

The background features a textured, cracked surface. The top half is a reddish-brown color, and the bottom half is a dark teal color, separated by a diagonal line. The cracks are irregular and run across the entire surface.

2018 ABIM FOUNDATION FORUM

[Re]Building Trust

Summary Paper

By Timothy Lynch

Health care leaders came together in July 2018 to consider the importance of trust and strategies for building and rebuilding it across a variety of health care relationships. Participants discussed relationships between clinicians and patients (both patients generally and underserved patients) and between physicians and the organizations with which they are affiliated. They also considered the public trust in the medical system as a whole, and issues of trust in how the public receives information about medical advances.

Building a Trustworthy Community

Richard Baron, MD, the President and CEO of the American Board of Internal Medicine and the ABIM Foundation, opened the Forum with thoughts about why the Foundation had chosen trust as a topic. He referenced the turmoil in the nation and the growth of a “post-fact, post-truth” environment. “I think historians will describe this era as one of profound change, in which people come to doubt scientific facts,” Dr. Baron said. “This will change how people interact with doctors; they trust what we have to offer, but that trust is under profound threat.”

Elizabeth McGlynn, PhD, Vice President, Kaiser Permanente Research, discussed how the ABIM Foundation came to adopt trust as a strategic focus area for its programmatic work. She noted how trust arises as an issue in so many different areas of health care, and said that as a researcher, it distresses her to think that the work she does to produce true and objective findings may no longer be valued.

After watching a video that featured many participants’ thoughts about trust, Dr. Baron suggested that making oneself vulnerable is a “precondition for trust.” Dr. McGlynn said that patients are often vulnerable when they visit their doctors, and that vulnerability, authenticity and transparency are all characteristics that can help physicians build trust. Dr. Baron echoed the importance of transparency. “In a world where people are fearful, you want to assure them they are seeing the whole picture,” he said.

Drs. Baron and McGlynn also highlighted the importance of reciprocity. Dr. McGlynn discussed it in the communication context. She said that research has demonstrated that patients are interrupted frequently, and shared a story about how she sought out a physician who would talk with her when she was deciding how to handle a medical issue. When that physician spent substantial time speaking with her about her options, it built significant trust.

The final theme they prioritized was reliability. “Part of both building and maintaining trust is saying what you’re going to do and then actually doing it,” Dr. McGlynn said. Dr. Baron discussed how betrayals of trust reverberate through future interactions. “Any time the health care system has failed to be reliable for someone, every subsequent clinician who encounters that patient will need to address that and re-earn that trust,” he said.

After these introductory thoughts, participants spoke with one another about their own stories of building and rebuilding trustworthiness. Some participants then shared elements of their discussions with the full group, including suggestions for additional important ingredients to build trust. These themes included communication, leadership, and the importance of building systems that can withstand potential breaches in trust.

“Part of both building and maintaining trust is saying what you’re going to do and then actually doing it.”

*Elizabeth McGlynn, Vice President,
Kaiser Permanente Research*

Kimball Lecture

Adam Berinsky, PhD, the Mitsui Professor of Political Science at MIT, delivered the Kimball Lecture, the Forum keynote address. Dr. Berinsky discussed trends in public perceptions of the media and science, and offered suggestions for addressing mistrust.

He cited a dramatic drop in public confidence in experts and expertise, citing serious declines in trust in the media and in medicine over the last few decades. Dr. Berinsky said that while confidence in the leaders of the scientific community had remained steady since the 1970s, confidence in medical science had actually declined. And trust in science had become a partisan issue, with significant declines among conservatives accompanied by increases among liberals.

Dr. Berinsky described how he advised his MIT colleagues working on climate science—who thought they could persuade skeptics by citing facts and their status as MIT scientists—that such appeals to authority were no longer effective. He then posed the question of what strategies *could* work to build credibility in a low-trust world.

He discussed a study he conducted to examine who believed the allegation that the Affordable Care Act authorized “death panels” to deny health care resources to particular individuals, and to test the effectiveness of a set of approaches to rebut that false claim. The approaches included providing counterarguments from a nonpartisan source; a Republican source; and a Democratic source. Of these, the only successful approach was the use of a Republican source, and the success of even that approach faded over time; across the board, correction rates faded. He extrapolated from this evidence about the value of ‘statements against interest’ from unexpected sources that a possible approach to promoting vaccine safety would be to highlight, for example, the mother of a child with autism who says that vaccines were not responsible.



