VIEWPOINT

TRUST IN HEALTH CARE

Why Physicians Should Trust in Patients

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Viewpoint

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Most of the existing literature on trust between patients and physicians focuses on whether patients trust their clinicians. When medical paternalism was the dominant model in health care, this focus may have been logical: if the physician knows best, the main role of patients is to trust and follow the guidance of physicians. But in the "new age of patient autonomy,"[1] a growing, but still limited, evidence base demonstrates the efficacy of patient-physician partnerships and co-produced care to improve quality and safety of care, patient health outcomes, and patient experience. A 2017 National Academy of Medicine report highlighted the potential of shared decision making, advance care planning, and family involvement to improve health outcomes.[2] Without intentional cultivation of these often-neglected aspects of patient-physician relationships, increasing reciprocal trust between patients and physicians—an important aspect of both quality of care and positive experiences with care for patients, families, and professionals—will remain an elusive goal.

Measures of physician trust in patients have included whether patients fulfill the expectations of physicians for providing accurate information, answering questions honestly, and adhering to physician guidance. One measure also assesses whether patients manipulate physicians for personal gain (for example, asking physicians if they suspect a patient is likely to attempt to procure excessive pain medication) and respect physicians' time and personal boundaries.[3] The focus has thus been on physicians trusting patients who trust them. However, the principles underlying the patient-physician relationship must shift from simply emphasizing patients' adherence to cultivating patients' ability to contribute to the development of care plans that reflect their own values and preferences. Physicians who wish to advance this transformation can contribute by presuming trust with each patient. There are numerous reasons to do so.

Trusting Patients Improves Diagnosis

While physicians may want to be present for each patient, failure to listen to patients is often the first manifestation of inadequate trust. A recent study involving 66 experienced specialty and primary care clinicians found that across 112 encounters, clinicians averaged 11 seconds before interrupting patients' opening statements.[4] This is consistent with studies conducted in the 1980s, 1990s, and 2000s, all of which documented average time to interruption of less than 30 seconds.[4] Many physicians begin constructing a mental model of problems and creating diagnostic plans without benefit of the patient's contribution, losing the value patients can contribute to the encounter and instead relying solely on their own knowledge, experience, and skills.

Patients are experts about their own experience and context; their narratives have demonstrated diagnostic value. For example, some patients' descriptions can signal whether their seizures are epileptic or whether episodes that appear to be seizures are nonepileptic, but clinicians often do not hear distinctions between how various patients use metaphors or recount what occurred when they lost consciousness. Trusting patients can make physicians better diagnosticians and more attuned healers.

Partnership Models of Care Depend on Physicians Trusting Patients

The National Academy of Medicine defines patient and family engaged care (PFEC) as care "planned, delivered, managed and continuously improved in active partnership with patients and their families… [with] explicit and partnered determination of goals and care options…."[2] Evidence shows that this model improves outcomes and patient experience, but it depends on engaged patients who are confident about their own ability to meaningfully contribute to their care. Clinicians' trust in their patients' knowledge and skills is essential to patients' ability to engage as partners. Effective, continuous communication, an indispensable element of PFEC, is also built on trust.

Trusting Patients May Contribute to Physician Satisfaction With Practice

Some physicians may experience symptoms generally thought to reflect physician dissatisfaction with practice and professional burnout, such as emotional exhaustion, a lack of empathy toward patients, and a sense of reduced personal accomplishment. It is possible, although not proven, that when physicians are less sensitive to the opinions of patients they may withdraw from relationships and develop a tendency toward callousness that may reflect or contribute to professional dissatisfaction. Entering into reciprocal trusting relationships with patients may help to replenish a physician's emotional sense of connection and could help facilitate the return of meaning and satisfaction in practice.[5] Trusting patients may also help physicians step off the imaginary pedestal of required perfection, an impossible standard that also may contribute to dissatisfaction and burnout symptoms.

Mutual Trust Most Effectively Begins With Physicians Trusting Patients

Pelligrini has suggested that when physicians demonstrate trust in patients, patients are more likely to reciprocate, and that the obverse applies as well: when physicians are distrustful, patients tend to follow suit.[5] Demonstrating trust can begin by affirming and celebrating patients' expertise about their health, circumstances, and abilities. The validation patients derive from

being trusted strengthens their experience in the relationship and their own ability to trust. As summarized in a qualitative study that analyzed 77 interviews with patients: "I overheard [the internist] talking to the nurse, and he said, 'Look, you want to know about myasthenia, you ask her [referring to the patient].... She knows more about it than I do.' I loved it... I have such confidence in them now that I know I can trust them!"[6]

