TRUST, RISK, and RACE
in American Medicine

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For many who have faced exploitation and discrimination, it's hard to trust in American medicine. Mistrust might well be rational. Yet trust is vital to the physician-patient relationship. In establishing trust, the responsibility lies with providers, and the answer requires recognizing and attending to the mistrust.

I n Michelle Obama's 2018 memoir *Becoming*, she mentions that her grandfather, Southside, died from advanced lung cancer because "his long-held view that doctors were untrustworthy . . . kept him from any timely intervention."[1] Southside's view is not unique. There is ample evidence that patient mistrust[2] toward the American medical system is to some extent associated with communal and individual experiences of racism.[3] Considering distant and more recent revelations of unethical research practices, such as the U.S. Public Health Service Syphilis Study (also known as the Tuskegee Syphilis Study) and the misappropriation of Henrietta Lacks's cells for research, the everyday prejudice that leads to the underprescribing of pain medication for patients of color, and systemic social issues that affect access to medical care, such mistrust is unsurprising.[4] For those who have faced exploitation and discrimination at the hands of physicians, the medical profession, and medical institu-

tions, trust is a tall order and, in many cases, would be naive.

Nevertheless, trust is often regarded as a central feature of the physician-patient relationship.[5] Given the complexity of decisions regarding medical treatment, clinicians' expertise, and patients' relative lack of experience in making such decisions, most patients must rely on physicians to help them make the choices that are best for them. This state of dependency persists despite the emphasis, through the informed consent process, on patients' right to choose their medical care. Many patients, no matter their ethnicity or race, will find themselves in situations in which mistrust frustrates their ability to receive adequate care. Even though mistrust is a rational response to a medical system that does not advance all patients' interests equally, mistrust may not be warranted in every situation, and in some cases, it can damage the physician-patient relationship to such an extent that medical care is compromised. The question, then, is how to move from mistrust to a state of trust, however tentative, that can allow necessary care to continue (or unnecessary care to cease).

One option can be dismissed immediately. In the work to resolve mistrust, the onus surely cannot lie with the potential trusters (that is, patients) to reevaluate their understanding of the situation and place their trust in the American medical system. To require individuals from a group that has historically been the subject of exploitation and discrimination to resolve the issue of mistrust in American medicine is to further burden them, exacerbating injustice. If the problem of mistrust in American medicine is to be resolved, the task must be taken up by those who would like to be seen as trustworthy.

Placing responsibility for resolving mistrust on the shoulders of providers has its own challenges. Many complex cases may not simply be about mistrust; they may be cases in which providers mislabel noncompliance as mistrust. When providers frame problematic cases through the lens of mistrust, they seemingly reduce their responsibility for the difficult dimensions of the relationship through the exhortation "if they would just trust us." From this perspective, resolving mistrust requires addressing systemic bias and prejudice in the medical system that lead certain types of patients and families to be perceived as difficult.[6]

In a hospital or clinic, however, addressing such structural issues can be challenging when a conflict over goals of care looms in an individual case. The aim is to resolve the case fairly, compassionately, but also expediently, and this often means that the forest is forsaken for the trees. In this article, I draw on empirical research, ethical theory, and clinical ethics practice to propose one way that providers might address and, ideally, resolve mistrust when it arises in an immediate case. This is not meant to completely disregard the forest, which I take to include systemic inequities that disproportionately affect patients of color and their families as well as implicit bias and prejudice on the part of many providers. Indeed,

these two aims must be pursued in tandem—the correction of structural injustice includes the rectification of interpersonal wrongs, and (when viewed over the long haul) vice versa.

Below, I describe the issue of medical mistrust as it has been characterized empirically within medical and bioethics scholarship. I provide an overview of theories of trust and discuss the fact that, while they may be able to explain how interpersonal trust is established within racially or ethnically homogeneous communities, they may not be able to account for the risks that providers must take in seeking to establish trust within many American medical institutions.

Using examples of a kind of case I have in mind when I consider mistrust, I highlight providers' options in such situations. Common assumptions in medical and bioethical scholarship on trust notwithstanding, caring and competence are not always enough to establish a trusting relationship between physician and patient. This is especially likely to be true when the physician and patient are from different cultural backgrounds and when there are good reasons for mistrust of medical professionals and institutions. I suggest that, in an atmosphere of mistrust, comprehension of the existence and source of suspicion is essential to effective signaling of trustworthiness. I then briefly address some objections to my proposal before identifying future directions for scholarship in this area.