Adam Berinsky, PhD, the Mitsui Professor of Political Science at MIT, shares his research insights on the challenges of combating misinformation among the public in the annual Kimball Lecture.

Dr. Berinsky proposed a few lessons for those who are interested in combating misinformation. First, he said that it is insufficient to tell people to trust; one must persuade them to do so. Second, he said one needs to speak the audience’s language, rather than the jargon of the expert on display in medical journal articles. Third, as in the “death panels” study, a reliance on messengers speaking against their apparent interest is more likely to succeed; for example, the decision of McDonald’s to discontinue selling “super-sized” portions of French fries spoke volumes about the healthiness of the product. Fourth, he suggested that some people were beyond persuasion and recommended focusing energies on the group of people whose belief in false claims is soft or uncertain.

Dr. Baron said he was “sobered” by the ineffectiveness of nonpartisan sources (such as fact-checking organizations) in combating misinformation. Dr. Berinsky called this the “most depressing part of my findings.” “We like to think the world is NBA basketball, but really it’s street basketball,” he said. “We’re playing a game where everything goes. So thinking about strategies that as experts we don’t think we should have to use is important.”

Dr. Baron then suggested that Dr. Berinsky was inviting the group to think about customizing how information is presented to patients. He agreed that a “one size fits all” strategy for communication is ineffective, and that clinicians do need to tailor their communication based on factors such as race, gender, levels of education, and even partisanship.

Mai Pham, MD, Vice President, Provider Alignment Solutions at Anthem, asked about communicating with patients who doubt established science about vaccines or other topics. Dr. Berinsky said clinicians need to make patients feel that they understand their concerns, and to experiment with different approaches to explaining why vaccination is appropriate. “Thinking creatively is the most important first step in the communication of information,” he said.

Gwen Darien, Executive Vice President, Patient Advocacy at the National Patient Advocate Foundation and Patient Advocate Foundation, asked how the credibility of experts can be maintained as evidence changes. “It’s really tricky to convey that authority sometimes leads you to a place where you’re not sure what the answer should be,” Dr. Berinsky said. “If you’re really unsure about something, presenting patients with different options and saying ‘Here’s what we know and here’s what we don’t’ is a good strategy.”

John Rother, JD, President and Chief Executive Officer of the National Coalition on Health Care, suggested that the growth of quality measurement may have undermined patients’ trust in the health care system. Dr. Berinsky said that transparency can have unintended consequences on trust and that information needs to be placed in the proper context to avoid them.

Trust and the Media

Participants heard from a panel discussing the state of reporting about health care in an era where trust in the media has fallen dramatically. Drawing on one of the themes from Adam Berinsky’s presentation, moderator Jackie Judd asked how journalists covering health care policy identify experts who will be trusted. Noam Levey, National Healthcare Reporter for the Los Angeles Times, said that reporting on the Affordable Care Act offered his first experience of how poorly equipped the media was to address false rumors such as the existence of death panels. “We needed to think more critically about who to go to as a trusted voice,” Levey said. “I’ve tried to find and reflect the viewpoint of some people who are skeptical of the policy I’m writing about. It behooves those of us who write about this to be more empathetic about where these people are coming from.” Joanne Kenen, Executive Editor, Health Care at Politico, suggested that writing about health care policy is “so complicated [because] the national debate about health policy is really about politics.”

Gary Schwitzer, Publisher of HealthNewsReview.org (HNR), founded HNR to analyze how the media covers stories about health and medical science and to help consumers and patients improve their critical thinking about health care claims. He said that 60–70 percent of the media stories and press releases that HNR reviews receive unsatisfactory grades for adequately quantifying the scope of potential benefits and harms of the intervention at issue, evaluating the quality of the evidence, and addressing cost issues. Looking just at press releases, up to 90 percent are graded poorly.

“We needed to think more critically about who to go to as a trusted voice.”

Noam Levey, National Health Care Reporter, Los Angeles Times

Mr. Schwitzer said that journalists are still producing some of the best health care journalism ever seen in the United States. At the same time, he described a “daily drumbeat of dreck” appearing in media outlets across the country. He attributed the poor quality of much health coverage to the demands placed on journalists to generate increasing amounts of content with reduced or nonexistent training.

