ORIGINAL ARTICLE

Is there a moral duty for doctors to trust patients?

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In this paper I argue that it is morally important for doctors to trust patients. Doctors' trust of patients lays the foundation for medical relationships which support the exercise of patient autonomy, and which lead to an enriched understanding of patients' interests. Despite the moral and practical desirability of trust, distrust may occur for reasons relating to the nature of medicine, and the social and cultural context within which medical care is provided. Whilst it may not be possible to trust at will, the conscious adoption of a trusting stance is both possible and warranted as the burdens of misplaced trust fall more heavily upon patients than doctors.

The obligation of doctors to be trustworthy is a recurrent theme in medical ethics, with breaches of this trust being widely discussed and heavily censured.[1–3] Relatively little attention has been paid to analysing other aspects of trust in the doctor-patient relationship, such as the trust, or lack of trust, that doctors may have in their patients.[4 5] The presence or absence of such trust has, however, both moral and practical implications. In this paper I discuss the importance of trust, the ways in which doctors may or may not trust patients, and potential barriers to trust. Despite the difficulties, I argue that there is a moral duty for doctors to trust patients.

TRUST OR RELIANCE?

Some degree of reliance is a necessary part of interactions between doctors and patients. Consultations typically start with the patient's account of what is wrong; the doctor relies upon this testimony to guide her subsequent history-taking and examination. The doctor then relies upon the patient to cooperate with suggested treatment, and to report back on any progress. Reliance of this sort is present in many medical encounters; the major exceptions occur in contexts in which patients are unable to participate, such as emergency medicine or intensive care.

Can we say that doctors rely on patients to give accurate accounts in the same way that they rely upon sphygmomanometers to give accurate blood pressure readings, or is this reliance better described as trust? Trust is an all encompassing term, ranging from limited domains in which A trusts B to do X, through to the ill-defined but all-pervasive interpersonal trust which characterises deep relationships. Trust may extend to institutions as well as to individuals.

Several recent analyses of trust offer useful insights into its nature.[6–9] Trust is a complex mixture of beliefs and expectations consisting of emotional as well as cognitive elements. Consciously trusting another person involves examining the reasons that form the basis for those beliefs and making a judgment about them.[7] But often we trust or distrust unthinkingly, reflecting our prejudices rather than a critical evaluation of our reasons to give or withhold trust. Trust involves an attitude of optimism about the possible responses and competence of the person trusted: not only must they have the skills to do what they are trusted to do, but they must also have some inclination to be trustworthy, to be favourably moved by the thought that they are being trusted.[8] Trust may lead to vulnerability because when we trust another person we grant them discretionary powers, which include the power to help or harm the one trusting.[6]

What of the distinction between trust and reliance? One difference seems to be the attitude we have towards being let down: when we trust and are let down we feel betrayed, in contrast to the annoyance or disappointment we feel if something proves unreliable. If my sphygmomanometer is faulty, leading to incorrect blood pressure readings, I may be annoyed but I do not feel betrayed in the way that I do if a patient knowingly deceives me. Betrayal is one of what are known as the reactive attitudes; these are attitudes that we are ready to hold in our dealings with other people, such as gratitude, betrayal, and resentment.[10] In contrast we do not hold these attitudes towards inanimate objects such as ladders or timetables; we do not blame these kind of things for letting us down the way we would blame a person. This attitudinal difference between trusting and relying has been described as taking the participant stance: "When you trust someone to do something, you rely on them to do it, and you regard that reliance in a certain way: you have a readiness to feel betrayal should it be disappointed".[11]

Trust is like a lens which colours our vision; if we trust a person we interpret their actions favourably in the light of that trust (conveniently for those who betray trust). Conversely, lack of trust may prevent us from ever seeing proof of trustworthiness.

THE MORAL AND PRACTICAL IMPORTANCE OF TRUST

Despite disagreements over the exact definition of trust, there is general agreement about the moral importance of trust: "*Whatever* matters to human beings, trust is the atmosphere in which it thrives."[12] Trust is intrinsically valuable as constitutive of relationships; friendships and partnerships of all degrees of intimacy are impossible in the absence of trust.[13] Trust also makes it possible for us to depend upon others and to cooperate, thus enriching the range of possibilities in our lives.[14 15] A willingness to trust can be seen as morally valuable because trusting another person involves treating that person as a moral agent.[16] Taking the participant stance requires treating the other as an autonomous person, responsible for their own choices and actions, otherwise there could be no blame for breaches of trust.[9] A refusal to consider a relationship of trust precludes treating the other as a moral agent by denying them the opportunity to demonstrate responsibility, thus reducing the other to object-like status.

