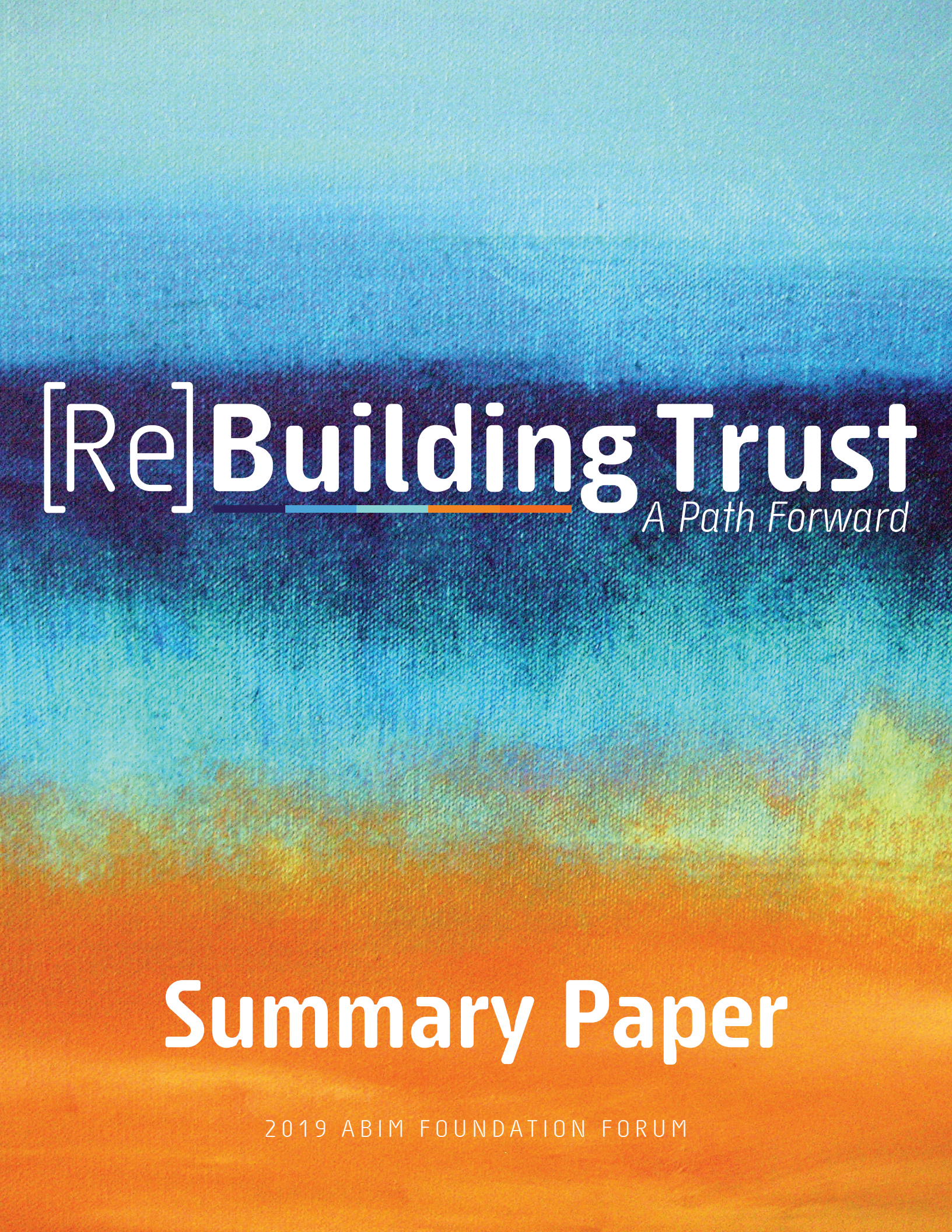
[Re]Building Trust
A Path Forward
Summary Paper
2019 ABIM FOUNDATION FORUM

Leaders from across the health care community joined together in August 2019 to consider ideas for how to enhance trust in, and between sectors of, the health care system. This was the second consecutive year that the annual ABIM Foundation (ABIMF) Forum focused on trust, which is a strategic priority for the Foundation. While the 2018 event largely explored why trust matters, this year's event examined specific approaches to building trust.