Ms. Judd asked Joseph Ross, MD, MHS, Associate Professor of Medicine and Public Health at Yale University, about the responsibilities of institutions that publish scientific research. Dr. Ross said that while press officers are tasked with spreading the word about their institution’s research accomplishments, he saw his role as helping journalists understand the context. He said that most health research is incremental, and that it can be challenging to write about incremental steps without misleading or overhyping findings. He said that the way that institutions choose to publicize findings has a significant impact on the resulting coverage. “We know that press releases matter,” Dr. Ross said. “If they talk about absolute risk reduction or harms of treatment, so do the articles. Packaging matters.” Ms. Kenen agreed, saying that less experienced reporters are particularly likely to “write it how they’re selling it” when they receive press releases from reputable institutions.

Ms. Kenen also noted that the ability of the media to influence how people understood scientific findings was limited by the vast volume of unmediated health and science information available on Facebook and other social media platforms.

Reflecting on Day One

Bob Wachter, MD, Chairman of the Department of Medicine at University of California, San Francisco, summarized a set of conditions that have affected and continue to influence trust in health care, including:

- a growing volume of competing and contradictory sources;
- recommendations that change over time;
- overhyped research findings;
- conflicts of interest and perceptions among the public that medicine is just a business;
- the quality and safety movements that highlighted medicine’s defects;
- clumsy efforts to restrain health care costs;
- an increasingly diverse society; and,
- tribalism in politics.

He suggested that our feelings about trust generally are complicated and contradictory (noting that a lack of trust is sometimes an appropriate and healthy stance), but that we all have communities of trust. In recent years, the tribes that compose these communities of trust have become hardened and ideologically homogenous, with declining trust in—or even contact with—those outside our tribe. He said this trend makes it harder for experts to generate trust from those who perceive them to be outside their tribe.

Dr. Wachter described both the growth in information available to patients and the elements of practice that draw physicians away from patients (e.g. EMR data entry requirements) as challenges to trusting clinician-patient relationships. He suggested that a move toward authenticity and vulnerability, and away from the concept of the all-knowing doctor, could help build trust, as could emphasizing transparency. Along those lines, he suggested that the success of Open Notes, which has provided 25 million patients with access to their notes, has engendered trust that the profession isn’t hiding anything. [View highlights of Dr. Wachter’s remarks.](#)

He closed by arguing that although the trust problem may be unsolvable at the national health care policy level (at least in the short term), there was reason for optimism at the level of the clinician-patient relationship. He suggested that a 1:1 relationship is more conducive to generating trust and avoiding tribalism, and that there were promising reforms for some of the technical issues impairing strong relationships, such as reducing documentation requirements for physicians or building digital systems that promote better clinician-patient communication.

Trust in Health Care: What Do We Know?

The Forum's second day began with presentations from two experts on trust in health care. Dhruv Khullar, MD, MPP, of the Weill Cornell Department of Healthcare Policy & Research, said that although Americans are generally more satisfied with their own care than residents of other nations, they are considerably less likely to trust doctors as a profession. He pointed to three reasons why this lack of trust matters:

Trust makes people more likely to engage in healthful behaviors: He pointed to research demonstrating that patients who trust their doctors are more likely to take their medications as prescribed, exercise, eat a healthy diet, and use condoms. Trust also is critical for patient satisfaction and the development of long-term physician-patient relationships.

Trust can enable innovation: Dr. Khullar noted the importance of patients' willingness to engage with new technologies and treatments, and said that trust was among the best predictors of whether patients would participate in a clinical trial.



Dhruv Khullar, MD, MPP, a researcher at the Weill Cornell Department of Healthcare Policy and Research, discusses why trust matters in health care.

Trust helps us respond to public health crises and other epidemics: Dr. Khullar pointed to a Liberian study showing that people who did not trust the government were less likely to engage in precautionary measures to protect themselves from the Ebola virus.

Dr. Khullar said that rebuilding trust requires answers on three dimensions of trust:

- 1) Competence: Do you know what you're doing?
- 2) Transparency: Will you tell me what you're doing?
- 3) Motive: Are you doing this to help me or yourself?

