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Default (Dis)trust and the Medical Profession

Nathalie DiBerardino

Abstract:

Trust is typically taken to be an essential constituent to the patient/physician relationship. One way that trust can manifest in the context of medical care is in a *default attitude*; that is, the initial stance of trusting one takes upon entering any given interaction with a medical professional. In this paper, I identify the current default attitude of (dis)trust that certain marginalized groups are justified in taking towards the medical profession, and I explain why this default is not ideal. I then argue for my account of the ideal default attitude of trust, which I call *medial trust*. I argue that medial trust is the default stance that one should be able to take towards the medical profession. My argument is grounded in the importance of respect for the value of a patient's own contribution to healthcare-related decisions. This account serves to bring attention to the existing attributes which allow for justified default *distrust*, and to establish an ideal to which the medical profession can work towards. This work thus ultimately aims to contribute to the imperative of justice and equality for those marginalized in society.

Trust is typically taken to be an essential constituent to the patient/medical professional relationship. We trust medical professionals in numerous ways; perhaps to prescribe us the right medication, to provide an accurate diagnosis or referral, or to uphold standards of confidentiality given the intensely personal and private nature of what we might share with them. We can easily see what makes trust particularly imperative to this relationship by considering what's at stake if the medical professional gets it wrong; that is, if they misprescribe, misdiagnose, mistreat, etc.

There are certainly substantial harms which can arise when our trust is betrayed in this context. And by trusting medical professionals, we open up that possibility. It is this particular nature of the harms at stake which I submit makes the matter of trust in our relationships with medical professionals so important.

One way in which trust can manifest in this setting is in what we might call a *default attitude*. A default attitude concerns those initial feelings, thoughts, and/or reservations about the other party, and so a default attitude of trust consists of that attitude of trusting one takes upon entering any interaction with a medical professional. The aim of this paper is to identify the existing justified default attitude of (dis)trust towards the medical profession for certain marginalized social groups, and to advocate for the ideal default attitude of (dis)trust one should be able to take towards the medical profession. In particular, I argue that the ideal default attitude we should be able to take is what I will call *medial trust*. This account is grounded on the importance of respect for the value of the patient's own contribution to necessary and important healthcare-related decisions.

In Section I, I will identify the existing default attitude of (dis)trust certain individuals are justified in taking, and in Section II, I will explain why this is unideal. In Section III, I will argue for my account of the ideal default attitude we should be able to take towards the medical profession, and in Section IV, I will consider two possible objections to my position.

It is important to note here as a preliminary that there is controversy in the literature regarding the nature of trust. The aim of this paper is not to defend any particular account of trust; my use of the concept is consistent with most popular accounts, with the only exception being those which fail to distinguish trust from mere reliance, which Jones (1999) calls risk-

assessment views (cited in McLeod 2020). In addition, the nature of the trust that I employ is one which comes in degrees. That is, trust and distrust are not binary relations.

Section I: Default attitudes of (dis)trust today

I take it to be uncontroversial that there exist great issues of inequality in modern society, many of which concern health and health care systems. In this section, I argue that a default attitude of distrust towards the medical profession is justified for certain groups, and I discuss certain historical injustices and current injustices to show how this is the case. Note that due to the scope of this paper, the examples I employ constitute a non-exhaustive list of possible reasons for distrust, but what I discuss should serve as sufficient justification.

The past shapes the present

Historical marginalization and mistreatment in the realm of medical care are strong reasons for members of certain marginalized groups to be wary of trusting, or even actively distrusting, today. Damon Tweedy raises concerns about black patients, asserting that they, "compared with those of other races, tend to be far less trusting of physicians and their medical advice" (2015). Much of this is rooted in a "dark history of experimentation on black people without their consent", with the Tuskegee syphilis study being one predominant example (Tweedy 2015). For reference, the Tuskegee syphilis study involved 600 non-consenting black men from Macon County, Alabama who were not only falsely told their syphilis would be treated, but were actively prevented from receiving that treatment which could save their lives (CDC 2020). Beginning in 1932, the study lasted 40 years (CDC 2020).

Another example of lingering damage to trust involves the Indigenous community in Canada; according to research done by Dalhousie University, "First Nations people mistrust the Canadian health care system" (West 2014), largely as a result of historical mistreatment.

Specifically, researchers found that “attempts to force patients into treatment that clashes with their cultural values is a strong echo of the residential school system” (West 2014), which involved attempts to destroy the culture, identities, and history of Indigenous peoples (Parks Canada 2020).

The cases above illustrate the lasting impact historical injustices have on certain groups and their attitudes towards the medical profession. All it takes for a member of a historically mistreated group is brief reflection on that gravely unjust past treatment of its members to arrive at the frightening conclusions: “what’s to stop them from doing it again?” and, thus, “why should I trust them now?” I take the lingering shadows of historical mistreatment to be a strong basis for a default attitude of distrust certain individuals are justified in taking towards the medical profession.