Measuring Trust and Mistrust

In the physician-patient relationship, trust requires patients to make

themselves vulnerable through their dependence on physicians' expertise. Historically, as physicians' presumed authority for medical decisions decreased and patients' ability to choose their own providers increased, interest in empirically characterizing the dynamics of trust between physicians and patients grew. A number of changes in the American medical system from roughly the 1980s to the 2000s, including the rise of managed care organizations and the increasing commodification of health care, also spurred this interest.[7]

In the late 1990s to early 2000s, researchers began to develop scales to measure trust in medicine.[8] These

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scales focused on patient-perceived dimensions of trust in physicians, patient-perceived dimensions of trust in institutions, and patients' attitudes toward trust and their self-reported levels of trust in physicians and institutions.[9] Aspects of the physician-patient relationship that these studies found to be central to trust were physicians' perceived caring and competence, as displayed through interpersonal skills such as careful listening, eye contact, clear communication, and conveying understanding of patients' experiences. In these studies, trust was clearly distinguished from satisfaction and was understood as a learnable skill, not a dimension of physician or patient personality.[10] On the whole, studies found that patients have a high level of trust in their physicians but a lower level of trust in medical institutions.[11]

As empirical research on trust developed, the possibility of measuring mistrust and of tracking this mistrust along racial and ethnic lines

emerged.[12] Studies found that minority groups cite negative experiences affecting trust that are never mentioned by white groups;[13] that distrust is a barrier to African American participation in clinical research;[14] that mistrust and perceived racism decrease satisfaction with care;[15] that black respondents report less trust in physicians than in medical plans;[16] that African American respondents report lower trust in health care providers than white respondents do and that they are more likely to use emergency departments, community health clinics, and hospitals, as opposed to primary care providers, as sources of care;[17] and that mistrust within minority populations is not uniform but varies depending on geographical region, education, income, age, gender, and insurance status.[18]

These empirical studies provide evidence of a difference between the experiences of white patients and patients of color with individual physicians and with the American medical system. Although the dimensions of this difference are difficult to characterize precisely and vary by region, socioeconomic status, education, and other factors, mistrust seems to be significantly higher in minority populations than among whites, and it can affect the type of medical care that members of minority populations seek and receive. The work of rectifying structural injustices and transforming social institutions will take a great deal of time and effort; while it is under way, many medical relationships must find a way to function within and despite this atmosphere of mistrust.

Providers may be inclined to approach a relationship with a mistrustful or suspicious patient by reinforcing their medical competence and their care for the patient as grounds for trust, as suggested by the major roles these factors play in developed scales of trust. However, given that most of these scales were first developed and validated with primarily white patients from privileged socioeconomic backgrounds, they may

not capture well what physicians can do to demonstrate their trustworthiness to patients from different cultural backgrounds and despite an atmosphere of mistrust. A look at established theories of trust helps illuminate the conceptual components of trust and highlights the challenges of communicating trustworthiness in the context of mistrust.

Theories of Trust and Trustworthiness

I focus on theories of interpersonal trust, rather than institutional trust, for two reasons: First, when mistrust is an element in an immediate case, it is usually too late to resolve the mistrust on an institutional level, although the situation might be remedied interpersonally as a stopgap measure. Second, even if (and as) medical institutions seek to resolve issues of prejudice, bias, and inequity that affect their trustworthiness for minority patients, there will be an inevitable lag in patients' expectations of mistreatment. This is not to say that interpersonal work relating to trust replaces institutional work, just that the former is an immediate means of establishing trust in an unjust environment.

Theoretical approaches to trust are broad. At a basic level, to trust someone is to entrust them with something, as when banks are entrusted with money, schools with children, cooks with hygienic meal preparation, and so on. Such trust is necessary for the success of a wide variety of social institutions premised on cooperation. Many services would quickly break down if users did not trust them to manage their interests appropriately (we do not want another run on the banks). Yet trust inevitably involves risk. Trust is necessary because there is no assurance that each and every service will manage our interests well; sometimes they will fail us.

To function well, a society needs sound methods of identifying and tracking the services that users can trust with less risk and those services

that require more risk. This tracking relates to risk-benefit ratios for given transactions (such as opening a savings account versus day-trading stocks), but it also involves identifying trustworthy institutions. When we are deciding whether to trust a person or institution, we assess their reliability (for example, their history of past success with interactions similar to what we are considering), but we also consider their trustworthiness, which is more personal. Reliability and dependability can be objectively assessed, but trustworthiness is subjective and interpersonal. As medical ethicists have recognized, some of the most developed theoretical accounts of trust and trustworthiness have come from feminist scholars who concentrate on ethics within interpersonal relationships.[19]

Annette Baier was one of the first to observe that trust goes beyond reliance.[20] I might rely on a given Internet provider because it is the only option in my area, but that does not mean that I trust it. Rather, trust involves an expectation by the truster that the trustee has goodwill toward the truster—that it will take the truster's interests seriously. I have no expectation that my Internet provider bears goodwill toward me, but I do expect my physician to have goodwill toward me, which is why our relationship is not one of just reliance. Indeed, trust is generally thought to be fundamentally relational and interpersonal in a way that excludes some professional relationships (such as with Internet providers) from the category of "trusting relationships" but necessarily includes others, such as relationships with educators, childcare providers, and therapists.

