

Trustworthiness and Injustice in American Medicine

Laura Specker Sullivan, PhD
Assistant Professor of Philosophy, Fordham University

Oregon Health Sciences University
Trust in the Ruins Lecture Series
February 25, 2022

Families of Color Have Good Reasons to Mistrust Schools. We Must Change That.

By Gemar Mills · Apr 23, 2021

OPINION | FREE EXPRESSION

Media Mistrust Won't Inoculate You Against Misinformation

The impressions we form about important events will still be driven by their unreliable reporting.

INJUSTICE IN HEALTH: MISTRUST COMES FROM UNTRUSTWORTHY BEHAVIOR

Posted by Reggie Jackson | Apr 9, 2021 | Columns, COVID-19, Featured, Reggie Jackson

Vaccine Rates Among the Incarcerated Remain Low Amid Mistrust and Misinformation

Many people behind bars are turning down or deferring vaccination, despite months of advocacy to get vaccines into jails and prisons.

Column: Pull down barriers that cause mistrust of “other” communities

By Minda Yamaga · April 28, 2021

Mistrust as a Social Determinant of Health

- The problem: (Justified) mistrust harms patients by preventing relationships and restricting communication, contributing to health disparities that result from racism in medical institutions.
- One response: Develop policies that address systemic inequity and injustice to reform institutions.
- Complementary response: Train individuals to understand the standpoint of those most affected by a climate of mistrust and to express that comprehension in action.

Who Assesses Trustworthiness?

- While many focus on how a truster (a patient) can assess the trustworthiness of a trustee (a clinician), in climates of mistrust due to injustice, the focus ought to be on how a clinician can signal trustworthiness.
- Otherwise nothing is done about the mistrust, which is untenable, or the patient, who already bears the disadvantage of injustice, must address the mistrust – and this is unfair.

Comprehension

- I will argue that *comprehension* of the patient's position and perspective is essential to signaling trustworthiness in a climate of mistrust due to injustice.

Preliminaries

Race & Racism in Medicine

- By talking about race, my goal is to address the disparities and injustices that have resulted from racist policies and institutions, not to reinforce racial naturalism or essentialism.

One Major Assumption & One Minor Hope

- **Assumption:** It is better for some medical relationships to function on an interpersonal level *despite* institutional and systemic injustice, than for individuals to give up on these relationships.
- **Hope:** Medical professionals critically interrogate the trustworthiness of their institutions and team. Over time, this interrogation *and* the effort to signal trustworthiness can improve institutions and climates.

Outline

- (I) Mistrust in clinical ethics
- (II) Theories of trust and trustworthiness
- (III) Climates of mistrust
- (IV) Trustworthiness and injustice

I. Mistrust in Clinical Ethics

Mistrust in Medicine

- Michelle Obama, *Becoming* (2018).
- Her grandfather, Southside, “died ... after having suffered with advanced lung cancer, his long-held view that doctors were untrustworthy having kept him from any timely intervention.”
- Southside’s view is not unique.

The art of medicine

More than medical mistrust

Prospects of COVID-19 vaccines becoming available look promising. But early surveys suggest that some people from historically disenfranchised and marginalised groups might feel hesitant. Some of it could be mistrust and fear—but we should also consider the rightful anger against the establishment that dehumanised Black people over and over again. Also, beyond resigning every minority to groupthink, recognition is needed that informed consent and refusal are individual choices—and rights.

Acknowledging every aspect of the multigenerational barriers for Black Americans to enrolment in clinical trials is critical to moving forward. We are not simply untrusting—we remember. And there is still far too much evidence of Black lives not mattering in our society. This evolution of trust will call for more than scientists with excellent communication skills. We need a seismic shift in our relationships with Black lives as demonstrated through government and societal actions, policies, investments, and outcomes. Medical mistrust is just the tip of a 400-year-old iceberg that has to be chipped away from every direction.

Kimberly D Manning

Division of General Medicine, Emory University School of Medicine,
Emory University, Atlanta, GA 30303, USA

kdmanni@emory.edu

www.thelancet.com Vol 396 November 7, 2020

Mistrust in Clinical Ethics

- Family and provider distress often leads to a consult.
- Decisions are not made – family will not trust the team to care for their patient, but there may not be other options.
 - This can look like non-adherence/non-compliance.
 - Yet from the family's perspective, there are good reasons to be mistrustful, given historical and ongoing injustice.

Mistrust Cases

- Case 1: A clinician doesn't attend a family meeting – “I know when I'm being given the run around.”
- Case 2: A patient is given a drug also used in lethal injections – “You're trying to kill my child.”

II. Trust & Trustworthiness

Defining Trust

- Three-place predicate
- A entrusts/depends on B with/for care of X.
 - Interpersonal (babysitters, teachers, lawyers, etc.)
 - Institutional (banks, the postal service, grocery stores, etc.)

Trust is not reliance: in trust one expects goodwill and feels betrayal if let down.

Trust & Risk

- Trust is necessary when there is no *guarantee* that reliance or dependence is well-placed, but in which dependency is difficult to avoid – no one is completely self-sufficient.
- Entrusting a person or institution with something involves risking that they may not follow through on their guarantee.

Trust in Medical Relationships

- Patients:
 - Are dependent on medical professionals for quality care *but* autonomous to define their own well-being.
 - Must be honest with clinicians about their needs for these needs to be met.
 - Need to identify trustworthy clinicians who are competent to practice medicine *and* are motivated to use their knowledge for the patient's benefit.

Trustworthiness

- To decide whether to place trust, the patient must assess the degree of the trustworthiness of the clinician.
- Trustworthiness is an essential element in the patient's calculation of risk – the more trustworthy the individual, the less risk.