Trust may be therapeutic, in the sense that trusting a person (perhaps in situations of uncertainty or the absence of good reasons to trust them) may increase their trustworthiness: this presupposes a belief in the possibility of such trust positively influencing the trusted person's behaviour.[16 17] In this sense, trust is a kind of moral support allowing the recipient the chance to live up to expectations. We may conceive of trust as a practical and ethical approach to constructively influencing behaviour.[7]

Placing these observations about trust into the medical context leads to some important conclusions. Both trust and distrust take place within a relationship which allows for the possibility of praise or blame. Such a relationship seems integral to the notion of respect for autonomy. We do not necessarily trust all those whose autonomy we respect, but we cannot respect autonomy if we do not even recognise the other as a moral agent, capable of making choices and bearing responsibility for those choices. If we think of autonomy as a capacity to be fostered and exercised, surely it is easier for a patient to act autonomously if they receive the moral support of trust from their doctor?

A trusting stance is central to the doctor-patient relationship. Some degree of trust is necessary to create a climate in which honest communication may flourish. Trust allows patients to express their concerns without fear of being disbelieved or disparaged. Over time, the presence of trust facilitates the development of deeper doctor-patient relationships, which may be necessary for certain types of care, such as disclosure and management of sensitive or potentially stigmatising problems. When a patient is trusted, her experiences are validated and her competence recognised. This can lead to an enriched view of beneficence which incorporates the patient's own expertise into the conception of her best interests.[18]

Distrust is not morally neutral since harms may ensue when doctors do not trust patients. Being distrusted can be very disempowering for distrust precludes the possibility of the distrusted person bringing about a change in the distruster's stance. Patients already lack power in the medical context; being distrusted shifts that balance of power further towards the doctor. Added to the existing burden of ill health, distrust can be an unwarranted extra harm to patients.

What of the potential therapeutic benefits of trusting patients? The therapeutic aspects of the doctor-patient relationship are difficult to identify and measure, however, some authors have argued for the indivisibility of personal and clinical contributions to wellbeing.[19] A doctor who trusts her patients may have greater therapeutic power than one who does not, because of the ill-defined but important effects on the patient of being trusted.[20] In specific circumstances, trust may be a way of offering crucial moral, and then medical, support for patients. This situation may occur in the care of patients who might otherwise be distrusted, such as patients with addictions. In addition, clinical care is more likely to flourish within a relationship characterised by trust because this facilitates cooperation. This has direct health benefits for the patient, and also benefits the doctor, who may more easily share responsibility with a trusted patient.

OPPORTUNITIES FOR DOCTORS' TRUST OR DISTRUST OF PATIENTS

Doctors generally take certain aspects of the consultation for granted: that the patient will be genuinely seeking medical care; that they will give a more or less accurate account of their problems, and that they will cooperate with treatment. In ideal consultations, doctors trust patients in these three areas of motive, testimony, and competence. However, it is worth trying to pin down exactly what it is that the patient may be trusted to be or do.

With regard to motives for seeking medical care, trust concerns the shared aims of the consultation, that is to diagnose the problem and work towards a solution. Trustworthy patients might be characterised by their desire to seek help for their illness and to understand and improve their health. The motives of the patient may be distrusted, however, if their request for medical care is seen as unwarranted or fraudulent in some way, or if the patient is judged to be an unworthy recipient of care. Suspicion about ulterior motives, or obvious personal gains can lead to a high index of distrust, as for example, in the care of patients eligible for compensation or disability payments. The untrustworthy patient does not share the overt goals of the consultation but feigns symptoms, for example, pain, to achieve her own agenda, which might be to obtain drugs of addiction. The notion of the worthy patient arises here, with doctors making judgments about the validity of patients' claims to medical services.

