COMMENTARY

Trust Takes Two...

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Research throughout the COVID-19 pandemic, including investigations of resulting pandemic response strategies, evolving public health recommendations, and vaccine development, has highlighted the role of trust between physicians and patients. The focus, however, has largely been on patient trust in physicians. Although the importance of patient trust in physicians has long been recognized, physician trust in patients remains underappreciated. Physician trust in patients is an important factor in the physician-patient relationship. When physicians trust patients, patients can communicate freely, their experiences are validated, and trust may be engendered through reciprocal trust. Thus, a bidirectional approach to trust is necessary that acknowledges the role of physician trust in patients. We posit that shared trust is the dyadic factor that influences positive patient outcomes and is the foundation of shared decision making. Recognizing shared trust as an important outcome of the physician-patient relationship is a necessary step in evaluating how our practice, research, and education can influence or sow distrust of patients. In this commentary, we discuss the importance of attending to shared trust and physician trust in patients, particularly in family medicine. (J Am Board Fam Med 2022;35:1179–1182.)

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Throughout the COVID-19 pandemic and the resulting vaccination campaigns, we have advocated for an increased role of primary care, driven in part by our understanding that patients trust their family physician.[1] This reflection on the role of trust[2] should extend beyond patient trust in physicians to also consider physician trust in patients. Despite some recognition of its importance,[3] physician trust in patients has been understudied. The dearth of literature in this area hampers our ability to fully understand how trust operates between clinicians and patients.

In 2016, Wilks and Plat published a literature review of trust in Social Science and Medicine. In their review, only 6.7% of articles described physician trust in patients, in contrast to 81.2% describing patient trust in physicians and 10.3% physicians trust in health care professionals.[4] Within that review, 1 article emerged from the Family Medicine literature – a 2011 piece in which Thom and colleagues recognized the clinical value of physician trust in patients and developed a validated scale.[5] However, 10 years on and this tool has been underutilized not only in Family Medicine but also broader primary care research.

The goal of the current commentary is to reintroduce family physicians to the role and need of physician trust in patients. Pelligrini suggested that when physicians demonstrate trust in patients, patients are more likely to trust physicians, creating a virtuous cycle that builds a trusting relationship.[6] Thus, physician trust, alongside patient trust in physicians, may be at the heart of building trust. Informed by the chronic care model, shared decision making, and interpersonal communication theory, we propose that the ideal family physician-patient relationship develops *shared trust*. Shared trust may be the foundation of shared

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decision making between the physician and patient and the dyadic factor that most influences positive patient outcomes. Therefore, discussions and empirical investigations into trust should account for physician trust and its impact on the physician-patient relationship.

Trust, a multi-dimensional construct that includes confidence, reliability and competence, and respect, honesty, fairness,[4] is fundamental to the doctor-patient relationship. Patient trust in physicians facilitates patient confidence in physician prevention advice, diagnostic decisions, and treatment recommendations. Instead of a unidirectional approach, we should consider a bidirectional perspective in which trust is positioned as moving in both directions between 2 people. This reciprocal trust occurs when there is a "mutual influence process whereby the trust 1 party has in the other, through its effects on trusting or cooperative behavior, influences the other party's trust."[7] We hypothesize that this mutual influence may also positively impact patient outcomes. When patients perceive they are trusted, their experiences are validated and their competence recognized.[8,9] Knowing they are trusted may enable a patient to communicate freely without fear of being disbelieved or disparaged; positive communication leads to reciprocity,[10] a practice that may extend to communicating trust.

The inverse, however, can be destructive: when doctors do not trust patients, patients perceive they are distrusted, which can disempower patients.[8] Existing research has explored physician trust (and mistrust) of patients in the context of patient drug-seeking behavior, patients withholding information about risky behaviors or stigmatized conditions, physician prejudice, and miscommunication linked to cultural or linguistic differences between physician and patient.[4,11] The importance of physician trust likely extends beyond these contexts but has been understudied.

In Family Medicine, perhaps shared trust is implicit in the underlying framework or assumptions of our discipline. As family physicians provide comprehensive, coordinated care in continuous relationships with patients, they maintain longitudinal, informational, and interpersonal continuity.[12] Physician-patient relationships are created through time together and experiencing health and illness together. In this relationship, trust naturally develops and grows over time.[9,13] However, as family physicians and patients see continuity erode,[14,15] the family physician-patient relationship may be less distinguishable from other physician-patient interactions that lack trust.

