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Discontinuity breeds mistrust



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The experience of being a patient in the hospital is one of perpetual discontinuity. Staff members change, strangers come into the room for various purposes, and every now and then the patient travels to yet another unfamiliar environment that is populated by a new cadre of strangers. We have invested serious organizational resources and made real strides in improving the safety and reliability of handoffs, identifying the patient to be sure we are dealing with the person we think we are dealing with, and avoiding “never events” like wrong-site surgery or administering drugs or blood to the wrong patient. But how much have we thought of building trust with patients as they confront stranger after stranger and new environment after the new environment?

There are innumerable things we do in the hospital that undermine trust, and we do not think of them as “mistrust events.” Examples include mispronouncing patients' names, restating their “chief complaint” in medical terms, and using words different than the ones they are using to describe their experience. At times, we do not follow up in ways we have promised to, and sometimes we never address the concern that brought the patient to the hospital in the first place, focusing instead on what we identify as the most salient or dangerous medical issue. Every time we show ourselves unaware of things about the patient they have already told others and they expect us to know, we are signaling a lack of recognition and creating a basis for mistrust.

Why does this matter? Because we are dealing with a period of widening mistrust. In a survey conducted by NORC and funded by the ABIM Foundation, 32% of patients—and 30% of physicians—said the pandemic had decreased their level of trust in the health system, while only 11% of the public and 17% of physicians thought it had increased trust. This is happening in a broader societal setting of decline in trust in all institutions, with Gallup showing a significant decline in confidence in “the medical system” since 1975.¹ We should not assume our patients trust us just because we have good intentions and are using evidence-based care.

Some of this mistrust is best understood as “earned mistrust”—a learned, adaptive behavior to respond to institutions that have not served people well. People in the BIPOC community, for example, have not just historical examples like Tuskegee,² but “right here, right

now” evidence of ongoing mistreatments such as glaring disparities in maternal health outcomes³ or COVID mortality rates⁴ by race. As health services researchers identify and characterize health disparities, members of affected populations experience these disparities as proof that their lack of trust in the healthcare system is justified. Mistrust is an adaptive response that protects against anticipated harm.

We can do better. The ABIM Foundation has launched the Building Trust initiative, which is designed to create a vanguard community of those in health care who are focused on building trust as a core strategic priority, both with the populations and communities they serve and with their medical staff who do the work. This community is committed to find ways to enlist staff, workflows, and technologies in the service of creating a more trustworthy experience for patients as well as those committed to rebuilding trust with medical staff whose own sense of trust in the institutions in which they work has been strained by the pandemic and subject to new disruptions as ownership structures of healthcare systems rapidly evolve, with ensuing changes in management and policy. It is not only trust between patients and the institutions that serve them that is fractured, but trust between healthcare workers and the institutions who employ them. In both situations, taking intentional steps to rebuild trust is an important success strategy for healthcare organizations.

Through this work, we have identified some exemplars and promising practices.⁵ For example, clinic workflow at the Prairie Parkway LGBTQ Clinic at UnityPoint Health in Iowa is designed to avoid any potential missteps that could alienate a population that has reason to be suspicious of the healthcare system. There is a dedicated phone line and email address managed by two people who are trained to ask patients about their pronouns and preferred names.⁶ This small but critical step helps affirm patients who identify as transgender or gender-fluid and rebuilds from the trust eroding events routinely experienced by members of this community.

Parkland Hospital in Dallas, TX conducted an internal “trust practice challenge” inviting all staff members to nominate a practice they were following that they believed built trust. Staff responded with a number of exemplary practices. One group described collocating mental health capacity on ambulances responding to

distress calls, which led to a growing number of 911 calls explicitly requesting this service. Another group nominated an intensive case management-based intervention harnessing peer navigation and integrated behavioral health services to improve health outcomes for young HIV-positive Black men who have sex with men; the population served had a 40% increase in linkage to care, a 35% increase in retention in care, and a 3% increase in those achieving viral suppression.

I would challenge all of my colleagues in hospital medicine to do a “trust audit” on your next clinical shift. If you are alert to it and looking out for it through the patients' eyes, I will bet you will see multiple examples of “mistrust events.” And given your skills at systems thinking, I will also bet that you can conceive of and implement solutions to avoid those behaviors in the future. You will likely also see examples of trust-building behavior that can potentially be adapted and spread. It is urgent that we undertake this work proactively to get ahead of our patients' mounting mistrust, which threatens to undermine our ability to offer them the considerable benefit of the care we can provide. Our patients deserve to trust the system that protects and advances their health; let us make our system trustworthy.

CONFLICT OF INTEREST

The author declares that there is no conflict of interest.

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