Goodwill can seem like a vague criterion, but Karen Jones provides a more exact formulation: to have robust goodwill toward someone is to take the fact that they are counting on you as a reason to act in line with their expectation.[21] This draws from Jones's earlier work, where she characterizes trust as an attitude of optimism that the trustee will have

goodwill and competence in managing the truster's interests.[22] Another way to describe goodwill is with the language of care, which is how trust is often discussed in medicine. Medical approaches to trust emphasize patients' vulnerability in their dependence on physicians and their optimistic beliefs that physicians will care for and will be competent to further their interests.[23]

Trustworthiness is thus marked by physicians' characteristics of competence and caring. Competence is required for one to dependably, reliably take care of something with which they are entrusted. Caring is necessary insofar as it helps to explain the trustee's motivation for exercising their competence in attending to that with which they are entrusted. The competence criterion is relatively uncontroversial; especially in medicine, there are exams and other requirements to ensure that those who take on the role of a medical professional are competent in their area. The element of caring can be more difficult to ascertain, especially in a relational context. How can patients know that their physicians will care enough about them and their situation to exercise their competence in the most effective way possible? In other words, the practical questions are how patients can know that a physician is trustworthy and how physicians can convey their competence and caring appropriately.

Many theories of trustworthiness require some level of background social knowledge to convey competence and caring. It is not always enough for a physician to feel that they are responsive to a patient's dependency on them—they must be able to signal this responsiveness in a way that the patient will recognize and accept. When the physician and patient share a cultural background, the means of this communication is often intuitive. When they do not share this background, signaling trustworthiness becomes more complicated.[24] Jones and Baier both acknowledge that we cannot just tell others to

"trust me"; signaling trustworthiness means demonstrating one's competence and caring in a given domain. As Jones notes, "Correctly signaling my trustworthiness . . . requires grasping what the other will count as a signal. Signaling rests on a set of highly complex socially mediated background understandings."[25] So, responsiveness to dependency is not enough, and sometimes being willing and able to signal trustworthiness is not enough either, if methods of communicating trustworthiness are not shared.

Communicating trustworthiness becomes even more complicated if the situation involves not just different cultural backgrounds but also active mistrust and suspicion. Whereas most theories of trust and trustworthiness presume some neutral level of social interaction, few address the complex task of signaling ones' trustworthiness when the potential truster does not have optimism about the potential trustee's competence and caring and is actively pessimistic about both traits. In medical cases, the encounter is not just one of forced and unexpected dependency on strangers whom one has never met—it involves patients who are vulnerable to those whom they would routinely not trust if they were not forced to do so. Indeed, in many of these cases, a common element is that the family searches for alternative hospitals to which they may bring their patient.

Few theorists have addressed trustworthiness and trust in such challenging circumstances.[26] Those who have include Margaret Urban Walker

in *Moral Repair* and Trudy Govier in articles on trust and distrust.[27] Walker proposes that, in interpersonal relationships, trust exists as "default trust"—a practical outlook of ease, comfort, and complacency.[28] She is interested in damages to trust—specifically in what she conceptualizes as violations of the default trust that exists in these relationships—and she suggests that damages to trust call out for assurance.[29] Yet while Walker is interested in how to repair trust once it has been lost, she does not address how to build trust within an atmosphere of mistrust, and in which default trust has never existed. Indeed, in the context of American medicine,

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an attitude of comfort and complacency is nearly opposite to the attitude of mistrust of many African American patients.

Govier addresses mistrust more directly. She is one of the few theorists to recognize that mistrust is, in many cases, a rational response to situations in which the truster is uncertain whether another person or institution will behave reliably and will take their interests seriously. Yet the practical problem she identifies in relation to mistrust is that individuals cannot always just avoid those whom they distrust. This is very much the issue in medicine, where patients often have no choice but to work with their current medical team (due to insurance restrictions, difficulty moving the patient, or work or family limitations). She points out that, in such cases, distrust has emotional costs, as trusters are forced to depend on those whom they believe to be suspicious yet who

nevertheless have power over their interests. Moreover, in these cases, patient distrust and suspicion can be part of self-fulfilling prophecies—the more someone is expected to disappoint expectations, the more they do. Although Govier (who is focused on disarmament) does not provide solutions that are helpful in the context of medicine, she raises one of the most important questions about distrust: "[G]iven that we cannot successfully communicate and cooperate without at least a moderate level of trust, and given that, so often and in so many important ways, there are compelling grounds for distrust, how can we progress from a situation of warranted distrust to one of well-founded trust?"[30]

Cases of Mistrust

In thinking about establishing trusting relationships in an environment of mistrust or suspicion, I have in mind a kind of case that I believe will be familiar to many medical providers and ethics consultants.[31] In cases of this type, the clinical ethicist may be called because the medical team has been unsuccessful in establishing its trustworthiness, and the atmosphere of mistrust disrupts the patient's medical care. This disruption can occur for a variety of reasons, not all of which involve the family's refusal to accept care from the team. An atmosphere of suspicion may simply make it more difficult for the family and the team to communicate about the patient's needs and goals.