BEGINNING THE CONVERSATION

Eight medical students and residents opened the Forum by sharing their stories about trust. Carmen Reid, a medical student at Emory University, noted that many patients harbor doubts about whether financial considerations influence the care and recommendations that physicians provide. She said that medical students and residents are underprepared to navigate their relationships with industry or to talk about conflicts of interest with patients. She called for training in this area "to build patient trust, and to become worthier of being trusted."

Medical students and residents (from left) Carmen Reid, Candice Kim, Mercy Adetoye, Kultaj Kaleka, James Wu, Quinn Bott, Andrew Kim and Alyse Wheelock.

Kultaj Kaleka, a medical student at Central Michigan University, offered a simple suggestion to build trust: Conclude conversations with patients by asking, "Anything else?" "Asking 'anything else' is an admission to your patient that you're as human and fallible as they are," Kaleka said. "It's an invitation to collaborate with you. The first step in building trust is listening to our patients."

Candice Kim, a Stanford University MD/PhD in education student, discussed widespread burnout among medical students, the pressures students feel to conceal any weaknesses, and the importance of "an educational system that teaches us from the beginning of training to trust each other." She suggested the "simple but authentic power of sharing vulnerable stories" as an antidote to the pressures affecting students and clinicians. She described storytelling workshops that she has helped lead at Stanford, in which invited guest instructors teach students about meaningful communication and the students share stories about challenges they face. She said that their program evaluations show a 40 percent decrease in distress among participants.

Quinn Bott, a medical student at the Uniformed Services University of Health Services, talked about building trust by engaging with patients about traditions and stories that are significant to them. He cited a recent patient visit in which an Apache woman was reticent to speak until the physician asked about her daughter's recent Sunshine Dance, a rite of passage. After that, the patient discussed concerns about her diabetes medication that she said she had been hesitant to raise.

Mercy Adetoye, MD, a resident at the University of Michigan, shared her experience of interviewing with residency programs. She said she had to give significant thought about how she would wear her hair, and how program directors would perceive her if she wore it in a natural Afro. “Would I be perceived as the angry black woman?” she said. “I wanted to be approachable, and make them comfortable, so I wore a weave.” She described her approach to determining whether, as an African American woman, she would be protected and supported at a given residency program. Ultimately, she asked why it should be up to medical students to figure that out, and said the onus should be on the programs. She proposed three steps for residency program personnel: (1) participate in bias training; (2) ask candidates if they are concerned about being one of a few minority program participants; and (3) state explicitly that education and training should not be affected by minority status, and that, if it is, residency program personnel should be informed and will respond.

James Wu, MD, a resident at UCLA, described survey research that demonstrated huge variances among surgeons in how they said they would handle clinical scenarios and balance risk and reward. “This illustrates the uncertainty we live in and operate in,” he said. “The status quo of hiding this uncertainty [from patients] is not sustainable anymore.” He said that to gain patient trust, physicians need to demonstrate that they understand risk and can explain the operative experience.

Andrew Kim, MD, a UCSF resident, distinguished between the traditional rotational model of residency—in which trust between residents and attending physicians is extremely hard to build and maintain—and a rotation in which he spent a year with the same physician. He described a patient whom he helped with a difficult pregnancy and who, while arriving by ambulance at the hospital to give birth, called him “my medical student” and said she wanted him to deliver her twins. He called for designing medical school and residency curricula that give significant time to build the trust necessary to help students develop into confident, caring physicians.

Alyse Wheelock, MD, a resident at Boston Medical Center, told a story from her internship that illustrated the importance of patient trust in physicians. The story involved a dying patient’s close-knit family, which viewed any discussion of palliative care as a surrender. Dr. Wheelock said she called the patient’s primary care physician, who agreed to come across town for a “goals of care” meeting with the family. “When she walked in, things started to shift and you could feel the trust,” she said. “The family realized we would aggressively fight for his comfort and peace; shortly thereafter he was transferred to hospice, where he died peacefully.”