For clinicians, he cited the importance of clear communication, a history of doing what you say will do for patients, creating an expectation for a long-term relationship through repeated interactions, minimizing the power difference with patients, disclosing conflicts of interest, and giving patients greater say in the design and goals of research.

Lisa Cooper, MD, MPH, Bloomberg Distinguished Professor at Johns Hopkins University, then spoke about trust in the health care system within racially and culturally diverse communities. She said that mistrust has developed among members of these communities due to their knowledge of historic discrimination and institutional racism, reinforced by their personal experience of discrimination and current events. She also cited the Institute of Medicine's 2003 report that differences in care received by members of minority communities resulted from discriminatory processes in the health care system.

Dr. Cooper noted that researchers had found that trust levels among racial and ethnic minority groups in their primary care physicians were much lower than among whites, and that African American and Mexican American patients in Chicago were twice as likely as white patients were to report low levels of trust in health care institutions.

She then described factors that could cause these lower levels of trust. One study found that physicians were more "verbally dominant" and sounded less friendly when talking to patients from minority groups. Another study found that where patients and physicians were from the same racial background, visits lasted 2.5 minutes longer.

Dr. Cooper said she and her colleagues did not believe that most physicians were intentionally providing lesser care to patients of another race; rather, they suspected, and wanted to study, the possibility that implicit bias was playing a role. As part of their research, physicians took the Implicit Association Test, which showed that about 70 percent had implicit bias. They found that physicians who scored high for implicit bias had poorer communication, particularly with African-American patients. In return, African-American patients rated these physicians as less respectful, and exhibited lower levels of trust in them.



Lisa Cooper, MD, MPH, Bloomberg Distinguished Professor of Medicine and Director of the Johns Hopkins Center for Health Equity, presented findings from studies of trust in health care among racially and ethnically diverse populations.

Dr. Cooper and her colleagues looked to help address this trust problem by helping improve physician communication skills. They conducted a randomized trial in which physicians received computer-based communications training and patients were coached by community health workers; the two approaches were tested alone and in combination. The study found that patients who received coaching and were treated by physicians who received training showed greater improvement in blood pressure control.

She discussed five ways in which health care organizations can build trust with minority patients, including having leaders speak about their commitment to health equity, using data to better understand the health and care patterns of the populations they serve, building relationships with community partners to better address patients' needs, and communicating with patients and community members in ways that are clear and responsive to their needs.

Dr. McGlynn asked how aware physicians were of their implicit biases, and whether awareness makes a difference in how they practice. Dr. Cooper said that physicians practicing in underserved areas do not practice there for the purpose of delivering disparate care, and that many were particularly disturbed that their implicit bias was manifested in their behavior. "You may not be able to change how your brain is wired, but you can change what you do," she said. "A lot of providers are receptive to that message."

David Meltzer, MD, PhD, Fanny L. Pritzker Professor and Chief, Section of Hospital Medicine at the University of Chicago, described a randomized trial that he and colleagues at the University of Chicago are conducting, in which some patients receive care from the same physician both inside and outside the hospital. He said the patient population was almost entirely African-American and had a median annual income of \$20,000. He said that trust levels among the intervention group have increased by 60 percent, and that they have risen by 30 percent even among the control group, which he said resulted from their receiving a new physician as a result of the study.

Larry Casalino, MD, PhD, Livingston Farrand Professor of Public Health at Weill Cornell Medical College, asked whether there is evidence of bias, and lower trust levels, as a result of class. Dr. Cooper said one study showed increased bias among surgeons based on social class, and that studies have shown that patients with lower levels of education have lower levels of trust in physicians and health systems.

Bright Spots

Six presenters then described successful innovations or trust-related projects they had conducted.

Patient-Physician Trusting Relationships: Thomas Lee, MD, MSc, Chief Medical Officer at Press Ganey, discussed research his firm had conducted to determine what patients really value. Through 937,000 patient surveys conducted after outpatient visits, Press Ganey analyzed what makes patients likely to recommend their physician or practice to others, which Dr. Lee said was the best marker for trust. Dr. Lee said the most important variable among the patient responses was confidence in the clinician, followed by teamwork, and then factors related to empathy and communication.

