Each year we gather at these Sessions, the world’s largest meeting of scientists and healthcare professionals dedicated to the basic, clinical, and population science of cardiovascular disease and stroke. We gather to learn and to teach, to meet today’s experts and tomorrow’s leaders, to review the new scientific discoveries, and to exchange ideas with colleagues and friends.

To be sure, we will learn about the emerging science and clinical practice of cardiovascular disease over the next four days. But there is an internal disease of the heart that confronts us as scientists, as physicians, and as healthcare professionals. It is a threat to us all—insidious and pervasive—and one that we unknowingly may spread. This threat is one of the most critical issues facing our profession today. How we address this problem will shape the future of medical care.

This issue is the erosion of trust.

Lack of trust is a barrier between our intellectual renewal and our ability to deliver this new knowledge to our research labs, to our offices, to the bedside of our patients, and to the public. Trust is a vital, unseen, and essential element in diagnosis, treatment, and healing. So it is fundamental that we understand what it is, why it’s important in medicine, its recent decline, and what we can all do to rebuild trust in our profession.

Trust is intrinsic to the relationship between citizens around the world and the institutions that serve their needs: government, education, business, religion, and, most certainly, medicine.

Albert Einstein recognized the importance of trust when he said, “Every kind of peaceful cooperation among men is primarily based on mutual trust.” In our time, trust has been broken, abused, misplaced, and violated. The media have been replete with commentaries, citing stories of negligence, corruption, and betrayal by individuals and groups in the public and private sectors, from governments to corporations, from educational institutions to the Olympic Organizing Committee. These all are front-page news. Perhaps the most extreme example is terrorism, in which strangers use acts of violence to shatter trust and splinter society in an ongoing assault on our shared reverence for human life.

Unfortunately, we are not immune in our own sphere of cardiovascular medicine. The physician-investigator conflicts of interest concerning enrollment of patients in clinical trials, the focus on medical and nursing errors, the high-profile medical malpractice cases, the mandate to control the cost of health care in ways that may not be aligned with the best interest of the patient—all of these undermine trust in our profession. At this time, when more and more public and private institutions have fallen in public esteem, restoring trust in the healthcare professions will require that we understand the importance of trust and the implications of its absence.

Trust is intuitive confidence and a sense of comfort that comes from the belief that we can rely on an individual or organization to perform competently, responsibly, and in a manner considerate of our interests. It is dynamic, it is fragile, and it is vulnerable. Trust can be damaged, but it can be repaired and restored. It is praised where it is evident and acknowledged in every profession. Yet it is very difficult to define and quantify.

Trust is easier to understand than to measure. For us, trust may be particularly difficult to embrace because it is not a science. Few instruments have been designed to allow us to evaluate it with any scientific rigor. Yet, trust is inherent to our profession, precisely because patients turn to us in their most vulnerable moments, for knowledge about their health and disease. We know trust when we experience it: when we advise patients in need of highly technical procedures that are associated with increased risk or when we return from being away to learn that our patient who became ill waited for us to make a decision and to discuss their concerns, despite being surrounded by competent colleagues acting on our behalf.

Many thought leaders in the medical field understand the importance of trust. When asked whether the public health system could be overrun by public panic over SARS and bioterrorism, Centers for Disease Control and Prevention Director Julie Gerberding replied, “You can manage people if they trust you. We’ve put a great deal of effort into improving....
state and local communications and scaled up our own public affairs capacity...we’re building credibility, competence and trust.”

Former Health and Human Services Secretary Donna Shalala also recognized the importance of trust when she said, “If we are to keep testing new medicines and new approaches to curing disease, we cannot compromise the trust and willingness of patients to participate in clinical trials.”

These seemingly intuitive concepts of the importance of trust in 21st century medicine actually have little foundation in our medical heritage. In fact, a review of the early history of medicine is astonishingly devoid of medical ethics. Even the Codes and Principles of Ethics of the American Medical Association, founded in 1847, required patients to place total trust in their physician’s judgment, to obey promptly, and to “entertain a just and enduring sense of value of the services rendered.” Such a bold assertion of the authority of the physician and the gratitude of the patient seems unimaginable today.