Following these eight stories, Richard Baron, MD, President and CEO of the American Board of Internal Medicine and ABIMF, and Christine Sinsky, MD, Chair of the ABIMF Board of Trustees and the Vice President of Professional Satisfaction at the American Medical Association, discussed their reactions. Both Dr. Baron and Dr. Sinsky said they heard a recurring theme in the presentations about the importance of the intentional creation of relationships. Dr. Baron talked about the idea of using patients’ own words to describe their “chief complaint,” starting a more equal relationship between patient and physician at the outset. Building on Kultaj Kaleka’s suggestion of asking “Anything else?” of patients, Dr. Sinsky proposed teaching trainees to begin every patient encounter by saying, “Tell me about yourself.”

THE KIMBALL LECTURE

Toyin Ajayi, MD, Chief Health Officer at Cityblock Health, delivered the Kimball Lecture, the Forum keynote address. Dr. Ajayi began her remarks by noting that “shocking things are happening these days” in health care. She included among these shocking things: a measles outbreak, a quarter of patients not taking their medications one week after a heart attack, a disproportionate number of patients of color leaving the hospital against medical advice, and more than half of practicing physicians exhibiting signs of burnout. “These equate to avoidable suffering, lives lost prematurely, and overwhelmingly bad outcomes,” Dr. Ajayi said. “These things are connected; their roots emerge from pervasive lack of trust in the institutions and individuals providing care.”

Although Dr. Ajayi noted that most would agree that trust is essential, she described it as a “complex and nebulous concept” that is therefore easy to lose sight of. “For a long time, we barely noticed as trust slipped away from us,” she said.

Although trust may be hard to measure, Dr. Ajayi pointed out that we’ve learned to measure pain and anxiety, proving that it is possible to harness and take action around "nebulous concepts." She suggested that the health care world has preferred to look away from trust. “As we focus on trust, we have to ask, ‘Have I earned this person’s faith, hope and belief?’ We look away and rely on lazy proxies for trust, which are scattered around. We treat it like love, something basic that’s imputed. ‘My clinic is overbooked, revenue is up, volume doubled, so it must be there.’ That’s where the conversation has ended.”

Toyin Ajayi, MD speaking during the Kimball Lecture.

Meanwhile, Dr. Ajayi said, some patients have stopped coming, others have rejected what their physicians recommend, and a variety of things have come between physicians and patients: prior authorization, computer screens, wings full of expensive equipment, starched white coats that obscure even physicians’ first names. “We must confront the truth,” she said. “It’s possible for our institutions to be thriving while we are failing to build trust with the people we serve, just as you can don a wedding band and share an address without love – they’re lazy proxies.”

Dr. Ajayi talked about her own residency, and said she “learned to be a great resident until shocking things began to happen to me and my patients.” She described a woman in her 50s who came to the clinic where she was seeing patients as a third year resident. The woman had not seen a doctor in 20 years, and she came to receive treatment for a cough that she feared would disrupt her granddaughter’s christening. At the end of the visit, Dr. Ajayi ordered a chest x-ray that revealed lung cancer; the patient then showed her a fungal mass on her breast: the true reason for her visit, which she almost left without revealing.

"I realized immediately that I had failed her, and likely many others before," Dr. Ajayi said. "I had diagnosed the cancers, but I had failed to build trust in the moment it mattered the most." She graduated from residency and took a job as a hospitalist. "I started practicing differently, less focused on prescriptions and obscure diagnoses and more focused on how each hospitalization fit into the arc of patients' lives," she said.

Almost a decade later, Dr. Ajayi said that at Cityblock Health she is focused on how to create a trustworthy system from the ground up. She shared insights from this work. First, she said it was necessary to acknowledge and seek to address power inequalities. This includes eliminating physicians' white coats and restoring their first names. It also includes home visits, an essential part of the care model that can even out the power differential between physician and patient. In addition, the model seeks to reduce distinctions between physicians and other members of the care team.