Defining Trustworthiness

- Trustworthiness is often described in terms of two features:
 - Competency
 - Ability to do what one is trusted to do (Jones 1996)
 - Care
 - Goodwill towards the truster (Baier 1986, Jones 1999)
- Trust is not *mere* reliance (Baier 1986).

Trustworthiness in Medical Relationships

- Trustworthiness in medicine is often described as a learnable skill that expresses care and competence.
 - Sitting down
 - Eye contact
 - Using patients' names
 - Clear communication

Who Bears the Risk of Trust?

- Usually, the truster assesses trustworthiness and takes on the risk.
- In the context of mistrust, trusters are *justifiably* wary of taking on the risk of trust.
- The trustee must work to *signal* trustworthiness through *comprehension* of the truster's position.

Rich Trustworthiness

- A disposition in which a person is not only trustworthy but “is willing and able to reliably signal those domains over which her competence and caring extend” (Jones 2012, 75).

Signaling Trustworthiness

- The challenge is in conveying trustworthiness: “Correctly signaling my trustworthiness requires grasping what the other will count as a signal. Signaling rests on a set of highly complex socially mediated background understandings” (Jones 2012, 76).
- Responsiveness to dependency is not enough: “This shows the role of background social knowledge in being trustworthy and explains why it can sometimes be hard to be trustworthy for someone from a radically different cultural background” (Jones 2012, 73).

Trustworthiness and Climates of Mistrust

- “If the network of relationships is systematically unjust or systematically coercive, then it may be that one’s status within that network will make it unwise of one to entrust anything to those persons whose interests, given their status, are systematically opposed to one’s own” (Baier 1986, 259).
- There are “climates” of mistrust that disrupt the formation of trust.

III. Climates of Mistrust

Climates of Mistrust

- Trust & trustworthiness assume a neutral backdrop.
- In an environment of mistrust, risk feels elevated.
- Trustees cannot signal trustworthiness through care and competency alone – these gestures can feel empty.
- Case 1: “I want to do the best I can for your family member.” “I have seen cases like these before.” “I have extensive training in this area. No additional tests are necessary.”

Displaying Trustworthiness

- No matter the extent of care that physicians exhibit towards mistrustful patients and the strength with which they prove their competency, if patients do not feel that physicians understand their unique situation, trust may not be established because the root of mistrust is not addressed.
- Across cultures, clinicians cannot assume that unspoken markers of trustworthiness are shared.
- Trustworthiness must be explicitly signaled.

Trustworthiness and Risk

- Understanding another person's perspective is not guaranteed; signaling trustworthiness involves risk.
- This risk is worth it if successful, and it can establish a trusting relationship.
- Case 1: “It sounds like an additional specialist worked in the past. You're right that I could bring in an additional specialist. That might be a good idea now.”

Case 2?

- In this particular case, a resolution was never reached.

IV. Trustworthiness and Injustice

Mistrust and Risk

- Usually, the patient assesses trustworthiness and takes on the risk of trust.
- In a climate of mistrust due to injustice, patients are *justifiably* wary of taking on the risk of trust. The clinician must work to establish trust, not the patient.
- How can trustees convey rich trustworthiness, and why is this a risk?

Displaying Rich Trustworthiness

- No matter the extent of care that clinicians exhibit towards mistrustful patients and the strength with which they prove their competency, if patients do not feel that clinicians understand their unique situation, trust may not be established because the root of mistrust is not addressed.
- Care and competence do not address the root of mistrust: expectations of mistreatment based in experience – *neither optimistic nor neutral*.

Signaling Trustworthiness

- Not just “trust me”
- *Showing* one understands or wants to understand the patient and family’s perspective.
 - Verbally
 - In action
- Inevitable uncertainty and risk

Meeting Unique Expectations

- When a climate of mistrust sets expectations negatively, signaling trustworthiness involves acting in accordance with that person's picture of trustworthiness.
 - “Tell me about your favorite physician.”
 - “What is an example of a medical experience you had that went well?”

Acknowledging Bad Expectations

- “Hospitals have a long history of treating African American patients poorly. We’re doing our best to rectify that now, and we really do have your child’s best interests in mind. We would never intentionally do something to hurt them.” (case 2)
- Verbalizing negative expectations risks misunderstanding *and* reinforcing these same expectations, but also shows the clinician is willing to acknowledge and take responsibility for injustice.

Trustworthiness and Humility

- If comprehension is not possible, asking questions can show that you are willing to *try* to comprehend, and move outside your own particular standpoint.
- “Tell me more about your hopes for this procedure.”

Structural Benefits

- By working to comprehend mistrustful patients' standpoints, providers contribute to broader understanding of the reasons for mistrust for individuals and within communities.
- This understanding can inform structural efforts to develop more trustworthy medical systems, if clinicians better understand why they are untrustworthy for some patients.

Conclusion

- Signaling trustworthiness involves:
 - Competence
 - Care
 - *Comprehension*
- In a climate of mistrust due to injustice, conveying trustworthiness requires expressing comprehension of the source of mistrust and reflecting what trustworthiness looks like to that unique individual.

Further Questions

- How can clinicians interrogate their own trustworthiness and that of their institution?
- How does trustworthiness function in the context of medical teams, not individuals?
- Are clinicians within unjust institutions “performing” trustworthiness?

Thank you!

“Trust, Risk, and Race in American Medicine.” *The Hastings Center Report* 50(1): 18-26. February 18, 2020.

Get in touch:

lspeckersullivan@fordham.edu