The history given by patients is a kind of testimony, consisting of two components. First, is the person telling the truth? Are they sincere and speaking with integrity, honestly reporting without important exaggerations or omissions? The second component of testimony is epistemic competence: is the person sufficiently skilled to recognise important symptoms? Can this patient recognise when she is ill and when medical attention is warranted? The doctor may trust the patient with respect to either or both of these components. Trust in the honesty of the patient is not usually questioned; a presenting complaint of abdominal pain is accepted as the patient's sincere perception of his problem, with the recognition that the doctor's expertise may in fact find differently. The epistemic competence of the patient may, however, come into question if the patient's account of symptoms seems far from reliable, or the urgent problem turns out to be trivial. Even though a lack of competence may not be blameworthy, the overall impact upon the testimony can be that the doctor questions its trustworthiness.

Doctors may have difficulty believing patients with surprising or unusual symptoms as the acceptance of astonishing reports requires both a high degree of trust in that person's veracity and also a willingness to suspend accepted medical orthodoxy. Some symptoms are less trustworthy than others, such as pain or fatigue which do not have a corresponding and accepted physical sign, and are therefore less easily trusted than broken bones or severed tendons. Distrust of testimony may lead to patients' symptoms being discounted or labelled with what are often pejorative terms such as "medically unexplained". Distrust may manifest in an unwillingness by the doctor to act on the patient's account, or by dismissal of symptoms as trivial and unworthy of further attention.

Competence is the final area in which doctors may trust or distrust patients, both in a general sense and in a more specific practical sense related to aspects of care. Patients whose general competence is trusted may be given sufficient information to make informed decisions about diagnosis or treatment, and their subsequent preferences respected. Lack of trust in a patient's competence to understand medical issues may lead to withholding information. This is not necessarily the result of a doctor consciously weighing up a patient's capacity for understanding and decision making, and deciding, on balance, that she does not trust the patient's capacities in these areas. Rather the doctor's thinking may revolve around reasons to do with belief in her own expertise and lack of belief in the patient's. These beliefs then prevent the doctor from trusting the patient enough to voice and act upon his own preferences, with the effect of giving the patient the message that the doctor is the expert and that patients are not competent to influence decisions.

Practically competent patients can be trusted to follow medical instructions, to fill the prescription and finish the course of antibiotics, and to recognise when further medical attention is necessary. Trust in patients' competence can lead

to greater degrees of cooperation and respect for autonomy, conversely the patient who is not trusted may be subject to greater surveillance through tests and check-ups.[21]

So far I have described situations of trust or distrust, but perhaps more worrying than distrust are those interactions in which the doctor does not take the participant stance at all. This is not so much a judgment about the trustworthiness of a patient's testimony or competence but a refusal to see the patient as a moral equal, as someone who *could* be trusted or distrusted. Sometimes this may be warranted in the treatment of unconscious or otherwise incompetent patients; the morally troubling situation is when this kind of objectification occurs with patients who should elicit the participant stance from their doctors.

The examples of distrust discussed above will be familiar to practitioners from all branches of medicine, but perhaps not under the label of distrust. Rather these actions may be seen as an integral part of the medical quest for diagnostic certainty, an important part of good clinicianship, or a way of safeguarding access to public resources. Despite these potentially justifiable reasons, I believe these are all examples of doctors distrusting patients with the consequence that patients can feel disbelieved, incompetent or somehow undeserving. If we accept that these examples of distrust occur in practice, it is worth asking why this should be so.

BARRIERS TO TRUST

There are a number of possible reasons why doctors might find it difficult to trust patients. The nature of medicine and the way in which it is taught may be one contributing factor. Medicine strives for objectivity; the purpose of the diagnostic interview and examination is to transform the initial chaos of the patient's presenting complaint into a series of symptoms and signs linked by reference to a pathophysiological disease state. This creates a need to standardise patients' signs and symptoms and to filter them through a medical sieve. Symptoms which fit the pattern are accepted, and those which do not are rejected, which is to say they are in some sense disbelieved. Physical signs and clinical investigations are privileged over accounts of symptoms. Systematic history-taking can be like a cross examination, with the attendant implication that the patient cannot be trusted to know the relevant details from the insignificant. Part of the doctor's clinical acumen lies in weeding out the inconsistencies and finding the important hidden clues in order to reach the correct diagnosis. Doubting and challenging patients' histories can be valuable attributes in this context; the cost of this scepticism is not counted in terms of fostering distrust of patients' testimonies. Related to this quest for diagnostic certainty is the fear of vulnerability or loss of face which may occur if a doctor trusts a patient's account against accepted medical orthodoxy. If the trust is misplaced, this can cast doubts on the doctor's own competence.