Engaging Health Care Consumers to Implement Value-Based Care: Donald Wesson, MD, MBA, President of Baylor Scott & White Health and Wellness Center, said that as systems move toward value-based care (VBC), they learn they need to engage proactively with patients to help them adopt healthy behaviors to achieve the good health outcomes that VBC is supposed to deliver. This need for proactive engagement is particularly important for health systems serving historically disengaged patient populations. Baylor Scott & White (BSW) recognized that their highest-cost patients lived in five ZIP codes in south Dallas, and partnered with the Dallas Park & Recreation Department to establish a Health and Wellness Center that could help manage this underserved population and develop and test effective VBC through its research enterprise. System leaders understood that providing services and conducting the necessary research to develop effective VBC strategies required that they earn the trust of this underserved, largely minority population.

They were able to do so by developing a collaborative, working relationship with the Ministerial Advisory Board that included the ministers of the churches with whom the Health and Wellness Center partners, and who advised BSW on research and service delivery issues. Outcomes included improvements in diabetes management, chronic kidney disease, and weight management, reductions in emergency department and inpatient utilization, and the furtherance of an ongoing research enterprise.

Psychological Safety and Trust in Teams: Andrew Morris-Singer, MD, Assistant Professor in the Department of Family Medicine at Oregon Health & Science University (OHSU), spoke about the Relational Leadership Institute at OHSU. The institute seeks to promote psychological safety by bringing together physicians, nurses, students and other team members for a learning collaborative about leadership development. The concept was based on the idea that a sense of psychological safety would improve coordination and communication within teams by making all team members feel comfortable in speaking openly. “Everyone on the team needs to be sharing,” Dr. Morris-Singer said. The institute has grown from 17 participants in the first cohort to 27 in the second and 50 in the third round, which OHSU is about to launch.

Organizational Trust: Jack Silversin, DMD, DrPH, Partner at Amicus, Inc., discussed the value of compacts between physicians and the organizations in which they work. These compacts define what each party expects from the other, which is particularly important as expectations of physicians change. Dr. Silversin said that the process of agreeing to a compact requires “deep conversations that allow issues to be raised and resolved” and that build trust. M. Michael Shabot, MD, Executive Vice President and System Chief Clinical Officer at Memorial Hermann Health System, then talked about the creation of compacts at Cedars-Sinai when he was the chief of staff there and at Memorial Hermann. At Cedars-Sinai, the initiative was led by the medical staff, and helped bring physicians and management together after a series of “semi-catastrophic events that disrupted trust.” At Memorial Hermann, the compact was instrumental to the system’s ability to organize as an ACO and participate in shared savings contracts, as physicians had already agreed to data transparency.

Trust Issues in Organizational Collaboration: Richard Riggs, MD, Vice President and Chief Medical Information at Cedars-Sinai Health System (CSHS), described how CSHS, Select Medical and UCLA Health joined forces to create a “marquee rehabilitation institute” to serve the Los Angeles area. He said that Cedars-Sinai and UCLA overcame their intense rivalry because they had a shared vision to create a community resource. The institute has now been open for two years and has achieved patient satisfaction scores of more than 95 percent.

Public and Physician Trust with Health Plans: Patrick Conway, MD, President and Chief Executive Officer at Blue Cross and Blue Shield of North Carolina (BCBS-NC), described how BCBS-NC, which insures the majority of North Carolina residents, is seeking to transform health by engaging in full partnerships with health systems based on value-based payment, transparency and major investments in data and analytics. He described how BCBS-NC has sought to build trust with physicians and health systems by offering to significantly limit prior authorization and documentation requirements as part of these partnerships, but has also made it clear that it will never agree to fee for service increases without a link to value.

Patient and Consumer Perspectives

A panel of patients and advocates, moderated by Jackie Judd, then reflected on patient and community perspectives on trust. Gwen Darien noted that participants had focused on how to build patient trust in physicians, but not how to build physician trust in patients, which she thought should be the framework. She said that the panelists all had experiences where they felt that their physicians did not trust them for one reason or another.

She also said that having challenging but necessary conversations requires “deep trust and psychologically safe space” and requires clinicians to believe that their patients are competent and capable of learning.

