

IMPACTS OF MODERN-DAY MEDICAL EDUCATION ON TRUST IN THE PATIENT-PHYSICIAN RELATIONSHIP

Mina Mirzaie
Creighton University

The importance of the patient-physician relationship has implications not only in healthcare practice, but also in medical education, where the resulting impacts of what occurs inside academic medical centers can have ripple effects after medical training is complete. However, patient-physician trust today seems at a standstill.¹ Patients are turning to health apps or the internet to discuss their ailments with any available physician, rather than visiting a local healthcare provider with whom they have built a relationship over time.²

As described by Blendon, Benson, and Hero, in 1966 73% of Americans described great confidence or trust in the leaders of the medical profession, however, as of 2012 only 34% of Americans reported such sentiment.³ This trend, though not surprising given the compounding effects of the world being more connected than ever to a web universe of medical information, will and should impact the

¹ Apfel, R. J., and S. M. Fisher. 1985. *To do no harm: DES and the dilemmas of modern medicine*. New Haven, CT: Yale University Press, 1-12.

² Usher, W. 2009. General practitioners' understanding pertaining to reliability, interactive and usability components associated with health websites. *Behaviour & Information Technology* 28 (1): 39-40.

³ Blendon, R. J., J. M. Benson, and J. O. Hero. 2014. Public trust in physicians – U.S. medicine in international perspective. *The New England Journal of Medicine* (371): 1570.

way students are trained in medical education. Failing to address the interpersonal, collaborative, and humanistic training of students can have detrimental impacts on trust within the patient-physician relationship which has the potential to hold back medical advancements and health overall. The following shines a spotlight on modern-day American medical education and the effects the current model of physician training can have on trust in the patient-physician relationship. This philosophical analysis and literature-based review will also consider the practical impact and inequities that result when at-risk populations express mistrust towards physicians. Finally, potential remedies for medical education to integrate into their learning experiences will be identified.

Discussion

I. The Modern Approach to Medicine - Training Based in Technē

The modern approach to American medical practice lacks psychosomatic unity, meaning physical, spiritual, or mental problems should not be dealt with in isolation from one another.⁴ With the void of psychosomatic unity comes *technē*, a Greek term that translates to “craft” or “technical skill.” Thereby, patients today are treated according to the industrial model as disordered machines, rather than as complete beings suffering both emotionally and physically. Therefore, dehumanization and depersonalization of suffering often coincide with the production-line quality of medicine when it comes to the care of individuals.⁵ It is not clear whether viewing individuals as disordered machines leads to medical training focused on the technical skill of diagnosing and treating symptoms, or the model of modern medical training leads to individuals being viewed as disordered machines. However, the overarching outcome is current medical practices that seem to lack the compassion necessary for the humanistic craft of a professional model of healthcare practice.

⁴ Antoniou, S. A., G. A. Antoniou, F. A. Granderath, A. Mavroforou, A. D. Giannoukas, and A. I. Antoniou. 2010. Reflections of the hippocratic oath in modern medicine *World J.Surg.*(34): 3078-9.

⁵ *Ibid.*, 3075.

Flawed from the Onset

Medical training and education for thousands of medical students every year begins with the heralded ritual of the White Coat Ceremony. In this ceremony, students are tasked by medical education institutions with the prospective challenge of virtuously caring for others by reciting the Hippocratic Oath. However, as Russell states, the White Coat Ceremony turns healthcare provider trust into an entitlement *given* by the medical education institution to the medical student. The purpose of the Hippocratic Oath is, in part, to establish acceptance by physicians of the responsibility that coincides their knowledge, yet, rather than trust as the virtue that is built with each patient during each patient-physician interaction, physicians medical training has become focused on the technical skill of diagnosing and treating symptoms as the forefront of student concerns.⁶ Therefore, authority and trust from the proverbial get-go of medical training are poorly distinguished.^{7,8}

Failing to distinguish trust from authority leads to the battle between the industrial and professional models of modern healthcare. On the one hand, healthcare can be a machine for profit with a supply and demand chain that goes on ad infinitum (i.e., the industrial model). This model can be seen through systems in place today in America that rely heavily on privatized medical care. On the other hand, another model of healthcare is the professional model. In this model, the profit motive is decreased or eliminated, and healthcare is regarded as caring for the person while doing no harm. In the professional model, the humane and virtuous attitudes of the physician are an important and unyielding part of medicine. Modern medical schools should be schools of virtue to combat and change the

⁶ Russell, P. C. 2002. The white coat ceremony: Turning trust into entitlement. *Teaching and Learning in Medicine* 14 (1): 56.