For example, in one case with which I am familiar, a family member noted during a meeting the absence of a physician whom they had expected to attend and, citing their experience with the insurance industry, said that they knew when they were being given the runaround. They stated that the physician had clearly intentionally missed the meeting to avoid a conversation with the family; they could not be convinced otherwise. In another case, a family member searched the Internet for all of the medications that had been given to the patient and, when one appeared to be a drug used in the context of lethal injections, concluded that the team must have been trying to kill the patient. This family member then began entering other patients' rooms to tell families not to trust the medical team. In both cases, the patients and their families were African American, and the majority (if not all) of the medical providers were white.

A trusting relationship was never established in the latter case and was the source of considerable distress on both sides. Agreement could not be reached about how to move forward, and so for a longer time than is usually appropriate in this type of situation, no decisions were made about what should be done for the patient.

In the former case, in the same family meeting where significant mistrust was communicated, the physician repeatedly worked to establish themselves as trustworthy, stressing their credentials, the tests they had run, and the experts they had consulted. These efforts correspond to the first element of Jones's description of trustworthiness—competence. When this did not work, the physician expressed care for the patient and stated that they shared the family's worries about the patient's situation—Jones's second element of trustworthiness. This still did not work, and the room remained tense.

Finally, the family described a situation in which another family member had been healed, seemingly miraculously, by a physician in another state. It was at this point that something seemed to click for the physician—the family's past experience, however unlikely, was influencing current expectations—and, rather than contradict the expectation of a miracle, the physician acknowledged the family's previous experience and stated that they would act just as the previous physician had in exploring all avenues that the family needed explored. It seemed to be this element of the conversation—the comprehension of the family's perspective on what they needed the physician to reflect back to them, not the efforts to convey competence or caring—that allowed the family to see the physician as trustworthy.

As is apparent in these cases, in contrast to a patient or family who feels trust, which involves optimism and expectations of goodwill, a suspicious family will display pessimism about the medical encounter and expectations of ill will and deception. It is natural for the medical team to be distressed by these negative expectations, but what often occasions a clinical ethics consultation is the concern that the patient is being harmed as a result of the interpersonal conflict. For example, a patient might be retained on an endotracheal tube for longer than two weeks, which can lead to complications if the family does not want to decide between removing the tube and pursuing palliative care, and a tracheostomy, which is a more permanent solution. Indeed, in many cases that are flagged as involving mistrust, the conflict centers around a major decision that must be made. The mistrust manifests as a refusal to make a decision, which providers may interpret as noncompliance. Yet from the family's perspective, such mistrust is surely warranted, and they find themselves in the position described by Govier—forced to rely on someone more powerful than they and who they do not feel will advance their and the patient's interests.

In cases such as the second one above, physicians may repeatedly attempt to establish their trustworthiness, operating as if there were a shared cultural background and as if the trust question centered only on competence. If emphasizing their competence does not work, they may then express their care for the patient and profess to share the family's worries about the patient. If this still does not work, the situation may seem to be at an impasse—what can the physician do to convey that they are trustworthy but express competence and concern?

I propose that, at this point, the clinician must bridge the gap between cultural backgrounds and address the mismatch in expectations about what the medical encounter ought to look like. The clinician must take a risk by attempting both to comprehend the family's standpoint, including the reasons behind their distrust, and to express that comprehension through a performance of their trustworthiness. The clinician must acknowledge these reasons and affirm their rationality. This comprehension can be narrow or broad; it can focus on the family and patient's immediate situation or it can cover a longer stretch of time, perhaps extending to the hospital's role in the community and the medical profession's historical mistreatment of African American patients. Comprehension as an element of trust cannot always be signaled verbally, but often must be displayed in action, as in the physician's affirmation of the family's expectation that a trustworthy physician is one who explores all possible avenues, however unlikely they are to help. If this comprehension is not signaled, then the family has no reason to think that the clinician's competence and care will be effectively directed at them and their patient.

