

## The doorway of trust

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Learning from one another in medical encounters

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## THE DOORWAY OF TRUST

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“**M**y shoulder pain was so bad the other morning that my husband had to help me dress. He said, ‘Isn’t it weird that I have to dress you like we dress our kids?’ We laughed it off, but inside I was thinking, ‘What if he has to do this for me the rest of my life?’”

Shoulder pain was only one of multiple concerns my patient, who I will call Mrs. Z, had that day. She spoke with merely a hint of trepidation in her voice which belied the desperation she felt underneath. I wondered what catastrophic thoughts hid behind an apparently mild shoulder issue.

“Why are you worried this may last the rest of your life?” I asked.

“Well, my life’s always been crappy. I’ve come to expect that things will always go badly for me. That’s just the way everything’s been,” replied Mrs. Z.

I knew something was emerging here, so I kept probing.

“What do you mean by that?”

This one simple question opened the Pandora’s box of Mrs. Z’s life. Rarely had I heard stories as devastating as hers, from her violent childhood abuse to death of family to chronic debilitating medical conditions. Her life had been one trial after another. I swiftly understood why she feared that her pain would never dissipate.

Over the next half hour, Mrs. Z shared with me more harrowing details of her difficult life. The entire time I nodded with sympathy while my N95 mask concealed my gritted teeth. But the most surprising detail was yet to come.

“Have you ever talked through this with a therapist?”

“No,” said Mrs. Z. “I rarely talk about these things with anybody. Only a few people know. I don’t tend to want to talk about it.”

“But you’ve spent the last thirty minutes sharing all of it with me.”

“Yeah, I don’t know. This is not normal. I guess I feel safe right now...”

“Have you ever told these things to your doctor?”

“No.”

I was floored. Mrs. Z had regularly seen doctors for most of her adult life because of her litany of health issues. In the past year she had attended more office visits than some people do in a lifetime. But beyond brief mentions of her abuse, she had never disclosed the extent of her trauma with any medical professionals – until now. With me. A medical student.

It was clear to me that Mrs. Z’s traumatic life experiences were crucial and immediately relevant to her chronic pain,[1] so her doctors would likely need to treat her unresolved psychological distress in order to fully treat her pain. But for years, Mrs. Z did not even feel like she had a real entryway into exploring these issues within the medical system. What potentially underlay all her pain, and her stunted recovery, was something she had not even made known to her doctors.

How could this have happened?

Among everything Mrs. Z told me, one provided an important clue.

“...I guess I feel safe right now. You seem like a very kind person. I see it in your eyes. My grandmother used to say you can see it in people’s eyes. I think I can trust you.”

Her implication was that she did not feel she could trust anyone in medicine before I came along. I took this not as a compliment of me, but as an indictment of the medical establishment. Fifteen-minute office visits

in which doctors spend more time looking at computer screens than at the patient were not going to uncover the depths of her heartache. There was barely enough time just to take a cursory history, perform a physical examination, review her labs and imaging, and discuss additional testing and treatment.

A shortage of time is but one constraint that quells the blossoming of trust between doctors and patients. A subtler but greatly more dangerous hindrance to trust – and yet one that is more shapable for those who are willing to confront it – is bias towards patients.

Bias in healthcare is a well-studied phenomenon, disproportionately affect minority persons seeking medical attention. Modern medicine values “hard” outcomes, and evidence shows that bias towards patients contributes to measurable, detrimental health consequences.[2] But when a patient is seeing a doctor in their office, and has any concern about the doctor’s clinical objectivity, I doubt the patient thinks primarily in terms of “hard” results: whether the doctor will prescribe them the right medication or recommend the best procedure. Instead, I believe the patient fundamentally thinks in terms of trust. *Is this doctor someone who cares about me, and has my best interests at heart?* An affirmative answer is the bedrock on which trust is built, and only then is shared decision-making about treatment possible. Only then can adherence be strengthened, and ongoing therapeutic alliance maintained. Although I am still early in my training, I have already encountered many patients who decided to switch doctors or seek a second opinion because they did not trust their original doctor.

In 2018, the American Board of Internal Medicine (ABIM) Foundation announced that they would begin to embrace a new focus: trust in healthcare. In doing so, they committed to “examining issues of trust in health care and how trust contributes to better health outcomes, increased patient satisfaction and greater physician well-being.”[3] It was a prescient vision. Only two years later, trust in Western medical institutions catapulted to the forefront of public consciousness with the debate over the safety and efficacy of the SARS-CoV-2 vaccine and fiery contentions over private freedoms versus public health.