It was not until the early 1920s that role models such as Boston’s Richard Cabot linked patient-centered medical ethics with the best that scientific medicine had to offer, and Frances Weld Peabody, the first Director of the Thorndike Memorial Laboratory at the Boston City Hospital, crystallized the ethical obligation of the physician to his patient in his essay “The Care of the Patient.” In one particularly insightful passage, Peabody captures the essence of the two elements of the physician’s ethical obligation: He must know his professional business and he must trouble to know the patient well enough to draw conclusions, jointly with the patient, as to what actions are indeed in the patient’s best interest. He states: “The treatment of a disease may be entirely impersonal: The care of the patient must be completely personal. The significance of the intimate personal relationship between physician and patient cannot be too completely personal. The significance of the intimate personal relationship between physician and patient cannot be too

This concept that links the quality of the physician-patient relationship to health outcomes has indeed stood the test of time. Trust has been shown to be important in its own right. It is essential to patients, in their willingness to seek care, their willingness to reveal sensitive information, their willingness to submit to treatment, and their willingness to follow recommendations. They must be willing for us to be able.

Furthermore, it is unclear why the widely documented and pervasive racial and ethnic inequalities in health care and health status exist, but perceptions of healthcare professionals’ style and trust may play a role. Several investigators have suggested that lower levels of trust in our current healthcare system among people of color, particularly African Americans, may help to explain their lower rates of seeking preventive services and receiving surgical treatment when compared with Caucasians.

Trust is not only vital for the practice of medicine, it is the moral glue of society. As noted by H.L. Mencken, “For it is mutual trust, even more than mutual interest, that holds human associations together.” Unfortunately, in many sectors of society, trust is at historically low levels.

Shalala also recognized the importance of trust when she said, “If we are to keep testing new medicines and new approaches to curing disease, we cannot compromise the trust and willingness of patients to participate in clinical trials.”

The public’s trust in those running its institutions has also declined steadily. Shown here (Figure 2) is the change in public confidence from the mid-1960s through 2002. Interestingly, confidence in medicine has been higher than in other institutions throughout the past few decades, but even it has fallen from 73% to 29% and now matches the confidence rating of other major institutions. Clearly, medicine is losing, or has lost, its privileged place as a trusted institution.

Finally, although poll data prior to 1970 are limited, a 1949 Gallup Poll survey asked American adults to consider a list of well-known professions and identify those they trusted most (Figure 3). Doctors of medicine topped the list. By 2000, doctors had fallen to fourth, placing them behind nurses, pharmacists, and veterinarians.

Numerous explanations have been offered for this decline in the public’s overall trust. Certainly, changes in medical practice have contributed to the problem. Rising healthcare costs have become prominent in the mind—and in the pocketbook—of the public, and this has led to a suspicion...
that medical decisions may be based on cost, rather than on what is best for the patient.

During the past decade, many hospitals have merged to form larger entities, leading to consumers’ perception that these organizations are created to capture market share, and have become a big business, rather than a local provider.

Increased public access to medical knowledge has resulted in some demystification of the body. Diagnoses of many medical conditions such as diabetes and pregnancy can now be made at home. Responsibility for personal health has shifted from paternalistic medical providers. Now, patients are viewed as personally responsible for their own health. Self-care in such arenas as nutrition, exercise, weight control, stress management, and self-examination are playing an increasingly important role. This is a positive development, although it is altering the previous relationships.

Other influences also challenge trust as we have known it. The first, and perhaps most significant, can be attributed to the managed care era. Attempts by some managed care organizations to control costs have focused on providing physicians with financial incentives to limit access to services. Such a mandate to do as little as possible in caring for patients is unprecedented in the history of medicine. The concept of rewarding physicians for limiting services has been noted in the press. Doctors were portrayed either as helpless to protect their patients’ interests or as willing to limit services to comply with the demands of managed care bureaucrat. Other stories depicted doctors as heroes, actually willing to resort to subterfuge to ensure access to lifesaving treatment options for their patients.

In their article entitled “The End of the Golden Age of Doctoring,” John McKinlay and Lisa Marceau capture the essence of the doctor–patient relationship and the impact of managed care on the erosion of patients’ trust. Perhaps the most notable measure of the change in this relationship lies in the words used to describe it. The “doctor” has become a “provider,” the “patient” has become a “client,” and the “relationship” is now an “encounter.”