Second, she said systems need to invest in promoting trustworthiness, such as through following up with patients. Third, the model must scale and offer dignity, and cannot depend on the "fickle generosity of others" for funding. Fourth, trust must be measured. Here, Dr. Ajayi said she did not yet have a solution, suggesting that we start by asking patients what trust means to them and inviting them to join us in building measures to track trust.

INNOVATIONS

Forum participants had the opportunity to attend small group sessions with the eight winners of the Foundation's Trust Practice Challenge. First, each of the eight offered brief presentations for all participants:

Lolita Alkureishi, MD

- **Graphic Medicine to Empower Patients to Trust Physicians Using Electronic Health Records:** Lolita Alkureishi, MD, Associate Professor and Clerkship Director at the University of Chicago Medicine's Department of Pediatrics, described how she saw excellent physicians and communicators struggle with the adoption of electronic health records, and compiled best practices for patient-centered EHR use. She realized that patients also needed help in navigating the EHR-based health system. This realization prompted the creation of a cartoon that educated patients about the EHR and encouraged them to ask to see the screen and to ask questions of their clinicians.

Melinda Ashton, MD

- **Getting Rid of Stupid Stuff:** Melinda Ashton, MD, Executive Vice President and Chief Quality Officer at Hawai'i Pacific Health, talked about this program, in which all employees reviewed their daily documentation experience and reported elements of the EHR system that they thought were poorly designed, unnecessary or "stupid." She said the program was a critical step to identify and remove obstacles to team-based care and help clinicians in her system thrive.

Kyle Christiason, MD

- **UnityPoint Health Prairie Parkway LGBTQ Clinic:** Kyle Christiason, MD told the story of a 12-year old transgender boy whom he met after the boy's third suicide attempt, and noted that about 20 percent of physicians decline to provide care to transgender people. He described how UnityPoint intentionally reorganized one voluntary site in its clinic system to create a safe place for LGBTQ people to access care, and said the principles they used there were being applied by participants elsewhere in the UnityPoint system.

Brian Park, MD, MPH

- **Relational Leadership Institute:** Brian Park, MD, MPH, Assistant Professor at Oregon Health & Science University (OHSU), described how he and others joined together in 2016 to create the institute, which sponsors three-month learning collaboratives that bring together diverse inter-professional groups of OHSU health professionals. Participants learn about principles of relational leadership, which emphasizes the importance of personal interactions in efforts to bring about change and innovation. After four cohorts and 100 participants, he said there had been a statistically significant impact on the culture.

Chris Queram

- **Wisconsin Collaborative for Healthcare Quality (WCHQ):** Chris Queram, MA, President and Chief Executive Officer of WCHQ, described how health systems in the state came together to develop a method of measuring physician performance for an entire patient population irrespective of payment source and to deploy that method to develop measures for public reporting. He said that 65 percent of Wisconsin physicians now participate in the collaborative and that there has been a continued upward trend in performance on key measures.

Robert Shochet, MD

- **The Colleges Advisory Program:** Robert Shochet, MD, Associate Professor of Medicine at the Johns Hopkins School of Medicine, described how the program was designed to provide all medical students with a network of longitudinal and trusting peer and faculty relationships to support their learning and professional growth. The program offers medical students opportunities for faculty and peer advising and mentoring, and has greatly enhanced the learning environment at the school. Each class is divided into four "colleges," with each group including one-quarter of each class and six faculty advisors.

Stephen Swensen, MD

- **The Leader Index:** Stephen Swensen, MD, Professor Emeritus at the Mayo Clinic College of Medicine & Science, discussed Mayo's Leader Index, which he said was created to help build a culture of trust. All Mayo clinicians rate their leaders on five trust-generating leader behaviors (inclusion, transparency, solicitation of input and ideas, support for professional development, and expression of appreciation and gratitude), and Mayo works with leaders to help them improve. Dr. Swensen said that improvements in leadership ratings have been associated with reductions in burnout; while national numbers on burnout worsened, burnout rates at Mayo dropped.