Comprehension may seem to be an unnecessary third element to the theoretical characterization of trusting relationships. Yet the distinction between comprehension, competence, and caring is not without merit. Competence is skill based and profession specific. It is signaled through qualifications, a history of good outcomes, and recognition by other professionals. Caring is an affective attitude that need not have an epistemological component, although it can. Caring in the context of theories of trust is often characterized as responsiveness to dependency. I need not know anything about you as an individual to respond to your dependence on me in certain situations and for specific things. All I must know is what you depend on me for. Comprehension, by contrast,

is the ability to know why someone acts the way that they do or expresses certain attitudes. While comprehension can ground certain emotional states that resemble care, such as empathy and compassion, it does not necessarily involve this affective component. Furthermore, comprehension is fundamentally uncertain; just as we can never know ourselves and our motivations with complete accuracy, so is this perfect knowledge of others unrealistic. Yet we can have our suppositions of others confirmed or denied when we act on them—when we suppose that we know how someone might want or need us to respond, for example. The risk of acting on imperfect comprehension is the inherent risk in this third element of signaling trustworthiness. If we are wrong in our supposed comprehension, then our misstep will only deepen mistrust, rather than alleviate it. It is for this reason that clinicians may feel more comfortable in the arenas of competence and caring, where there is less risk but also less potential benefit to the relationship.

While acknowledging mistrust may seem to undermine potential trustees' claims of trustworthiness, it seems that this is exactly what the individuals need to do in order to rectify an atmosphere of mistrust. Otherwise, the atmosphere of mistrust and the prejudiced practices that led to its development are like the proverbial elephant in the room—everyone knows it is there, but no one wants to talk about it. If the potential trustee is willing to acknowledge the atmosphere of mistrust and to work to rectify it based on the patient's or family's expectations of what is nec-

essary, this highlights not only their capacity to be honest and forthright but also their ability to respond to the potential truster's needs.

Establishing Trustworthiness by Taking Risks

Providers seeking to establish their trustworthiness in an atmosphere of mistrust will often feel anxious about this mistrust. This is not surprising; it is perfectly reasonable to respond to the suspicion and instability of mistrust with anxiety, especially if one is wary of being misinterpreted. Medical professionals often respond to such anxiety by relying on the

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knowledge, behaviors, and habits on which they feel they have their surest footing, drawing on their medical training and focusing on their desire to benefit the patient. Yet when providers stress their qualifications and knowledge in the face of difficult medical decisions, it can seem as if they do not understand the source of a patient and family's suspicion. If they overly stress their care for a patient's well-being without acknowledging one of the main sources of the patient's and family's anxiety—mistrust of the very institution in which the patient is being treated and of the members of the profession who are treating them—these potential trusters may feel as if the medical team's professions of care are disingenuous. The best way to rectify this situation is for providers to recognize the aspect of the situation most difficult to deal with, the atmosphere of mistrust.

Acknowledging an atmosphere of mistrust, unlike establishing one's competence or care, involves sig-

nificant risk. While risk is already an integral component of trust, as trust is required only when uncertainty renders the truster vulnerable, the trustee's attempts to establish their trustworthiness involve significant risk as well. This is because potential trustees can never be certain that they are reading the situation, or their interlocutor, correctly, especially when the people involved are from different cultural backgrounds and have different expectations about what will be communicated and how. Potential trustees may mistake the existence of mistrust, or they may misjudge the source of it. As with most interpersonal skills, recognizing and judging mistrust is a skill or a competence that must be developed and can be executed well or poorly. A potential trustee can never know, before voicing their sense that the other party feels mistrust, that it is actually present. Calling it out when it does not exist may lead it to develop. While the risks are real, the potential benefits of acknowledging mistrust are strong: by doing so, the trustee can sow or deepen the trust within the relationship by communicating their ability to judge the situation accurately and demonstrating their honesty to the truster.

This is clear in the types of cases I describe above. Sometimes, it is not until the physician affirms the family's expectations and acknowledges the family's need for specific avenues to be explored that the family will see the physician as trustworthy. From a relational perspective, it is unsurprising that this would be the turning point in such a situation. If all a clinician communicates is competence and caring about an outcome for some patient, without seeking to acquire and express knowledge about why a desired outcome matters, then, unless the family can assume a shared cultural background of values and beliefs, suspicion is a perfectly reasonable response.