Sarah Krüg, Founder of the Health Collaboratory and CEO of the CANCER101 Foundation, described the ideal physician-patient relationship as a tango: a balanced partnership with communication and improvisation throughout the relationship to respond to patients’ preferences and life experiences. “In an ideal relationship, the patient’s life expertise is embraced in partnership with the doctor’s medical expertise,” she said.

“In an ideal relationship, the patient’s life expertise is embraced in partnership with the doctor’s medical expertise.”

Sara Krüg, Founder of the Health Collaboratory and CEO of the CANCER101 Foundation

Ms. Judd asked Jeremiah White, MA, President of White and Associates, about trust issues he has seen among underserved and minority communities. He questioned whether the medical establishment truly listens to and credits the voices from those communities, and posed a series of questions. “Do you really trust me?” he asked, speaking in the first person as the community. “Do you believe my life experience and interactions have value? Why has it taken so long to address health-related tragedy in the community?” He said the community relationship with clinicians was “forced.” “I have to live with you just as much as you have to live with me,” he said. “I come to you because you have knowledge, skill and capability I don’t have. If I’m in a forced relationship, what does that mean about trust? Power?”

Ms. Judd asked the panelists for the one thing they would institutionalize to build trust. “The patient story is health data with a soul. It’s important that we use our ears as often as we use diagnostic tests and encourage the patient to share their stories,” Ms. Krüg said. “Do what you can to empower people to take care of their own health,” Mr. White said. “Ask the people you’re co-creating health and health outcomes with what they want and value,” Ms. Darien said.

Developing Strategies for Rebuilding Trust

During three sessions over the Forum’s second and third days, participants met in small groups to discuss specific areas of trust. Each group included leaders who had volunteered to write articles on these topics and submit them for publication in peer-reviewed journals. These groups and their leaders were:

- Trust of underrepresented minorities and the health system: Lisa Cooper, Catherine Lucey and Don Wesson
- Patient trust in health systems/medical groups: Dana Gelb Safran, Thomas Lee and Carolyn Clancy
- Patient-physician/clinician relationships: Gwen Darien and Rachel Grob
- Clinician trust in health systems/medical groups: Jack Silversin, Mary Jane Kornacki and Dave Chokshi
- Trust between physicians/clinicians and health plans/insurers: Lew Sandy, Sharon L. Levine and Mai Pham
- Patient and physician trust in technology: Tara Montgomery, Robert Wachter and Shantanu Nundy
- Physician trust in government: Don Berwick, Peter Lee and Chris Sinsky
- Students, residents and practicing physicians’ trust in educators/mentors: David Sklar and Graham McMahon

- Doctors’ trust of one another and other health care providers (teams): Rich Frankel and Tony Suchman
- Trust in science, expertise and integrity of clinical guidelines: Seth Landefeld and Richard Hawkins
- Public trust in the media and social media: David Rousseau, Vinny Arora and Gary Schwitzer
- Trust between multi-sector, community organizations and health systems: Lisa Simpson and Prabhjot Singh

Reflecting on Day Two

Don Berwick, MD, President Emeritus and Senior Fellow at the Institute for Healthcare Improvement, summarized a number of themes from the first two days of the meeting, including the importance of vulnerability, transparency, reciprocity, reliability, integrity and communication. He agreed with earlier speakers that the greatest opportunities for building trust were at the local level, but that success will require us, among other things, to confront resource issues (particularly time) and develop enhanced skills (particularly communications).

He pointed to the research and thought of the late economist Elinor Ostrom about the “tragedy of the commons,” the concept that any shared resource will be depleted by individuals acting out of self-interest. Dr. Ostrom believed that the tragedy of the commons could be avoided through local, coordinated action, and Dr. Berwick suggested that local action was similarly most effective to resolving trust issues in health care.

Dr. Berwick said he was left with a number of challenging questions and thoughts. First, he wondered whether building trust is simply too hard for most people, requiring skills that most of us don’t have. Second, he suggested that our “reductionist” measurement environment was eroding trust, and that we need to find a way to “restore and preserve narrative and “put measurement in its place.” Third, he questioned how we can construct good local platforms to build trust in a toxic macro-environment. Fourth, he doubted the commitment of health system executives—what he termed as “vertical authenticity”—to prioritizing building trust. Fifth, he worried that we do not have an effective response to structural racism. [View highlights of Dr. Berwick’s remarks.](#)

He closed with his final question: “Is it naïve to assume good intentions?” He said he did not think it was naïve, embracing Jeremiah White’s statement that we have to believe in one another to heal our system.