Shown here (Figure 4) are the differences in this relationship during the past 50 years. Note the change in the duration of the relationship and the length of the patient’s visit. The quality of trust depends on a relationship evolving between the patient and his or her physician. This takes time. More time also allows us to teach our patients, lets them really participate in treatment choices, and gives opportunities for discussion about their concerns. Note, too, the change in treatment options and the threat to confidentiality in our current system of health care.

High-profile medical malpractice cases and widely publicized medical errors also erode trust, particularly trust in physicians. The public reads and hears about frightening statistics, such as those published by Barbara Starfield in her article “Is US Health Really the Best in the World?” She suggests there are 12 000 deaths per year from unnecessary surgery, 7000 deaths per year from medication errors in hospitals, 106 000 deaths per year from nonerror adverse effects of medication. Numbers like these reinforce the perception that medical care is suboptimal.

Finally, there is the issue of conflicts of interest in medical research. In recent years, numerous stories chronicled in the media have suggested that the potential financial gain of an investigator was responsible for the adverse outcomes in a patient participating in a clinical trial. Other stories suggest that conflicts of interest of authors affect the content of statements recommending various therapies. Whether individuals with relationships with industry, arguably often the most knowledgeable experts in a field, should be allowed to participate in the writing of scientific statements and guidelines is a subject of active debate.

Beset as we are by these contemporary issues that fuel mounting mistrust and increasing public scrutiny, it is critical that we answer the questions posed by Dr Alfred Tauber in his essay “Balancing Medicine’s Moral Ledger: Realigning Trust and Responsibility.” He asks, “In what ways can the moral milieu of clinical practice be fortified to off-set the corporate character of healthcare delivery and the technical character of contemporary diagnostics and therapies?” What might healthcare professionals do to instill trust in themselves? Certainly, there are no simple answers, but thought leaders in trust initiatives such as Dr David Shore at Harvard University and Dr Jordan Cohen, past president of the Association of American Medical Colleges, have proposed plausible potential solutions based on the concepts underlying trust and trusting relationships.

For physicians and other healthcare providers, the aspects of trust can be organized to form three pillars: technical competency, interpersonal competency, and agency. Technical competency is fairly self-evident, although patients and
medical colleagues may judge physician competency quite differently. Technical competency is how skilled you are at diagnosing and treating patients, and certainly how skilled you are in knowing the safest and best and most cost-effective ways to accomplish these goals, aware that cost must be reckoned in human discomfort and suffering, as well as in dollars. How can we strengthen this pillar?

We must make health care safer. No initiative would be more indicative of our trustworthiness than a concerted effort to reduce the avoidable errors that occur in our complex medical system. Fortunately, a roadmap for this work is available. The Institute of Medicine’s landmark reports “To Err is Human”21 and “Crossing the Quality Chasm”22 place the issue of medical errors within the broad context of quality improvement. They remind us that patient safety must be priority No. 1. The American Heart Association’s own Get With The Guidelines program is a quality-improvement initiative that helps us at the point of care to remember what the best current guidelines recommend for our patients. As with all such systems, clinical judgment about individual patients is necessary, but tools like this have substantial ability to reduce errors and enhance our own technical competence. Clearly, research is the key to determining how best to accomplish the Institute of Medicine’s goals to reduce medical errors in patients with cardiovascular disease and stroke. We must advocate for increased funding in this area.

Interpersonal competency refers primarily to our communication and relationship-building skills—listening, understanding, providing complete and honest information, and showing you care—as so genuinely expressed by Frances Peabody. Increasing competency is important, but it alone will not restore trust. Patients don’t necessarily care how much you know until they know how much you care. So, in the future, we must ensure that healthcare professionals have both the technical and people skills necessary to be effective. This means we must prepare tomorrow’s healthcare professionals to deliver tomorrow’s discoveries.

The public understands that academic medical centers have the responsibility of preparing the next generation of healthcare professionals. And the public needs to know that we are dedicated to training these men and women to be proficient in an IT-empowered age. We must see that these students are culturally competent as population diversity escalates and collaborative in an era of patient-centered care delivered by unified teams of healthcare professionals. We also must ensure that they practice the ageless skills of good doctoring and are infused with the professional values that sustain medicine as a moral enterprise.