⁷ Michalec, B., and W. H. Frederic. 2013. Stunting professionalism: The potency and durability of the hidden curriculum within medical education. *Social Theory & Health* 11 (4): 388.

⁸ Russell, 56.

dehumanizing effect that the industrial model of medicine has had for so many years.^{9,10}

The Toil and Triumph of Technē Based Medicine

Today, the humanity that comes with healing others is often lost as students watch their professional elders treat patients with a default detachment, rather than socializing students to discern when appropriate detachment is needed. Trust is understood in the literature as an interaction developed and described sociologically.¹¹ For example, in some emergency situations calm, clear detachment is needed. However, there are also times when patients may need physicians to demonstrate connection and vulnerability.¹² As asserted by Dr. Daniel Sulmasy in his book *The Rebirth of the Clinic*, when patient suffering is ignored, medicine has lost the subjectivity that compassion demands and, therefore, has lost the subjectivity of suffering altogether.¹³ No longer are physicians socialized and expected to pose problems to be addressed collaboratively; rather, they are to solve them using only the technical skills the current medical education model prepares them to use.¹⁴ This preparation, however, does not include enough opportunities to emulate and engage in trustworthy processes with patients.

⁹ Sulmasy, D. P. 2015. Should medical schools be schools for virtue? *World J. Surg.* (15): 514-5.

¹⁰ Sharma, N., K. Walsh, G. Myers, and R. Macvicar. 2015. What is the place of trust in competency- based medical education? *Education for Primary Care : An Official Publication of the Association of Course Organisers, National Association of GP Tutors, World Organisation of Family Doctors* 26 (2): 63.

¹¹ Shionoya, Y. 2001. Trust as virtue. In *Studies in economic ethics and philosophy*. Springer, Berlin, Heidelberg, 3-5.

¹² Piemonte, N. M. 2018. *Afflicted: how vulnerability can heal medical education and practice*. Cambridge, MA: The MIT Press, 63-96.

¹³ Sulmasy, D. P. 2006. *The rebirth of the clinic an introduction to spirituality in health care*, ed. Inc NetLibrary. Washington, D.C.: Washington, D.C. : Georgetown University Press, 3-43.

¹⁴ Piemonte, 34-50.

II. Status of Trust in the Patient-Physician Relationship

The myth of Gyges in *The Republic* establishes the same moral predicament that medical students and practicing physicians today face: are persons in the medical profession still doing the right thing even when no one is watching or aware? Modern medical education, rooted in skill-based *technē*, is complicated by the additional need to socialize and cultivate the social, emotional, and moral character of future physicians who may have grown up in a Western culture with low empathy and high self-protectiveness.¹⁵ The co-construction of trust as a virtue within medical education is necessary for a physician to be considered worthy of trust by a patient.¹⁶ When a physician is applying trust as a virtue, they are neither following a pattern nor applying a rule. S/he must do the right thing at the right time for the right reasons, and then follow through with the action that will have the intended effect of emotional presence, openness to the situational complexity of the patient, synchrony in communication, mutual influence, empathy, and perspective taking.¹⁷

Plato proposes an apt patient-physician relationship within *Laws* that strikes a balance between paternalism and autonomy through collaboration.¹⁸ Within such a relationship, clarity and the ability of both the patient and physician to work on a plan for clinical care is a precondition of collaboration and collaborative professionalism.¹⁹ However, as Molenaar et al. discerns, the development, coaching, and execution of the physician's technical judgment dominate the current state of physician preparation, leaving little room for the development of the physician's humanist judgment.²⁰ Thus, the care of the patient devolves into the assessment

¹⁵ Narvaez, D. 2014. The co-construction of virtue: Epigenetics, development, and culture. In *Cultivating virtue*. New York, NY: Oxford University Press, 251-268.

¹⁶ Shinoya, 14-25.

¹⁷ D'Olimpio, L. 2018. Trust as a virtue in education. *Educational Philosophy & Theory* 50 : 193-202.

¹⁸ Levin, S. B. 2012. The Doctor-Patient tie in Plato's laws: A backdrop for reflection. *Journal of Medicine and Philosophy* 37: 351-72.

¹⁹ *Ibid.*, 351.

²⁰ Molenaar, W. M., A. Zanting, P. Van Beukelen, W. De Grave, J. A. Baane, J. A. Bustraan, R. Engbers, Th E. Fick, J. C. G. Jacobs, and J. M.

and evaluation of the individual physician's technical ability to stave off symptoms, rather than the collective patient-physician's collaborative abilities to achieve better health.