The suggestion that medical professionals carry the moral obligation to express their comprehension of the family's situation relates to the epistemological component of trust, especially when the suspicion impeding trust comes from a history of marginalization. Feminist standpoint epistemology proposes that each individual's knowledge is unique to the perspective granted by their particular standpoint in their social environment. Some perspectives, especially those held by individuals in advantageous positions, can be relatively narrow—a CEO does not need to know what it is like to be her office assistant. But the perspectives of those who must respond to people in more advantageous positions, such as the office assistant, are broader and include knowledge of these other perspectives to successfully navigate their roles. For inequality to be reduced or eradicated, people in advantageous positions must make efforts to gain knowledge of those who are more marginalized and to understand what this marginalization looks like from their perspective.[32]

In relationships between white clinicians and African American patients and families, the former is the privileged group, and the latter the marginalized group. Work on epistemic injustice and testimony can be helpful in understanding the normative imperatives here, although the normative valence of justice and trustworthiness point in different directions in the types of situations I describe. In questions of injustice and testimony, the person giving testimony is the person whose speech is not trusted or is not seen as trustworthy, and this is what constitutes the injustice against them. In the issue I am highlighting about trustworthiness and race in medicine, a history of injustice against the potential truster leads the trustee to be seen as untrustworthy.[33] Likewise, although the normative imperative to change one's behavior in the former case lies with the person who mistrusts the agent's testimony for unjust reasons, in this latter case, the normative imperative lies with the person who seeks to be seen as trustworthy, in spite of their membership in a group with a history of unjust action.

Unless clinicians attempt to display their comprehension of patients' particular expectations and concerns about the medical encounter, they will not be seen as trustworthy, and a trusting relationship will not be established. While making the attempt poses a risk of misunderstanding and offense, the potential benefits are substantial. The attempt can contribute to a gradual chipping away at the atmosphere of mistrust that frustrates the patients seeking care and the professionals who are in a position to provide it.

Objections

I have proposed that, contra common assumptions in medical and bioethical scholarship on trust, caring and competence are not always enough to establish a trusting relationship between physician and patient, especially when the physician and patient are from different cultural backgrounds and when there are good reasons for mistrust of medical professionals and institutions. In an atmosphere of mistrust, comprehension of the existence and source of suspicion is essential if the physician is to effectively signal trustworthiness. This is not just because trustworthiness relies on comprehension in general, but also because suspicion is evidence of an epistemological gap between the trustee and the truster—a lack of a shared system of signaling and acknowledging trustworthiness. While theories of trust envision trusting relationships as emerging from shared systems of meaning and common daily routines, in the absence of these shared systems, the two parties in the relationship must work to understand—to comprehend—each other's expectations and experience. In the context of a history of oppression, the burden falls on members of the group with greater power to understand how to be trustworthy and how to signal their trustworthiness.

Although this suggestion may seem uncontroversial, there are a couple of possible objections to this proposal. First is the response that there is nothing medical professionals can do to rectify mistrust and that this is really a job for hospitals' public relations teams to solve. If patients mistrust medical professionals, then the solution is to better convey that medical institutions have instituted reliable methods of responding to and preventing racial discrimination and exploitation. Indeed, it seems unfair for medical professionals who believe that they lack prejudice or bias to shoulder the burden of rectifying the behavior of past bad actors. To this objection, I would respond that, while it may feel unfair to this hypothetical provider, when an atmosphere of suspicion clouds the development of trust within a medical relationship, there is nothing that can be done but for the medical professional to take on the burden of establishing trust. The only alternatives are to allow the mistrust to simmer, which is untenable, or to expect the family to take on the burden of trust, which is unjust. While public relations efforts are certainly helpful and ought to be continuously pursued, they can do nothing to rectify an atmosphere of mistrust once it has pervaded a given relationship.

Second is the reaction that acknowledging mistrust might work in some cases but will not work in all of them, and in some may even be inappropriate. In some situations, it is medically inappropriate to attempt to signal ones' trustworthiness by acquiescing to family requests. This reaction is surely correct. An action-based acknowledgment of mistrust need not always take the form of doing whatever the other party wants.[34] It would be inappropriate, for example, to give a patient an intervention that is clearly not medically indicated, is harmful, or is ineffective. Expressing comprehension of the form that mistrust takes in any given situation is contextually specified. In some cases, mistrust may manifest in a refusal to talk with certain members of a team, or in a demand that all possible interventions be provided (even if harmful or ineffective), or in a stonewalling of any attempts to move the care forward or to discuss goals. Getting to the root of mistrust and attempting to signal ones' trustworthiness will look different in different cases. For example, if the family will not talk to certain members of the team, it may be best not to force them to talk to those providers, but to make a clear attempt to find providers with whom the family feels comfortable.

Effecting Change

The relationship between race and trust in American medicine is complicated, and I do not intend to suggest that mistrust can be resolved through interpersonal and professional relationships alone. Much of the atmosphere of mistrust is not interpersonal but institutional, and it is warranted. A general attitude of mistrust is directed at health care institutions and the medical establishment and not necessarily at specific medical professionals, and mistrust is a logical response to historical and ongoing injustice. Nevertheless, I am interested in how particular individuals working in medical institutions can work to establish interpersonal trust within a more general atmosphere of mistrust, as this is one way that the atmosphere can change. Indeed, this atmosphere must change. Every time a medical relationship fails due to ineffective provider responses to mistrust, a patient's interests are frustrated. In the day-to-day care of patients, we cannot afford to focus exclusively on systemic change.