Wise Crowds

After meeting in small groups to discuss journal articles that participants are writing about trust topics, participants gathered for a “Wise Crowds” exercise designed to advise the ABIM Foundation about what it could do to enhance trust in health care.

Dr. Baron began the session by describing the Foundation’s current positioning and desire for advice. He said the Foundation’s “working hypothesis” was that “trust is fraying in society broadly and in health care in particular, and that will have dramatic consequences for the health care system.” He described the Foundation as seeking to help the delivery system become more trustworthy.

Panelists then had the opportunity to ask Dr. Baron questions, which addressed the Foundation’s core competencies, goals and potential partners. Each panelist then presented advice. Arnold Milstein, MD, Professor of Medicine at Stanford, suggested harnessing clinicians as uniquely well-positioned role models for trustworthy interpersonal behaviors. He noted that since most people feel psychologically vulnerable when they visit a doctor, they are especially attentive to signals of trustworthiness. He called for promoting three underused physician behaviors with the potential to boost patients’ trust of clinicians and inclination toward trustworthy behaviors in daily life: letting patients finish their opening statements; inquiring about patients’ lives and preferences before advising them; and understanding patients’ financial circumstances before engaging a collections company to obtain payment.

David Blumenthal, MD, President of the Commonwealth Fund, said that although the physician-patient relationship may ultimately be the appropriate level of engagement, the Foundation should seek to understand how systemic forces make it possible to establish trust. “What we do every day as clinicians and patients is often conditioned by forces outside the office,” he said.

Karen Wolk Feinstein, PhD, President and Chief Executive Officer of the Pittsburgh Regional Health Initiative, recommended an emphasis on teamwork, which she said was responsible for some of the best care she has seen delivered. She called for a focus on efforts to expand scope of practice for allied professionals and building respect among the health professions.

Soma Stout, MD, Vice President of the Institute for Healthcare Improvement, suggested creating a Trustworthy Health Care or Trustworthy Hospital campaign that could focus on three levels of trust: between organizations and their people, between care teams and patients, and between institutions and the community. She said the campaign could offer a menu of trustworthy behaviors that are achievable and connect interested actors with resources.

Participants had a number of additional suggestions for the Foundation, including:

- Helping practitioners understand issues related to disparities across all patient populations
- Fund prizes for research on how trust can be improved
- Develop a physician-patient compact that would be created in part through crowdsourcing for patient input
- Training providers and patients on the communications skills needed to create trustworthy encounters
- Convene experts to develop measures on trustworthiness

Organizational Trust

The Wise Crowds session was followed by a panel of leaders of health care organizations who shared stories about trust issues their institutions faced.

Frederick Cerise, MD, President and Chief Executive Officer of the Parkland Health & Hospital System, spoke about the challenges Parkland faced in restoring trust after a series of patient safety incidents that left the hospital under close supervision from CMS and under public scrutiny. After a set of difficult issues in the hospital’s psychiatric emergency department, Dr. Cerise said Parkland focused on training personnel and building relationships with the people who worked in the department. When a patient subsequently was able to sneak a knife into the facility, there was a widespread expectation that employees would be terminated. Instead, Dr. Cerise visited the unit to assure the employees that their jobs were safe, demonstrating trust in the caregivers that they were valued.

Regina Cunningham, PHD, RN, Chief Executive Officer at the Hospital of the University of Pennsylvania, spoke about her and her system’s response to a medical error that harmed an oncology patient. She described how she and HUP’s Chief Medical Officer held multiple meetings with the patient and her family and acknowledged the error, and how the system provided additional resources to the patient. She stressed the value of using a nurse manager as an advocate for the patient and family, and noted how nurses are among the most trusted professions in society. She also stressed the importance of leadership, saying that it is important for patients to see that C-suite leaders are involved when there’s a serious patient error.