Trusting Vulnerable Patients Improves Relationships and Care

Disparities in care and outcomes continue to be a major problem in health care in the United States. A recent report that analyzed 4068 consumer survey responses in addition to in-depth interviews and focus groups with 65 consumers highlighted trust and respect as the primary concerns of lower-income patients. Participants provided explicit negative examples, such as clinicians "avoiding eye contact, speaking condescendingly, showing physical disgust when touching patients, brushing off patient concerns and symptoms, and ignoring adverse events that patients reported from prescribed treatments."[7] Poor relationships with physicians harm not only patient experiences of care but also their health and connection to health services. For example, lack of mutual trust is associated with whether members of racial minority groups use preventive care; with mental and physical health of patients with HIV infection; and with whether low-income patients disengage from care.[8]

Demonstrating Trust

Trusting patients is a necessary but not sufficient condition to achieve benefits in the patient-physician relationship and in clinical encounters. Equally important is for physicians to demonstrate their confidence and trust directly to patients. Some potential strategies for demonstrating trust include the following.

- *Pay careful attention to verbal and nonverbal communication*. It matters to patients that physicians make eye contact, introduce themselves, show an interest in their stories and lives, and balance listening well with asking attentive questions. Physicians should openly share what they know and acknowledge the limits of their own knowledge and of medical science.
- *Understand and address implicit bias*. Unconscious forms of bias, which manifest as "microaggressions" that unintentionally communicate derogatory, hostile, or negative slights, remain pervasive despite best intentions. No profession is immune: a systematic review by Hall et al[9] cited several studies showing that health care professionals manifest ethnic and racial bias at rates similar to the general population. Several evidence-based strategies for reducing trust-destroying bias can be implemented in health care settings, such as enhancing understanding of the psychological basis of bias and increasing internal motivation to reduce bias while avoiding external pressures.
- *Invite shared decision making*. Care plans developed with patients, rather than for them, communicate the confidence that physicians have in the knowledge, skills, and abilities of patients and place cooperation at the center of the relationship. Physicians may have concerns that asking patients about their preferences and goals will require long discussions, although a few simple questions (such as "What are you hoping for?" or "What are you most worried about?") may lead to choices consistent with evidence-based treatment.
- *Embrace roles patients and families value*. Patients with chronic health issues want physicians who can balance detachment and connectedness in the relationship and can engage as partners or "nonjudgmental collaborators." They also value physicians who can mirror their strengths, reflecting back their own self-knowledge, abilities, and efforts to live well.[6]

Maintaining health and addressing illness are inherently collaborative processes: these processes cannot effectively proceed unless physicians and patients can count on each other. When physicians stop simply seeking patients' adherence to their proposed care plans and instead work with patients toward a co-created strategy that reflects each patient's beliefs, values, preferences, and abilities, the groundwork for mutual trust is effectively laid and healing can begin.

ARTICLE INFORMATION

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REFERENCES

1. Kilbride MK, Joffe S. The new age of patient autonomy. *JAMA*. 2018;320(19):1973-1974. doi:10.1001/jama.2018.14382

2. Frampton SB, Guastello S, Hoy L, Naylor M, Sheridan S, Johnston-Fleece M. Harnessing Evidence and Experience to Change Culture: A Guiding Framework for Patient and Family Engaged Care. https://nam.edu/harnessing-evidence-and-experience-to-change-culture-a-guiding-framework-for-patient-and-family-engaged-care/. Published January 31, 2017. Accessed March 11, 2019.

3. Thom DH, Wong ST, Guzman D, et al. Physician trust in the patient. *Ann Fam Med*. 2011;9(2):148-154. doi:10.1370/afm.1224

4. Singh Ospina N, Phillips KA, Rodriguez-Gutierrez R, et al. Eliciting the patient's agenda—secondary analysis of recorded clinical encounters. *J Gen Intern Med*. 2019;34(1):36-40. doi:10.1007/s11606-018-4540-5

5. Pellegrini CA. Trust: the keystone of the patient-physician relationship. *J Am Coll Surg*. 2017;224(2):95-102. doi:10.1016/j.jamcollsurg.2016.10.032

6. Robinson CA. Trust, health care relationships, and chronic illness: a theoretical coalescence. *Glob Qual Nurs Res*. 2016;3:2333393616664823.

7. Leis H, Garg P, Soh I. Right Place, Right Time: Marketplace Responses to the Health Information Needs of Vulnerable Consumers: Final Report. https://www.oliverwyman.com/content/dam/oliver-wyman/v2/publications/2017/jan/right-place-right-time/Oliver%20Wyman%20Right%20Place%20Right%20Time.pdf. Published 2017. Accessed January 29, 2019.

8. Duke CC, Stanik C. Overcoming lower-income patients' concerns about trust and respect from providers. https://www.healthaffairs.org/do/10.1377/hblog20160811.056138/full/. August 11, 2016. Accessed January 29, 2019.

9. Hall WJ, Chapman MV, Lee KM, et al. Implicit racial/ethnic bias among health care professionals and its influence on health care outcomes: a systematic review. *Am J Public Health*. 2015;105(12):e60-e76. doi:10.2105/AJPH.2015.302903