This is not to discount efforts to reestablish trust in institutions by making those institutions more just; instead, my work here merely emphasizes a different approach to the issue. Further questions remain about whether medical professionals' institutions allow them to be responsive to patients' expectations in ways that signal trustworthiness. Such questions concern not only whether trustworthiness is incentivized but also whether professionals are given the time and the training to be able to respond effectively to the different ways in which patients' dependency manifests. Finally, I have proposed a theoretical perspective on trustworthiness in an atmosphere of mistrust, and it needs testing. Empirical work is required to give voice to the particular experiences of those for whom the American medical system is an object of suspicion, both to understand the elements of mistrust and also to collaboratively imagine what a more trustworthy system might look like.

Notes

1. M. Obama, *Becoming* (New York: Crown Publishing Group, 2018), 90.

2. In this essay, I use "mistrust" and "distrust" interchangeably, as other authors such as Edmund Pellegrino do (E. Pellegrino, "Trust and Distrust in Professional Ethics," in *Ethics, Trust, and the Professions: Philosophical and Cultural Aspects*, ed. E. Pellegrino, R. Veatch, and J. Langan [Washington, DC: Georgetown University Press, 1991], 69-85). I also use "suspicion" to describe an element of mistrust. I appreciate the suggestion of an anonymous reviewer that suspicion and mistrust may not be quite the same thing, and I agree that exploring this would be a fruitful direction for future work on mistrust.

3. S. S. Smith, "Race and Trust," *Annual Review of Sociology* 36 (2010): 453-75.

4. K. M. Hoffman et al., "Racial Bias in Pain Assessment and Treatment Recommendations, and False Beliefs about Biological Differences between Blacks and Whites," *Proceedings of the National Academy of Sciences* 113 (2016): 4296-301; T. M. Cottom, "Dying to Be Competent," *Time*, January 8, 2019.

5. J. Katz, *The Silent World of Doctor and Patient* (Baltimore, MD: Johns Hopkins University Press, 1984); Pellegrino, "Trust and Distrust in Professional Ethics."

6. An important aspect of this is uncovering the extent to which clinical ethics consultation requests correlate with race and gender (B. Spielman et al., "Gender and Race in the Timing of Requests for Ethics Consultations: A Single-Center Study," *Journal of Clinical Ethics* 27, no. 2 [2016]: 154-62).

7. B. H. Gray, "Trust and Trustworthy Care in the Managed Care Era," *Health Affairs* 16, no. 1 (1997): 34-49; A. Buchanan, "Trust in Managed Care Organizations," *Kennedy Institute of Ethics Journal* 10, no. 3 (2000): 189-212; R. Rhodes and J. J. Strain, "Trust and Transforming Medical Institutions," *Cambridge Quarterly of Healthcare Ethics* 9, no. 2 (2000): 205-17.

8. S. D. Goold, "Trust, Distrust, and Trustworthiness," *Journal of General Internal Medicine* 17, no. 1 (2002): 79-81.

9. D. H. Thom and B. Campbell, "Physician-Patient Trust: An Exploratory Study," *Journal of Family Practice* 44, no. 2 (1997): 169-76; D. Mechanic and S. Meyer, "Concepts of Trust among Patients with Serious Illness," *Social Science & Medicine* 51, no. 5 (2000): 657-68; S. D. Pearson and L. H. Raeke, "Patients' Trust in Physicians: Many Theories, Few Measures, and Little Data," *Journal of General Internal Medicine* 15, no. 7 (2000): 509-13; M. A. Hall et al., "Trust in Physicians and Medical Institutions: What Is It, Can It Be Measured, and Does It Matter?," *Milbank Quarterly* 79, no. 4 (2001): 613-39; L. E. Egede and C. Ellis, "Development and Testing of the Multidimensional Trust in Health Care Systems Scale," *Journal of General Internal Medicine* 23, no. 6 (2008): 808-15.

10. Thom and Campbell, "Physician-Patient Trust."

11. Hall et al., "Trust in Physicians and Medical Institutions."

12. Goold, "Trust, Distrust, and Trustworthiness"; K. L. Moseley et al., "Measuring African-American Parents' Cultural Mistrust While in a Healthcare Setting: A Pilot Study," *Journal of the National Medical Association* 99, no. 1 (2007): 15-21.

13. Thom and Campbell, "Physician-Patient Trust."

14. G. Corbie-Smith et al., "Attitudes and Beliefs of African Americans toward Participation in Medical Research," *Journal of General Internal Medicine* 14, no. 9 (1999): 537-46.