The third and last aspect of trust is agency—doing what is best for patients—for example, putting the patient’s welfare before cost or other considerations. To strengthen this pillar we must remodel the system of healthcare delivery, Ralph Snyderman’s call to action for a prospective healthcare initiative reminds us that our healthcare delivery system, designed to address acute episodes of illness and injury, is poorly equipped to manage the growing burden of chronic disease and the rapidly approaching challenges of the genomic revolution. It is suggested that visible collaboration by academic medical centers to implement models of prospective preventive health care, rather than waiting for disease to occur, would inspire public trust.

We must also manage real or perceived conflicts of interest in clinical research. Clearly, this is an issue in which there is a significant opportunity for the medical community to strengthen the public’s trust. To do so will require visibly implementing effective policies that address both individual investigators who have financial (or academic) interests in the outcomes of their studies and institutions that have financial ties to sponsors of human subject research performed under their jurisdiction. The public must be reassured that our legitimate relationships with commercial entities are never allowed to compromise, or be perceived to compromise, the safety of those who volunteer to participate in clinical trials.

Last June, the American College of Cardiology and the American Heart Association co-sponsored a Bethesda Conference on Professionalism and Ethics. Issues addressed included a code of conduct in human subject research, the disclosure of relationships with commercial interests, and self-referral. While there was consensus on many issues, several others will require ongoing observation and discussion. What was clear, however, is that transparency and full disclosure are paramount and that in every situation the interest of the patient must be the highest priority.

To restore trust, we must first acknowledge its absence. The lack of trust is a threat to the health of our patients, our profession, and our society. To restore trust in science and medicine, we need to change individually, and collectively we need to change the systems we have created. We must restore confidence in the integrity of the healthcare system because it cannot survive without the support of those it serves. Amid the technologic revolution and as the potential for gene therapy unfolds, we cannot allow the human dimension to be lost. Despite the pressures, we must hold fast to this truth in our hearts and heads: We are not providers; we are physicians or nurses or other healthcare professionals who personally care for our fellow human beings. Our patients are patients, not clients. And our relationships are not encounters.

As scientists and clinicians we must acknowledge the unique position science and medicine hold in society. The potential for emerging science to reduce the global burden of cardiovascular disease and stroke is greater than ever before, but so, too, is the vulnerability of our patients.

As scientists, as physicians, as nurses, as pharmacists, and as physician assistants, we have come from around the world to this meeting to better understand cardiovascular disease. At the same time, we must also remember that caring for patients is more than a career or even a profession. It defines us; it is part of who we are. This understanding transcends race and religion and geography. Those of us who are responsible for the lives of others, during health and during illness and when the end is near live by the dictum that we must care for all patients at all times. We cannot, however, believe that we are entitled to be trusted. We must reach out to others, for trust is earned, and it is fragile.

These Scientific Sessions will stimulate and engage our intellectual curiosity. I urge you return home not just with new knowledge, but with a passion for rebuilding enduring trust, for the thrill and the reward of scientific discovery, for
the privilege of caring for our patients, and for the potential impact that our collective action will have on the health of the public around the world.

Thank you.

References

KEY WORDS: ethics ■ trust ■ delivery of health care
Rebuilding an Enduring Trust in Medicine: A Global Mandate: Presidential Address
American Heart Association Scientific Sessions 2004
Alice K. Jacobs

Circulation. 2005;111:3494-3498
doi: 10.1161/CIRCULATIONAHA.105.166277
Circulation is published by the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231
Copyright © 2005 American Heart Association, Inc. All rights reserved.
Print ISSN: 0009-7322. Online ISSN: 1524-4539

The online version of this article, along with updated information and services, is located on the World Wide Web at:
http://circ.ahajournals.org/content/111/25/3494

Permissions: Requests for permissions to reproduce figures, tables, or portions of articles originally published in Circulation can be obtained via RightsLink, a service of the Copyright Clearance Center, not the Editorial Office. Once the online version of the published article for which permission is being requested is located, click Request Permissions in the middle column of the Web page under Services. Further information about this process is available in the Permissions and Rights Question and Answer document.

Reprints: Information about reprints can be found online at:
http://www.lww.com/reprints

Subscriptions: Information about subscribing to Circulation is online at:
http://circ.ahajournals.org/subscriptions/