Not all has changed

But many of the contributing historical problems have been far from eradicated. To see this, one need only turn to the statistics: in the United States, infant mortality in the black population is twice as high as in the white population, “black men are seven times more likely than white men to receive a diagnosis of H.I.V. and more than twice as likely to die of prostate cancer,” and “black women have nearly double the obesity rate of white women and are 40 percent more likely to die from breast cancer” (Tweedy 2015). Furthermore, black women are three to four times as likely to die of child-birth related causes than white women across the United States (Bobrow 2020). We can especially see the alarming continuing presence of this issue in the context of the COVID-19 pandemic; according to Lester et al., scientific articles describing the skin manifestations of the virus “almost exclusively show clinical images from patients with lighter skin,” even though black people make up roughly 13.4% of USA’s

population but accounted for 30% of cases of COVID-19 at time of publication (2020). Without the knowledge of how the COVID-19 virus manifests on black skin, healthcare providers may be less likely to properly diagnosis and treat otherwise asymptomatic patients (Lester et al. 2020).

And issues of underrepresentation go even further. In general, "black people are more likely to feel comfortable with black doctors", but only five percent of practicing physicians in America are black (Tweedy 2015). This is a problem identified by researchers in the First Nations population in Canada as well, concerning not only the physicians themselves but other aspects of the health care environment, such as unfamiliar styles of artwork and lack of diversity in brochures in waiting rooms, for example (West 2014). When the community doesn't feel represented in the system, it makes them less willing to trust the system.

We can also again consider the First Nations population in Canada to see the continuing injustices they face in the context of medical care. In 2017, Boyer and Bartlett released a report concerning First Nations women in Saskatoon, CA who were coerced into having tubal litigation immediately after birth (2017). The majority of women did not understand that the procedure was permanent, and their experiences consequently led to a "complete lack of trust and avoidance of healthcare" (Boyer and Bartlett 2017).

Each of these existing issues serve to illustrate the continuing inequalities and injustices in the health care system which serve as justification for a default attitude of distrust for some marginalized groups.

Section II: Why is a default attitude of distrust unideal?

Of course, though it may be justified for some, a default attitude of distrust is far from ideal. A lack of a trusting relationship with a health care professional can lead to detrimental effects in one's reception to and quality of health care as a whole. This is in part due to the

monopolistic health care system structure in Canada, where provincial and territorial governments deliver health care services as regulated and mandated by the national government (Health Canada 2011). Accordingly, any quality alternative options for care – which one may turn to if they have good reason to distrust the medical profession – are highly limited. The result is that those with significant enough default distrust may fail to seek out healthcare at all when they need it. This is a clear and significant harm to the default distruster's health.

And even if an individual does continue to seek out the care they need, default distrust burdens its quality. Walker raises the importance of positive atmospheres following default trust, stating that "undisturbed default trust, especially when broad and deep, can constitute a "climate" in which specific trusting relationships of many kinds seem normal and ordinary; robust default trust within a work environment, for example, is likely to foster the willingness of individuals to work cooperatively and to rely on others" (Walker 2006). This can easily be applied to health care environments; a climate of distrust and discomfort might restrict a patient's willingness to share important information with a medical professional which might have bolstered the quality of received care, while default trust contributes to openness, comfort, and cooperation. With this being said, we can now turn to my account of the ideal default stance of trust one should be able to take towards the medical profession.

Section III: Defending an account of the ideal default (dis)trust

Given what has been said above, the answer to what is the default attitude of trust one should be able to take towards the medical profession might seem obvious. Trust strengthens our comfort in and quality of health care; of course the ideal default attitude should be one of trust. While I do not disagree with this sentiment, my account makes important distinctions. Recall that the nature of the trust that I employ is one which comes in degrees. For my purposes, I will adopt

the language of Meyer (1998) and distinguish between minimal, medial and maximal (dis)trust. To have default maximal trust is to have complete trust in the medical professional; it is a sentiment of "I am entirely in your hands." But this position fails to make space for the necessary contribution of the patient in a given health care decision. Instead, I argue for an ideal default stance of *medial* trust which leaves space for the patient's respect and knowledge of their own self.

Interactions with a medical professional often include decision-making in some capacity, perhaps regarding treatments or procedures. Sometimes there is much at stake in these decisions. In any given scenario, a medical professional will often provide their professional opinion on the best course of action, and it is at this point where the degree of that default trust an individual takes is crucial.