Anton Zuiker

- **Voices of Duke Health:** Anton Zuiker, Communications Director at Duke University's Department of Medicine, talked about Duke's creation of a listening booth that initially captured patient stories. With burnout concerns in mind, hospital leaders asked that the booth concept be adapted to solicit stories from physicians, who recorded entries about grief and loss, parenthood, cancer and other topics. Duke has made the recorded conversations available through a podcast, which has become popular among the system's physicians.

REFLECTING ON DAY ONE

Catherine Lucey, MD, giving recap of first-day presentations.

In remarks bringing an end to the Forum's first day, Catherine Lucey, MD, Executive Vice Dean and Vice Dean for Education at UCSF, offered another way to think about the challenge of trust, distrust and trustworthiness: as an epidemic of distrust. She talked about how the HIV epidemic changed her conception of her role as a new resident at UCSF in 1982. She said she would challenge UCSF's new residents to consider what epidemic they might face in their careers. She noted the existence of "silent epidemics" and argued that we currently face a "silent epidemic of distrust."

Dr. Lucey suggested that viewing distrust as an epidemic could motivate colleagues to join in the effort to combat it. She noted that distrust is at the root of health care disparities, suicide attempts among transgender youth, and low-value care, pointing out how the chief complaint of the patient in Dr. Ajayi's story (a cough) was not actually her chief concern. For students, she said, distrust is a barrier to optimal learning environments, and a lack of trust in educators places a particular burden on students of color.

"Trust does not have only instrumental value in improving the quality of care," Dr. Lucey said. "It has intrinsic value, because trusting relationships are rejuvenating relationships and distrusting relationships are damaging."

As with the HIV epidemic, Dr. Lucey noted there is no single magic bullet that will solve the problem of distrust. Rather, she said it will take the "collective action of thousands on the front lines, and wise investments of big organizations and the government." She proposed three important steps.

First, she called for adopting trustworthiness as the "North Star" for our health care system. "It may be elusive, but it's more concrete in our patients' eyes than professionalism or altruism," she said. "People know whether they trust someone." She said that this will require meaningful investments in re-engineering systems through which care is provided and research is conducted, among other things.

Second, she said system leaders must "name and own the challenge of creating trustworthy systems and a trustworthy workforce." She noted that no health care system has stood up and said it will not allow for disparities, and commented that it should not be surprising that trustworthiness is in decline.

Third, she stressed the importance of clinicians trusting patients in order to build trustworthiness. "We can only earn and build trust by being reciprocal in our disclosures with patients, whether that is uncertainty about what is best for them, discomfort if we do not know enough, or just stating that we are not at our best on a particular day," she said.

DAY TWO: INNOVATOR COMMENTS

The second day of the Forum began with reflections from the Trust Practice Challenge winners. Moderator Jackie Judd, Vice Chair of the ABIMF Board of Trustees and a communications consultant, asked the panelists for what resonated with them based on their small group sessions and the Forum's first day. Highlights of their comments included:

- "The patient has to be central in our mind and conversations and vision and goals and strategies. What can we do for the patient to call out lazy proxies?" – Stephen Swensen, MD, The Leader Index
- "There is an inequitable access to and distribution of trust, and an unfair burden of the lack of trust falls on those without traditional power in our system. Trust requires at least two people; it's incumbent upon us to pay attention to those on the lower end of that power dynamic." – Brian Park, MD, Relational Leadership Institute
- "Trust doesn't happen by chance; if we leave it to chance we fail. You need to design an experience with intention; for each stage and contact point, you need to pay attention to each person and their perspective." – Kyle Christiason, MD, UnityPoint Health LGBTQ Clinic
- "We create complexity that does not need to be there. Sometimes you can simplify by better understanding regulatory requirements." – Melinda Ashton, MD, Getting Rid of Stupid Stuff
- "One comment that struck me was about the 'tyranny of false precision' in measurement, as if every approach to measurement has to be delineated and specified to the nth degree before it can be used to try and change behavior." – Chris Queram, WCHQ
- "The theme of gratitude emerged throughout our work with the listening booth and podcast series. We need to figure out how gratitude makes a difference" in improving health and health care. – Anton Zuiker, Voices of Duke Health
- "The concept of humility hit me when reflecting on the day. We see the EHR as 'our thing;' it's really our patients' thing. We have to have humility for ourselves, and remain teachable and coachable." – Lolita Alkureishi, MD, Graphic Medicine

Ms. Judd asked the panel about "lazy proxies" in their programs, and how trust could be better measured. Panelists pointed to some clinical measures and to financial incentives for physicians based on patient experience and their productivity as lazy proxies. Rob Shochet, MD, said that an important measure is when medical students begin to embody practices of trust to which faculty aspire.