III. Social Disparities in Patient-Physician Interaction Impact Trust

In healthcare, as in other professional fields, discrimination and prejudice are two behaviors that are highly discouraged. However, discouragement is not enough. Medical students do not come to medical education institutions as blank slates, completely without prejudice, and medical training institutions are not completely free of systemic discrimination. Therefore, the medical training model needs to actively work against the perpetuation of discrimination and prejudice that lead to social disparities in healthcare outcomes. When it comes to the relationship between physicians and specific at-risk patient populations, an important consideration is the level of trust in the patient-physician relationship.

The Silver Lining: Patient Rights

One medical education model that institutions have attempted to employ to counter discrimination and prejudice among trainees is to focus on patient rights. On the one hand, medical education focuses on patient rights through the idea of patient-centered care. Patient rights in medicine are related to three fundamental aspects; (1) health as a human right, (2) equitable health care provisions by institutions, and (3) professional relationships between the healthcare provider and the patient.²¹ On the other hand, despite the proposed focus on patient rights and a worldwide push toward a more progressive understanding of treating all individuals with an equitable level of care, disparities still exist in who gets access to and benefits from the technological advances that have been made in medicine and healthcare. This disparity skews patient-physician

Vervoorn. 2009. A framework of teaching competencies across the medical education continuum. *Medical Teacher*, 2009, 31; Vol.31 (5; 5): 390; 390,396; 396.

²¹ Sulmasy, 20-53.

trust toward an overall level of distrust of physicians by historically marginalized, oppressed, and exploited groups.²²

Case in Point: A Clear Discriminatory Dilemma

Based on opinion polls on the public trust of physicians, conducted by Blendon et al., less than half of low-income Americans agreed that physicians can be trusted.²³ Compared to middle and high-income Americans, low-income Americans expressed more (48% v 59%) dissatisfaction with medical treatment at their last visit to the doctor.²⁴

Further, the literature notes that, historically, African Americans have experienced maltreatment when seeking care.²⁵ As highlighted by Cuffee et al., in a sample of African-American patients with hypertension, it was found that racial discrimination was associated with lower medication adherence.²⁶ Based on Cuffee et al.'s findings, the lower medication adherence was associated with a lack of patient trust in their physicians.²⁷ The lack of trust essentially devolved into a lack of adherence to physician suggestions and guidance and leads to a vicious cycle of patient-physician mistrust.²⁸

Another at-risk group, the homeless, also have been found to mistrust physicians due to a history of challenges. Utilizing the Vulnerable Populations Healthcare Behavior Model (VPHB), O'Toole et al. found that homeless veterans had various reasons to hold

²² Sohler, N., L. Fitzpatrick, R. Lindsay, K. Anastos, and C. Cunningham. 2007. Does patient- provider racial/ ethnic concordance influence ratings of trust in people with HIV infection? *AIDS and Behavior* 11 (6): 884-96.

²³ Blendon, R. J., J. M. Benson, and J. O. Hero. 2014. Public trust in physicians — U.S. medicine in international perspective. *The New England Journal of Medicine*(371): 1570-2.

²⁴ Blendon et al., 1560-1572.

²⁵ Cuffee, Y. L., J. L. Hargraves, M. Rosal, B. A. Briesacher, A. Schoenthaler, S. Person, S. Hullett, and J. Allison. 2013. Reported racial discrimination, trust in physicians, and medication adherence among inner-city african americans with hypertension *American Journal of Public Health* 103 (11): e55-62.

²⁶ Ibid., e55.

²⁷ Ibid., e57.

²⁸ Ibid., e56.

distrustful attitudes towards healthcare providers.²⁹ For example, based on a survey, O'Toole et al. found that poor treatment and stigma surrounding their socioeconomic ability to pay for care often hindered homeless veterans from seeking treatment.³⁰ The unfortunate outcome of mistrust plaguing the patient-physician relationship is a further hindrance in addressing the health disparities based on socioeconomic stigmatization.