Gary Kaplan, MD, Chairman and Chief Executive Officer of the Virginia Mason Health System, discussed his board's decision to end the election of CEOs at Virginia Mason only six months after his own election. Although he believed the step was critical to enable Virginia Mason to make necessary changes, he said it engendered considerable dissent among physicians and created the need to rebuild their trust. To do so, he conducted a series of physician town halls, held a multi-day retreat, and enabled the creation of a new compact between physicians and the system. He stressed that it was the process of creating the compact that was most important to building trust. "A fair process comes in many forms, but people will often go where they don't think they want to go if there's a fair process," he said.

"A fair process comes in many forms, but people will often go where they don't think they want to go if there's a fair process."

Gary Kaplan, Chairman and CEO of the Virginia Mason Health System

High-Level Strategies and Tactics to Enhance Trust

Participants next took part in a 25–10 exercise designed to identify appealing strategies and tactics for enhancing trust. In this exercise, participants each propose a strategy or tactic and have it rated on a 1-5 scale by five other attendees. The highest-scoring concepts are then shared with the full group; they were:

- Enhancing diverse membership on health care boards
- Taking responsibility for identifying and remediating underperforming physicians
- Broadening participation in the 'health care conversation'
- Training health care teams in establishing and maintaining psychological safety
- Identifying meso- and macro-level issues that undermine trust and developing strategies for addressing them
- Apply a team paradigm to a "Trusting Wisely" initiative
- Make "What matters to you?" a question we ask at every level of care
- Promote price transparency
- Design series of conversations with patients/community to find out what they believe would make health care more trustworthy
- Health systems do more to promote community health

Conclusions

Catherine Lucey, MD, Executive Vice Dean and Vice Dean for Education at UCSF, offered closing remarks. She said that the medical profession has been wrestling with transformational changes, but that it is time to accelerate those changes because "Americans are now trusting people who are not trustworthy, and do not have a relationship with people who are trustworthy." She suggested that many of these Americans feel they are not respected, and that problem can be solved.

She summarized what the group had learned about trustworthiness:

- It is not about expertise alone, or truth, but about the relationships that create a healing space for our patients.
- It requires competence, transparency, motivation, communication and other commitments.

- Trust in our patients is an essential component to trustworthiness in physicians.
- Trust can't happen at the micro-level alone; institutions have to develop systems and structures that make it possible to develop trusting relationships.

She highlighted a few elements she thought had been missing or underemphasized during the Forum. She said there should be more of a focus on humility, while cautioning that when it comes to vulnerability, physicians will never be as vulnerable as the people they are treating. She also cited confidentiality, wonder, presence, empathy, empowerment, joy, gratitude and learning as important but missing elements.

Dr. Lucey said that achieving trustworthiness was a complex adaptive problem, and that there will be controversy and conflict about the appropriate steps to follow. She said that we will need transformational leaders, but that those leaders cannot simply devise and impose solutions. Transformational leaders, she suggested, do not care who receives credit, and are willing to challenge the way business has been done in the past.

She called for defining and emphasizing our purpose in pursuing trustworthiness, and proposed that our purpose is “because this is our business and our job is to reduce suffering from illness and disease.” “People are dying without trust and trustworthiness,” she said. “We should have a sense of urgency.”

Dr. Lucey highlighted some of the specific implementation concepts discussed during the meeting:

- Compacts: she suggested allowing patients to draw up proposed compacts that clinicians and systems could respond to
- Simplifying complex problems: she referenced Tom Lee's effort to isolate the small set of factors that actually shape patient satisfaction with their practices
- Teach physicians how to talk to patients more effectively

Finally, Dr. Lucey proposed a series of ‘next steps’:

- Capitalize on the strengths of the ABIM Foundation to convene, catalyze, develop partnerships and build consensus
- Create incentives for local solutions to build trust and seek a tipping point of 15–20 percent of organizations seeking to improve trust
- Learn the business case for improving trust without making trust an attribute driving market competition; she cited as an example the children's hospitals commitment to collaborate rather than compete on patient safety
- Commit to reaching multiple audiences, including the lay press

She closed by saying that we will never finish our journey of promoting trust.

The ABIM Foundation hopes that the Forum provided the background necessary for participants to appreciate how they might take this journey at their own institutions and among the communities they serve. We would be very interested in learning about your efforts in the coming year; we look forward to hearing from you.

[View highlights of Dr. Lucey's remarks.](#)

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Catherine Lucey, Executive Vice Dean and Vice Dean for Education, University of California, San Francisco