Participants then had an opportunity to comment and ask questions; a number discussed the patient experience, including the disproportionate burden carried by patients of color in the journey toward mutual trust. A number of participants referenced the idea of "assuming good intentions" on the part of clinicians and patients alike. Meg Gaines, JD, Director of the Center for Patient Partnerships and a law professor at the University of Wisconsin, said that although she has trusted the clinicians who have treated her, "health care is a business that's designed to produce health care widgets at a profit, not to achieve health. We're invited into a trusting relationship with an untrustworthy landlord."

Participants also expressed differing views about measuring trust, with some concerned that attempts to measure trust could undermine it or lead down unproductive paths, and others saying that organizations that aspire to trustworthiness need ways to determine whether they are succeeding.

IDEA DEVELOPMENT

Forum participants spent much of the meeting's second day in workgroups devoted to beginning the process of developing papers on trust topics such as leadership, transparency and communication. They also engaged in crowdsourcing and then developing practical approaches to building trust, working in Open Space groups that would continue to meet and ultimately present their concepts on the Forum's third day.

REFLECTING ON DAY TWO

Don Berwick, MD, MPP, President Emeritus and Senior Fellow at the Institute for Healthcare Improvement, offered concluding thoughts on the Forum's second day. He divided his remarks among three topics: What we are trying to accomplish in trust; what we can do to accomplish it; and how we "are" as we do so.

Don Berwick, MD, MPP giving recap of second-day discussions.

In his discussion of what we are trying to accomplish, he cited a number of quotes from the Forum's first two days and noted that the landlord metaphor that Ms. Gaines offered accurately described the untrustworthy environment that clinicians work within. "To build trust, we can't just change ourselves," he said. "We have to connect things that can be uncomfortable." Quoting French laureate Antoine de Saint-Exupéry, he stressed the need "to be ashamed of miseries you did not cause" such as racism, gun violence and inequity. "You can't say this isn't our job and still build trust like we're called to do," he said.

Turning to how we can accomplish a more trustworthy system, he pointed to the innovations offered by the Trust Practice Challenge winners as paths to "change the story" of our health system. He called for a transition from a transactional system to a relationship-based one, with hallmarks such as gratitude, humility and vulnerability.

Finally, Dr. Berwick talked about how clinicians and other members of the health care community treat themselves poorly, with a particular focus on measurement. He confessed to "extreme ambivalence" about measurement despite his own work to promote it, and disputed the idea that management requires measurement to improve the quality of care. He suggested a rethinking of measurement as part of a larger focus on clinician well-being. "When we treat ourselves kindly, we have more capacity to address miseries we did not cause," he concluded.

DAY THREE: TRUST PRINCIPLES AND PROJECTS

Participants began the Forum's last day with one-on-one and small group discussions designed to identify overarching principles for building and restoring trust. Principles that arose included:

- A heightened sense of situational awareness and the "ability to notice"
- Living up to commitments
- Mindfulness and intention about how we communicate with and relate to one another
- Vulnerability
- Working simultaneously to build trust at the patient-physician, organizational and community levels

After this session, participants re-joined their Open Space groups to continue to refine their ideas. After their discussions, they received advice from attendees who served as consultants and then presented their ideas to the full group. The panel of consultants selected three top entries:

Trusting Wisely: This group would create one menu or toolkit for patients and another for clinicians. The patient component would suggest trust-building questions/topics to explore during the office visit (e.g., financial conflicts, experience performing a particular operation). The clinician component would include tools to build trust, such as questions clinicians can ask to build trust with patients (e.g., "What would you like to know about me?").