Sometimes doctors may distrust patients' accounts of treatment failures, doubting either their veracity or their competence in having complied with the treatment. A reaction of distrust may be part of a natural human tendency to distrust accounts which one wishes to disbelieve. This kind of distrust can be likened to shooting the messenger, especially when the doctor feels that medical science is on her side and that the patient *should* be better. If they are not, this must surely be due to their incompetence as patients.

Part of the medical role in publicly funded health services is that of guarding access to resources. This role suggests another possible reason for distrust of patients' symptoms. Refusing a patient access to an investigation or treatment may be easier if the doctor does not believe that the patient is telling the truth about her symptoms. If accounts of symptoms can be distrusted, they may then be discounted, in which case there is no need for further attention. This may be an easier option at times than admitting patient need which cannot be met by the existing resources of health services (raising the question as to whether private medical care circumvents this cause of distrust). In addition, admitting patient competence in assessing their own needs takes diagnostic power and authority away from doctors. This undermines the medical role of resource guardian, providing a further possible reason to distrust patient competence.

The social context of medicine may also contribute to distrust of patients. Many medical interactions occur between strangers and under pressure of time, requiring doctors to make very swift decisions about how much to trust the stranger-patient. There is no time to consciously reflect on the warrantedness or otherwise of distrust in these situations. Violence towards doctors has become more common, both in emergency departments and on home visits, giving doctors in some circumstances reason to distrust the motives of those requesting medical attention. There has also been an increase in complaints and litigation against doctors, leading to a climate which fosters distrust rather than trust.

In addition there have been several widely publicised incidents of medical untrustworthiness through dishonesty or incompetence, with the subsequent airing of often very forceful views about the untrustworthiness of doctors. Faced with this public suspicion, distrust on the part of doctors may be a fairly natural defensive response.

Finally, distrust may be a manifestation of dissatisfaction or weariness experienced by doctors, and may be a way of guarding against demand and keeping patients at a distance. Trusting a person involves vulnerability and creates expectations; distrusting patients makes it easier to maintain distance, reduce demand, and avoid expectations.

TRUSTING PATIENTS

Is it coherent to argue that doctors should trust patients? Making the argument implies that trust is a matter of will and that it is possible for doctors to trust as they choose. Perhaps the more cautious claim should be that it is morally desirable for doctors to aspire to trust and to adopt a trusting attitude or willingness to trust. This leaves open the question as to whether it is possible to trust at will, while recognising that it is possible to try and alter one's readiness to trust. We can direct our attention towards the grounds for trust and away from distrust; a kind of voluntary refocusing which allows us to trust.[8] Aspiring to trust requires evaluation of reasons for not trusting, such as prejudice or stereotyping. If negative attitudes can be suspended, this may allow a more open assessment about the warrantedness of trust in this specific situation.[7]

Adopting a willingness to trust will not be suitable for all encounters; deceptive patients do exist. Trusting the untrustworthy can lead to exploitation and loss of meaning in the doctor-patient relationship, although it is worth looking where the risks of misplaced trust fall. If a patient has been deceptive in soliciting medical care, there is the risk that the doctor's time and efforts are wasted or misplaced. In some cases the risks are borne by society rather than the individual doctor; if, for example, a deceptive patient gains unjustified access to sickness benefits or compensation. The situation is more complex with problems such as addiction. On the one hand, doctors often feel betrayed by addicted patients; the vulnerability here seems to be professional, in that not detecting the deceptive addict strikes to the heart of professional competence. In addition, there are medical reasons for striving for the right diagnosis; medical care is misdirected unless the patient is correctly diagnosed as suffering from an addiction disorder rather than whatever presenting complaint is used as a cover for requesting drugs.

CONCLUSION

In summary, there are several reasons why doctors' trust of patients is morally desirable. In offering trust, doctors reaffirm

the moral agency of patients. Trust contributes to the fulfilment of the patient's capacity for autonomy, and can enrich the medical understanding of beneficence. Lack of trust is an unfair burden added to existing burdens of ill health, creating hostility and inhibiting good clinical care. Perhaps most importantly, trust is crucial to the development of morally respectful relationships, which in turn are central to medical practice. Despite potential pitfalls and very real practical barriers, doctors should consciously direct their attention towards trusting patients, for the burdens of misplaced trust fall more heavily upon patients than doctors.

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