15. T. A. LaVeist, K. J. Nickerson, and J. V. Bowie, "Attitudes about Racism, Medical Mistrust, and Satisfaction with Care among African American and White Cardiac Patients," *Medical Care Research and Review* 57, no. 1, supplement (2000): 146-61.

16. L. E. Boulware et al., "Race and Trust in the Health Care System," *Public Health Reports* 118, no. 4 (2003): 358-65.

17. M. J. Arnett et al., "Race, Medical Mistrust, and Segregation in Primary Care as Usual Source of Care: Findings from the Exploring Health Disparities in Integrated Communities Study," *Journal of Urban Health* 93, no. 3 (2016): 456-67; C. H. Halbert et al., "Racial Differences in Trust in Health Care Providers," *Archives of Internal Medicine* 166 (2006): 896-901.

18. J. C. Wiltshire, S. D. Person, and J. Allison, "Exploring Differences in Trust in Doctors among African-American Men and Women," *Journal of the National Medical Association* 103, no. 9-10 (2011): 845-51.

19. Pellegrino, "Trust and Distrust in Professional Ethics."

20. A. Baier, "Trust and Antitrust," *Ethics* 96, no. 2 (1986): 231-60, at 235.

21. K. Jones, "Trustworthiness," *Ethics* 123, no. 1 (2012): 61-85, at 67.

22. K. Jones, "Trust as an Affective Attitude," *Ethics* 107, no. 1 (1996): 4-25, at 4.

23. Hall, "Trust in Physicians and Medical Institutions." There is also ample theoretical work on trust in medical institutions (C. Clark, "Trust in Medicine," *Journal of Medicine and Philosophy* 27, no. 1 [2002]: 11-29). Here, I focus on interpersonal trust between physicians and patients and so draw primarily from work on relational ethics.

24. K. S. Johnson et al., "Improving the Care of Culturally Diverse Patients: Strategies to Address and Navigate the Elephant in the Room," *Journal of Pain and Symptom Management* 57, no. 2 (2019): 357. This is part of the reason for the explosion of interest in cultural competence, which takes a broader approach to improving intercultural communication in health care than the relatively narrow focus on trust here (J. R. Betancourt et al., "Defining Cultural Competence: A Practical Framework for Addressing Racial/Ethnic Disparities in Health and Health Care," *Public Health Reports* 118, no. 4 [2003]: 293-302; S. Saha, M. C. Beach, and L. A. Cooper, "Patient Centeredness, Cultural Competence and Healthcare Quality," *Journal of the National Medical Association* 100, no. 11 [2008]: 1275-85).

25. Jones, "Trustworthiness," 76.

26. Pellegrino also discusses distrust, but primarily as an ethos in contrast to trust in physicians. In other words, he considers distrust as an approach that patients might take to physicians in general as a profession not to be trusted, which is different from the historically conditioned caution at issue here (Pellegrino, "Trust and Distrust in Professional Ethics").

27. M. U. Walker, *Moral Repair: Reconstructing Moral Relations after Wrongdoing* (New York: Cambridge University Press, 2006); T. Govier, "Distrust as a Practical Problem," *Journal of Social Philosophy* 23, no. 1 (1992): 52-63; T. Govier, "Trust, Distrust, and Feminist Theory," *Hypatia* 7, no. 1 (1992): 16-33. Katherine Hawley also addresses distrust directly, highlighting that its absence does not necessarily indicate distrust. There are situations in which neither trust nor distrust is appropriate. Distrust is appropriate when someone has made an explicit commitment to doing something, yet we distrust that they will follow through. To be trustworthy, on Hawley's account, is to "ensure that our commitments do not outstrip our actions" (K. Hawley, "Trust, Distrust, and Commitment," *Nous* 48, no.1 [2014]: 1-20, at 15). Yet while Hawley's account provides a taxonomy of distrust and trustworthiness, it does not seem to address how trustworthiness might respond to distrust, other than by reinforcing one's seriousness about one's commitments.

28. Walker, *Moral Repair*, 85.

29. Ibid., 89, 106.

30. Govier, "Distrust as a Practical Problem."

31. J. N. Zitter, "The Never-Ending Mistreatment of Black Patients," *New York Times*, June 29, 2019.

32. S. Harding, "Rethinking Standpoint Epistemology: What Is 'Strong Objectivity?,'" in *Feminist Epistemologies*, ed. L. Alcoff and E. Potter (New York: Routledge, 1992), 68.

33. K. Hawley, "Trust, Distrust, and Epistemic Injustice," in *The Routledge Handbook of Epistemic Injustice*, ed. I. J. Kidd, J. Medina, and G. Pohlhaus Jr. (New York: Routledge, 2017).

34. S. Wright, "Trust and Trustworthiness," *Philosophia* 38, no. 3 (2010): 615-27.