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# Communication as a tool to rebuild trust



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Caring for patients with COVID-19 has changed in many ways over the last 18 months, but few are as significant as the changes in presuppositions and misgivings in patients and families. One year ago, healthcare providers were hailed as heroes. “Frontline workers” were a crucial defense between an aggressive virus and a susceptible population. Now we are often seen as cogs in a vast machine of intrigue and maleficent design.

I work as a hospitalist in a tertiary care hospital in the Blue Ridge mountains. I was born here, returned for elective rotations in medical school, and accepted an attending position in 2019, moving my family just before the outbreak of the pandemic. My roots here are deep. My ancestors survived as subsistence farmers, moonshiners, and any other occupation that would pay the bills and feed the kids. There's a deeply seated autonomous streak that has allowed generations to persevere through hardships. Past experiences and family traditions promoted independence and leerness of authority. Although highly patriotic, people found their support in neighbors and family, identifying more with their immediate community than with a homogenous federal system.

Perhaps it is no surprise that I am a social libertarian and fiscal conservative. I will admit I have an instinctual bias in favor of personal autonomy over centralized government. But I have a professional respect for the roles of discovery, expert recommendations, and consensus decision making in science and the practice of medicine. My clinical role for the last eighteen months has been caring for hospitalized patients with SARS-CoV-2. I have had a front-row seat to the progress of clinical trials, medical practice, and public health guidelines. Sometimes encouraging, and sometimes frustrating, our experience has been dynamic as new information is gathered and perspectives change. Patient care is more evidence-based and data-driven now than at the beginning of the pandemic, but this is after months of questioning and reviewing outcomes. Not long ago we did not know what role steroids played, if convalescent plasma was a cure, and many other therapeutic uncertainties. Even now, more questions remain than have been answered.

Despite our limited knowledge and experience, or perhaps because of it, patients and families in mid-2020 were incredibly gracious, appreciative, and forgiving. They understood the visitor

restrictions on isolation units. They realized that our therapeutic armamentarium was limited. They were thankful when their condition improved and they could go home. And when patients died, families showed unspeakable grace and fortitude.

We all breathed a great sign of relief in the Spring of 2021 when our cases declined. What a relief to be immunized! How great was it to do normal things again, like family reunions and neighborhood cookouts? There was something deliciously indulgent about going into a grocery store unmasked. And most importantly, there were those few weeks where we had only a handful of hospitalized patients who tested positive for SARS-CoV-2, many coincidentally positive and not fighting for every breath.

Now we find ourselves going into the fall and winter with recurring trepidation. Covid hospitalization numbers are high again. There are unanswered questions about schools, booster shots, treatment strategies, and more. But while last year I worried about the virus (Will I bring it home to my wife and kids? Will I get sick? Will I unknowingly infect someone who is vulnerable to severe illness?), this year I find myself worried about society.

One fascinating side story in my front row seat to a pandemic has been the changes in patient demographics from week to week. I saw my census reflect the communities circulating the virus. Sometimes it was a particular race or ethnicity that was more prominent. Sometimes, a particular age cohort. Other times, a specific residential facility or faith community. Now, more than a particular demographic characteristic, my patient census is primarily people who have not been immunized.

Although there are some cases of breakthrough Covid, most of my patients with severe COVID-19 respiratory failure are unvaccinated, and many are adamantly opposed to becoming vaccinated. And they often share something else in common—a deep mistrust of expert opinion, government guidelines, and the healthcare system. Many request therapeutics their friends have promoted or they have read about online. Several have delayed coming to the hospital while taking various products, some not even intended for human consumption, thinking that these treatments were better for them than simply getting vaccinated in the first place.

It is at this point that I realize a gulf developing between myself and many of my friends and neighbors. A year ago there was a certain cohesion between healthcare workers and patients. I imagine it is like being stranded on a desert island. We were going to make do with what we had and work together to overcome the crisis. Between the waves of the pandemic, this spirit has changed. Grace and solidarity are being replaced by anger and cynicism. Sometimes there is more trust in unverified internet sources than the local physician, despite the fact that we know more now than we did a year ago and have better tools at our disposal. This phenomenon of disunity will likely increase, as the growth of populist thought on both sides of the political spectrum is producing a society with less trust in experts,<sup>1</sup> including healthcare practitioners.

Building a functional physician-patient relationship without starting from a shared place of trust is disheartening. A few years ago I heard Dr. Thomas Lee, the CMO of Press Ganey, discuss the importance of the metric “likelihood to recommend,” and that this metric best captures the patient experience. He stated that this was largely a function of trust and communication, two principles I have come to see as directly related and mutually dependent. Add to the one, and the other will increase. Withhold one, and the other will decrease.

As I survey my local pandemic landscape, I am saddened to see people I care about retreating into bunkers of fear and doubt. They are not only my neighbors, but they comprise the community that shares many of my own cultural origins and values. Having to build trust with my own community seems ironic, but this is the current reality. Rather than being the outsider looking in, I have become the insider on the outside looking in, watching as mistrust cripples the ability to dialog with objectivity and moderation. Caring for people who disregard experts requires concerted efforts to re-establish communication and rebuild trust. This cannot happen by simply

sharing facts, and is certainly not accomplished with directives and mandates. Rather, the attention of a healthcare provider who is willing to ask questions and listen to replies, who can offer the personal assurances of providing the most thorough and competent care possible, and who is willing to call families at the end of the workday with updates on their loved ones—this attention, when provided with concerned and compassionate communication, will rebuild trust. This is hard work, especially when a lack of trust means that a large amount of communication needs to happen. In my experience, time spent at the bedside or on the phone with families is far more productive than any media content or data sharing. Building trust requires time and effort—the elbow grease of communication. But this work is crucial. In fact, I think it is the only way to combat mistrust and populism, and move us toward the ultimate goal of ending the pandemic.

### CONFLICT OF INTEREST

The author declares that there is no conflict of interest.

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### REFERENCE

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