A default attitude of *maximal* trust easily places the responsibility of such decisions onto the medical professional. A default maximal truster has complete confidence in the medical professional's expertise and knowledge, and so will follow any recommendations provided, no questions asked.

But the problem is that this attitude fails to allow for the contribution of the patient's knowledge of their own unique lives. When placing maximal trust into a health care professional to make a decision in a given scenario, we forfeit our own contribution of relevant factors in the equation arising out of our experiences, values, and relationships. Though the physician may be the expert on the medical knowledge involved, the patient is the expert on themselves (McLeod and Ryman 2020). Adopting a default attitude of maximal trust is inappropriate because it transfers the responsibility without transferring the expertise. The default attitude of medial trust that I argue for tempers that complete transfer of responsibility. It is a sentiment of still trusting

the professional, while "holding back" out of respect for the fact that the patient's knowledge is important, even if it is not of the medical technicalities. It recognizes that such technicalities are one factor of many in healthcare-related decisions.

The concerns with too much trust are especially pertinent if the patient is in a significantly different socio-economic position than the medical professional. As McLeod and Ryman point out, "experts can get things wrong – sometimes terribly wrong – when they lack guidance from the people they serve, because of the limits to their experiential knowledge of the lives of people who have different social positions or backgrounds than theirs" (2020). If the medical professional is in any position where the risks of their decision-making without patient contribution can directly compromise the wellbeing of the patient, then an attitude of medial trust taken by the patient is especially imperative to allow for the supplying of that contribution. The maximal alternative is the professional making that decision *for you*; a decision which could very much be disastrous.

A default attitude of medial trust is also preferable to minimal trust. While a default stance of minimal trust may mitigate issues of lack of patient contribution, less trust means there will likely be less fulfillment of those previously mentioned benefits of a trusting relationship. A default attitude of medial trust is ideal because it saves the space for that experiential knowledge only the patient can have, while still allowing for the reaping of those benefits of a trusting relationship. We must aim for trusting relationships with the medical profession, and we must also hold back some trust to preserve the value of our own contribution based on our expertise of those relevant elements of our own life – elements the medical professional could never truly know. These aims are best achieved with a default attitude of medial trust.

Section IV: Possible Objections

I anticipate some initial concerns regarding my account that the ideal default attitude towards medical professionals should be medial trust. Upon reflection of the typical interactions one might have with a medical professional, it may appear as though there are some circumstances in where maximal default trust is surely appropriate. Kongsholm and Kappel invoke the following scenario to highlight common decision-making in this capacity: "suppose, having a nasty infection, I go to see my family doctor, who has been treating me since I was a child (and my parents before me). He has compassion for my suffering, pulls out a powerful antibiotic from his medicine cabinet that he happens to have on hand, and recommends that I start taking it immediately to combat my infection" (Kongsholm and Kappel 2017).

It seems as though, in cases like these, it is perfectly reasonable to adopt an attitude of maximal trust towards a medical professional; you have trusted him all your life, you know he has your best interests in mind, and so you have no issue handing him the reigns and taking what he prescribes you without question.

Recall, though, that what I am interested in here is the *default* attitude of trust we should be able to take. It may very well be that a certain scenario does appropriately call for maximal trust, but a default attitude is one which is adopted at the onset of any given interaction with a medical professional. That is, what I argue for is an attitude which you *enter* a given situation with; one you default to. But this does not entail that you must stick with that default attitude; that you may never move away from it after assessing the particular situation you find yourself in. The working attitude of (dis)trust in any given scenario need not stay equivalent to the default. As such, the ideal default attitude of medial trust that I am interested in is not infringed upon where specific cases call for alteration of that initial attitude one holds.

Another objector to my account may assert that there cannot be one singular appropriate default stance of (dis)trust towards the medical profession, even with all past and present discrimination, injustices, or mistreatments aside. They might argue that even if everyone is, in fact, able to adopt an attitude of trust rather than distrust towards the medical profession, the complexities involved across different individual's specific medical care needs cannot be dissolved into one default applicable to all.

In response, I wish to acknowledge the fact that it may be unrealistic to pin down a singular appropriate default attitude of (dis)trust for everyone given their own unique circumstances. However, I am truly interested in the *ideal*. I do not deny the difficulties in realizing this ideal; there is surely much work to be done to eliminate those barriers which prevent us from doing so. And I do not deny that once a default attitude is developed by an individual, it may be difficult to change. But if we can identify an ideal, we can begin to set our aims on achieving it.

Ultimately, the goals of my account of the ideal default stance of (dis)trust are to bring awareness to the attributes that allow for a current justified default attitude of distrust, and to identify the ideal to which the medical profession can work towards. Effort is needed to get closer to that ideal – perhaps grounded in new policy or acknowledgement of past injustices – but my hope is that we can at least take those steps in the right direction.

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