Co-Creating Health Through the EHR: Patients would have the authority and ability to see the information in their electronic records under this concept. The workgroup members believed that rethinking how clinicians use the EHR could build trust, giving patients a sense of ownership and potentially increasing physician satisfaction by using a highly-criticized technology in a positive, collaborative way.

Point of Care Disclosure of Financial Conflicts of Interest to Maintain Trust: Under this concept, clinicians would discuss any of their relevant financial interests with patients during office visits, empowering patients to decide how to weigh potential conflicts.

The other eight proposed concepts were:

Restoring Trust: Health systems would adopt restorative justice principles, in which all stakeholders affected by an injustice have the opportunity to discuss how they have been affected and decide what should be done to repair the harm, rather than employing traditional punitive responses to instances of medical error or harm.

Payment Reform: Because the current payment system engenders mistrust, this group would bolster integrity and trust by embracing models that incentivize health outcomes and total health, including attentiveness to social determinants of health. This group believed that payment reform is a critical precursor to most other initiatives to build trust.

Trust and Experience Mapping: This group would use journey maps to track how various aspects of patient-clinician encounters contribute to or detract from trust. The maps would focus exclusively on trust and would highlight opportunities for improvement.

Walk in My Shoes: All personnel in an institution would spend time learning what their colleagues' jobs are like through structured shadowing of team members. This workgroup envisioned that this exercise would increase trust among team members and reduce attrition and dissatisfaction, and that personnel would publicly reflect on the experience with their colleagues.

Building Trusted Leaders: This proposed initiative would publicize the behaviors associated with good leadership and publish research on engagement, professional satisfaction and burnout. It could create toolkits for clinicians and staff on effective leadership.

Won't You Be My Neighbor?: This initiative would have the goal of health systems and clinicians acting as, and being seen as, neighbors in their communities. This would involve partnerships with community organizations to achieve the health care system's vested goal in community health.

Leadership Trust Cards: This group proposed creating a deck of cards that contained leadership qualities that can engender trust. Organizations could use the cards as conversation-starters to foster these qualities among clinicians, staff, etc.

Patient Checkout Survey: Under this concept, patients would answer three yes/no questions after completing clinical visits: (1) My medical needs were addressed today; (2) I have trust and confidence in the care and recommendations I received today; and (3) I know what to do next for my health. The workgroup was interested more in developing a culture of asking the questions than in creating an instrument.

CONCLUSIONS

The final Forum session was a panel that included many of the consultants from the Open Space exercise. Dr. Baron moderated the session and began by saying that he was struck by the concepts that would invite health care actors to "see" things that they routinely miss, such as how patients feel very alone when physicians are focused on the EHR. He said he thought many of the proposed projects would be useful steps in the critical mission of changing culture. Dr. Sinsky focused on the common thread of relationships, and stressed the importance of continuity in building trust.

Jo Shapiro, MD, an associate professor of otolaryngology at Harvard Medical School, said that the importance of creating psychological safety was a common theme across the discussions at the Forum, both for patients who need to be able to ask questions and for clinicians who want to raise concerns or admit errors without being punished. Robert Wachter, MD, Professor and Chair of the Department of Medicine at UCSF, cited predictability as an important theme for fostering trust within large organizations; he referred back to the Getting Rid of Stupid Stuff program as an example of the importance of flattening hierarchies and creating an environment where people can report problems and believe they will be addressed.

The panel discussed continuity, with Dr. Sinsky expressing concern that people are too eager to grasp at technological solutions that cannot take the place of trusting relationships. Dr. Wachter acknowledged the ideal of continuity, but suggested that perfect continuity is impossible and that we need to have a strategic approach to tasks such as care transitions.

Dr. Baron noted that Forum participants had told him how energized they had been by the discussion, and asked what we should take home from the meeting to sustain that energy. Dr. Shapiro suggested close listening, openness to others' perspectives, and humility as key takeaways.

Dr. Baron closed the meeting with the hope that participants were leaving with concrete examples of how trust can be enhanced. We would be very interested in learning about your efforts to foster trust in the coming year; we look forward to hearing from you.

Tim Lynch, Senior Director of Programs, ABIM Foundation