they owned the unit, and were responsible for its outcomes.

Then an interesting experiment of nature took place. I watched with fascination as a stiff-necked Annapolis graduate assumed command of the research station. I felt that we were probably in for trouble when, during his first week, he had a porthole taken from a destroyer installed in his office door. It was clear from his discussions with me that he was appalled by the lack of military hierarchy and the absence of discipline or written rules. I could answer almost none of his questions about when people showed up, when they went home, why they wore such outrageous clothes, failed to get haircuts, or paid so little attention to lines of authority. A stream of memos soon began to flow from his office.

> Personnel at this station shall report for work at 08:00 and complete their day at 16:30. Lunch will last 45 minutes and will be taken between 12:45 and 13:30,

was one of the original gems. The response to this kind of approach was swift and absolutely predictable. Suddenly, highly responsible scientists began to drift in at 9:15 or 9:30, slouch past his office and delight in taking 2 h lunch breaks. They behaved, in general, like outrageous children and flagrantly flaunted virtually every order. They felt his lack of trust and they fed it quite deliberately. Obviously there was little that a naval commander could do to punish this group of civilian upstarts as they were all paid by the University.

My conversations with the commandant were equally interesting, for his interpretation of the 'why' for this turn of events was 180° from my own. This reprehensible, irresponsible behaviour and thumbing of their noses at him, absolutely proved his point. In his view, he had uncovered a massive problem caused by a lack of adequate military discipline, insufficient regulations, lack of punishment and abdication of command at the top. Their behaviour simply reinforced his conclusion and nothing I could say would dissuade him. His righteousness was majestic and, subsequently, he had to run harder and harder to stay in place. Productivity plummeted and creativity was the loser.

I believe that kind of behaviour may soon be seen among physicians in the UK. Clearly, the NHS in the UK has survived on starvation funding because of the dedication of physicians, who worked many hours beyond what was required by their contracts, and who had great pride in a system they felt was theirs. All that now seems to be changing. The lack of confidence, shown by the UK Government in its physicians, will inevitably be followed by a lack of trust from the patients, particularly as a few physicians begin to behave less nobly.

The remedy

So what can be done to stem the dizzying gallop both the UK and the USA seem to be taking down a road which, I believe, will quite predictably lead to increasing lack of trust and confidence in physicians by those whom they treat? This vital ingredient, so important in the human transactions which characterize much of medicine, has made it special and rewarding for both parties. It needs to be regained.

To state the obvious, I am afraid that the trust factor cannot be regained by sweet reason. Simply asserting to those who are regulators that they will get the biggest value for the buck by placing responsibilities for major decisions about resource allocation back in the hands of physicians will, for the reasons I have outlined, not do the trick. However, perhaps we can begin to regain the confidence which we have lost by reaffirming the basic social contract that distinguishes us as a profession.

First, I would suggest that medicine as a profession becomes the vocal and articulate advocate for the health care of the have-nots in our societies. To have a strong and powerful profession consistently and single-mindedly defend the right of the less fortunate to medical care, would, I believe, gain us considerable respect. Perhaps the UK has done better than the USA in assuming this role. Like Rudolf Virchow, I believe we have a collective responsibility as a profession to be social activists and use our considerable power and prestige to address social wrongs which interfere with mental and physical well-being as well as more obvious and direct health hazards. At a minimum, we should view it as unconscionable that anyone in need of medical care should go without it in both the UK and the USA, two wealthy nations, but this should be only the starting point.

Why are we not more vocal about the problems? Clearly we should not exaggerate what medical care alone can do. It is quite apparent from the NHS experience, that simple access to medical care does not create health. Access to a decent standard of living and education correlate better with health than the amounts of medical care received. We should be clear about this and not be ashamed to push for the non-medical necessities and human support systems required for a healthier society.

Secondly, I have long believed that a period of community service as a general physician should be part of what one gives as part of his or her social contract for the privilege of becoming a physician. I think that if every doctor had to spend at least 2 years serving in a medically underserved area as part of the trade-off for a place in medical school this would do much to improve our image. It would increase the sensitivity of physicians who subsequently moved to more specialized forms of practice. It would also better demonstrate physician commitment to the medical care needs of the larger society. It has a nice ring to it and might give stronger evidence that young people enter medicine because of its social, rather than its economic rewards.

Third, particularly in the USA, I believe, that we should reduce the clinical services of our medical schools. To watch USA medical schools try to meet the demands of their large, tertiary care hospitals by pretending that those service needs correlate well with their educational mission is disheartening at best, and at worst utter nonsense. Here, I believe the British system, ie the use of part of a hospital, the establishment of professorial units which care for sufficient patients to meet the educational needs, but not the whole universe of specialized medical care, must come to pass if we are to instil in those becoming doctors the kinds of values which medicine needs. With it might come better rewards for teaching. We might place in positions of teaching prominence, thoughtful, less harried role models who engaged in more leisurely student-clinician interactions that characterize medical education at its best.

In recent years, we have done much hand-wringing in medicine about our fall from grace as competition, micro management, and more and more regulations have entered our hallowed world. As a profession, we have done too little to demonstrate our social conscience, our commitment to our patients and to the welfare of the broader community, which might have stemmed this tide. Returning to some of these simple touchstones might, I believe, also allow us to begin to regain that precious climatic ambience we call trust. In my judgement, it forms the basis for much that is good in medicine and it is worth a large effort to regain it.

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