Chan names reciprocal trust as a lesson of the pandemic – but places it more broadly in the context of the public and the system, specifying that reciprocal trust is a "continuous process, requiring a constant negotiation and readjustments of actions."[16] This idea of reciprocal trust can be useful for Family Medicine as well. We know that both patient and physician trust in each other is an outcome of their relationship, not just the individual factors and behaviors on which much research focuses.[4] The research we conduct around trust should reflect this dynamic. An increase in qualitative and quantitative research examining these relationships is crucial as it has implications across our practice and education and provides insights for subsequent research endeavors. Mixed methods, longitudinal inquiry may reveal evidence of the virtuous cycle that can build a trusting relationship.

In clinical practice, language and documentation may communicate distrust. Particularly as the "open note" movement grows,[17] patients see clinicians' words that could have connotations of mistrust and distrust. Whether intentional or not, a note that a "patient denies" a behavior implicitly communicates an accusation; language that is more likely to be placed in the notes of Black and female patients.[18] This language could influence the next clinician who reads that note leading them to question the patient's response or enter the encounter with suspicion and bias. Physician bias, even if implicit, can influence communicative practices and patient perceptions.[19]

Indeed, in the era of the electronic record and the "open note," we may find ourselves taking pause to reflect on what our patients will think of us and our opinion of them, based on the words we use to document the sacred interaction we call the "doctor-patient encounter." And even more so, how others' words have influenced this encounter before it even occurs, as we all try to become more time-efficient by "precharting" based on our review of previously documented encounters our patients may have had with others. *Am I trusting that other clinicians have told the truth? That my patient has told the truth? That there was adequate trust between patient and physician during these other encounters for any of this to occur?*

Terminology is also important because how physicians frame and think about patient actions and behavior, such as compliance versus adherence, can communicate physician distrust of patients. Osterberg reframes these patient actions as "concordance."[20] Adherence is defined as the extent to which people follow the instructions they are given for prescribed treatments; it involves patient choice and is intended to be nonjudgmental, unlike compliance, which reinforces patient passivity and blame. On the other hand, concordance refers to an emerging consultative and consensual partnership between the patient and their doctor—that is, a mutual trust, which we denominate a "trust-balance."[20] Concordance of trust, or a "trust-balance" between clinician and patient improves the therapeutic relationship and is built over time – again, something family medicine providers are in a unique position to build through our continuity of care model.

Truth-telling may be intertwined with preserving dignity for our patients, within the context of empowering the patient and bringing greater "trust-balance" to the doctor-patient relationship. It is well-recognized that telling the truth has emerged among the most widely valued qualities of health professionals in contemporary biomedical ethics.[21] For example, informing patients the full truth about a life-threatening disease does *not* result in a greater incidence of anxiety, despair, sadness, depression, insomnia, or fear.[22] Not trusting our patients with the truth can strip them of their dignity and power. Empirical work, however, is needed to explicate the causal relationships between truth-telling, trust, and other aspects of physician-patient interactions.

Physician trust in patients may act as a clinician-level mediator of racial disparities in health care.[23] Given the reciprocal nature of trust, physician distrust combined with the earned mistrust of persistently marginalized communities may serve to exacerbate health disparities. Clinicians who create partnerships of mutual trust with patients are more likely to develop a sense that their "partner" is on the same team, working toward a common goal, thereby mitigating some impact of unconscious bias on clinical care.[24] Empirical efforts should be made to determine exactly what characteristics and practices might engender reciprocal trust and aid in reducing disparities. Although some work has suggested that similarity in thinking, values, and communicating (ie, personal similarity) is impacted by clinicians' patient-centered communication and influences patient trust,[25] we do not yet have data on whether these domains of similarity also influence physician trust. Amid recommendations to build trust with persistently marginalized communities,[26] understanding and facilitating shared trust may be a pivotal component of these efforts.

Addressing physician trust in patients as an understudied aspect of primary care requires our attention and further research. If we simply investigate trust unidirectionally, we neglect the mutual influence and possibilities of shared trust. High quality research on this dyadic longitudinal relationship, both quantitative and qualitative, can help us more fully understand how shared trust unfolds in physician-patient interactions. Investigation of physician trust in patients will be challenging, but if we neglect to do so, we may miss opportunities for improving shared trust and fostering fruitful physician-patient relationships. In the midst of the chorus chanting the importance of trust in the physician-patient relationship, we cannot forget the role of physicians to trust their patients.

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