Bias matters because trust matters, and experienced or perceived bias can compromise patients’ trust in their doctors. From late December 2020 to early February 2021, a research group at the University of Chicago conducted a national survey on behalf of the ABIM Foundation of adult patients in the United States. Among the 2,069 patients surveyed, 59 percent agreed that implicit bias and discrimination in medicine is a problem in the United States healthcare system. Additionally, 12 percent of patients reported experiencing discrimination in a medical setting, and these respondents were twice as likely to report having no or limited trust in healthcare.[4]

I will never forget the experience of a patient I will call Mr. C, whom I helped take care of as a medical student. If there was ever a patient whose medical records were more extensive than Mrs. Z’s, it was Mr.

C. He had a complicated surgical history, frequently presented to the hospital for pain, and had been on daily prescription opioids for years. On this particular visit to the emergency department, Mr. C complained of severe chest pain. The voice of bias immediately questioned whether this was “real” pain or a factitious presentation. Imaging studies revealed a blood clot, and Mr. C continued to writhe in agony despite being placed on intravenous heparin and morphine. The voice of bias whispered, “He’s exaggerating; that’s what he always does.” More morphine, no relief. Frustration began to set in for the medical team. Bias, again: “He’s one of those complicated, opioid-seeking patients whom we can’t really help.” At this point, Mr. C was yelling at staff incessantly. Colored by bias, the belief was that his real underlying issue was his chronic pain, thus the temptation was to simply push more opioids to appease him and send him on his way after his blood clot resolved. In the meantime, we would not take anything else he told us too seriously.

And then I faced the hard work of trust-building. As a medical student, I had much more time to spend with patients than did the busy inpatient team, who often encouraged me to sit with patients and get to know them better. So, I sat with Mr. C for hours each day, hearing him tell me about his physical pain, which led to stories about his emotional pain and his mistrust of the medical system. He had so many relationships with so many doctors, and yet had difficulty believing that most of them truly cared about him.

It did not take anything revolutionary for Mr. C to begin to trust our team again. It just took someone who was willing to face him (instead of the computer screen) and just listen. I came to find that Mr. C did not want to keep taking opioids. He was open to treatment for his substance use disorder and wanted to eventually wean off opioids completely. He was simply addicted, and in so much pain, and did not know how to start. Bias led us to think he was merely seeking opioids; seeing him as a suffering person opened the doorway of trust that led to new information, softened Mr. C’s anger, and even reduced his physical pain.

I have found that many of us in medicine are, in fact, willing and wanting to hear our patients’ life stories and address their emotional needs, particularly when they pertain to present health issues. Unfortunately, we are constrained by external factors (such as limited time) and internal biases that pressure us, at best, to refer patients with “complex” psychosocial problems to psychiatrists or social workers. But when patients already do not feel safe with their current doctors, why would they trust their referrals?

As a medical student I am only scratching the surface of what day-to-day interactions with patients look like. Sometimes I am disappointed and enervated by the increasingly transactional nature of the patient-doctor relationship. I occasionally wonder what it will take to stay unwaveringly committed to the heart of patient care in the long haul, especially when hounded by the ever-increasing threat of technocratic medicine, wherein billing, technology, and litigation often steer the actions of healthcare teams against the arc of genuine human flourishing.[5]

Both Mr. C and Mrs. Z taught me an indispensable lesson: while we cannot immediately mitigate the external forces warring against our relationships with patients, we can always seek to resolve the internal impedances within ourselves that interfere with the hard-won trust that patients place in us.

Had I decided to ignore Mrs. Z's subtle hint that something might be really wrong – namely, her passing, easily discreditable worry that her husband might need to dress her for the rest of her life – I would not have explored why she felt that way. After she vaguely mentioned that her life had always been terrible, I could have extended a contrived apology and steered the conversation back “on track” (something I had been advised to do before). And after she began to open up about her trauma, I could have decided not to ask whether she had previously shared this with any of her doctors. But I kept prodding, and she kept confiding in me, and rapport began to emerge between patient and medical student – someone who could not offer her any medications or procedures, but who could advocate for her and help her come to a place of trust. Could that perhaps be the care she really needed?

We hear in medical training how trust is vital to patient care. I have wondered what real difference this theory makes to patients beyond their level of satisfaction with their medical team. Can trust influence “hard” outcomes, like healthcare utilization, morbidity, and mortality, or does it serve primarily to make patients feel warm and fuzzy inside? And does this even matter?

Mrs. Z answered both questions for me. For one, the tears she shed and the relief I saw in her eyes from feeling like someone truly cared about her was enough to teach me that trust mattered. And when I asked her if she would like to explore these issues further with a therapist, she hesitated, but said she was open, something she had never been before. Trust was the doorway leading to something new and potentially healing for her, and she was beginning – for the first time – to pry open that door. ■

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