IV. Embedding Collaborative Professionalism as an Innovative Methodology

Thus far, the problem at hand is apparent: medical professionals lack in their training the ability to garner the trustworthy patient-physician relationship needed to do their work. Based on this presentation of medical education practices and the cases of patient-physician mistrust documented, it is clear that a solution, or at least a clearer emphasis on the enrichment of physician training, if not for all healthcare professionals, is needed. More recent discussions in the literature concerning a new era of professional enrichment and collaboration that may be a start to solving the problem concerning patient-physician trust is related to collaborative and transdisciplinary professionalism.³¹

It must be noted that there are academic institutions that are making improvements to train future physicians in a patient-centered manner, through which students' actions and their effects within the medical setting are evaluated.³² As one study reveals, medical students in a family medicine clerkship at one academic medical institution found it beneficial for students to write out their reflections

²⁹ O'Toole, T. P., E. E. Johnson, S. Redihan, M. Borgia, and J. Rose. 2015. Needing primary care but not getting it: The role of trust, stigma and organizational obstacles reported by homeless veterans. *Journal of Health Care for the Poor and Underserved* 26 (3): 1019.

³⁰ Ibid.

³¹ Cuff, P. 2013. Establishing transdisciplinary professionalism for improving health outcomes: Workshop summary. *The National Academies Press*, 43-54.

³² Schwiebert, P., D. Cacy, A. Davis, and S. Crandall. 1996. Using narrative student feedback to evaluate the impact of a family medicine clerkship. *Teaching and Learning in Medicine* 8 (3): 158-63.

on what they had experienced during their clerkship.^{33,34} The institution concluded that students' reflections led to a deeper understanding of not only the patient-physician relationship, but also how to earn patient trust and how that trust benefits the patient and the physician.^{35,36,37} Achieving a better understanding of the necessity and value of trust in the patient-physician relationship can be, as exemplified, initiated during medical education through reflective student exercises.^{38,39}

A Sense of Togetherness

The saying goes, "it takes a village to raise a child." In the same way, it takes a team of radiologists, nutritionists, social workers, nurses, and so many more specialized individuals to aptly care for a patient to full recovery. When it comes to the concept of collaborative professionalism, teamwork must have two characteristics for efficiency: (1) a nature of interdependence and (2) the development of specialized expertise.⁴⁰ Not only should the team surrounding a patient depend on one another for input and collaborative discernment, but also each individual must present their expertise as a foundation for any plan of action for a patient. The concept here, per Racko, is given the name 'collaborative professionalism.' Such systemic interdependence and trust garners for the patient a sense of *cura personalis*. The Latin term *cura personalis* translates as *care for the*

³³ Levin, 352.

³⁴ Wong, A., and K. Trollope-Kumar. 2014. Reflections: An inquiry into medical students' professional identity formation. *Medical Education* 48 (5): 489-501.

³⁵ Levin, 356.

³⁶ Wong and Trollope-Kumar, 491.

³⁷ Pellegrino, E. D., D. C. Thomasma, and J. L. Kissell. 2000. *The health care professional as friend and healer: Building on the work of edmund D. pellegrino*. Washington, D.C.: Washington, D.C.: Georgetown University Press, 1-34.

³⁸ Wong and Trollope-Kumar, 492.

³⁹ Pellegrino, Thomasma, and Kissell, 5-6

⁴⁰ Racko, G., E. Oborn, and M. Barrett. 2017. Developing collaborative professionalism: An investigation of status differentiation in academic organizations in knowledge transfer partnerships *The International Journal of Human Resource Management*: 1-22.

person. By building a team of professionals to uplift patient care beyond performing rounds and hourly patient check-ins, professional interdependence in patient care embeds trust more naturally and intrinsically into the physician armamentarium.

Further, as part of this innovative methodology, transdisciplinary professionalism encourages positive patient-physician outcomes.⁴¹ By encouraging the concepts of collaborative professionalism at the outset of training for medical professionals in their medical education, the conceptual schemas of trust and human care transcend and assert the psychosomatic unity needed in modern medicine for efficient and trustworthy care by physicians.

Conclusions

Healthcare is currently at a crossroads in the United States. Trust as a central force in healthcare is key. While there are attempts by institutions to 'clear the air' and train their future healthcare professionals to avoid social discrimination and prejudice, it is clear the garnered and heralded notion of 'doctor knows best' often takes precedence, even from the beginning of healthcare professional training. In addition to deterring patient trust in general, this notion perpetuates inequities and further places at-risk groups in harm's way. This brief exploration of the current system of medical education and the impact that the modern approaches to medicine has had on patient-physician trust contributes to the case for improving the effectiveness of physician preparation. One strategy to introduce more humanistic and collaborative professionalism considerations into the medical education journey is to incorporate elements of collaborative, transdisciplinary, professional education and reflective practices that prepare future physicians to work collaboratively with patients to build a trustworthy relationship.

⁴¹ Cuff, 90.

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