LETTER FROM THE EDITOR-IN-CHIEF

A Crisis of Trust

The conversation was going nowhere. After 15 minutes of explaining my concerns about the possibility of COVID-19, the lack of indication for antibiotics, the unreliability of rapid testing, I was no closer to satisfying my patient, Mrs. Fletcher, than when I first introduced myself. Joan Fletcher was a 40-something working mother of three who came to urgent care on a mission, as many patients do. The reason for her visit: an antibiotic prescription and a note allowing her to return to work. My medical opinion was not on her shopping list.

I used all the basic techniques (and some more advanced ones, too) to convince her that I felt she had COVID-19 and not bacterial sinusitis. I listened to her concerns and addressed them directly. I used analogies, cited research, and shared stories of similar patients who ultimately turned out to have COVID-19. I was polite and respectful in my tone and diction. It got me nowhere. Joan Fletcher was a rock.

It wasn't until after she left the clinic, on her way to decimate my Net Promoter Score, that I realized the fundamental issue with our disagreement. I had not met her expectations, certainly, but that was not the root of the conflict. Mrs. Fletcher simply didn't trust me. And without trust, it's no wonder she saw me as she did: a vending machine that had taken her money and left her candy bar dangling from the tip of the spiral dispenser.

In the midst of the pandemic, we are facing an underappreciated crisis in urgent care, as well as in healthcare as a whole—to put it simply, we lack our patients' trust. Frankly, even in pre-COVID times, winning the confidence of our patients was rarely an easy task in UC. You're probably well aware of some of the more common obstacles we face, such as doubts about our training and urgent care in general, as well as the lack of pre-existing relationship with our patients.

However, with this backdrop, the COVID-19 era has introduced new barriers to building rapport with patients. We'd be wise to be mindful of the impact of these impediments on not only patients' experience, but also our own. Having settled into the "new normal," it's easy to lose sight of how many of the details in our interpersonal interactions with patients have changed dramatically. Before the pandemic, I'd start each encounter by walking into the patient's room with a warm smile on my face, introducing myself with a handshake. I'd then pull up a chair and lean in to hear their story. Now, all the mechanics of this first impression have been restricted. Attempting any similar choreography during the pandemic would do far worse than compromise trust.

Instead, in the name of infection control and the social contract, I enter the patient's room wearing a surgical mask (or two) and a face shield. They're often wearing the same. In a job where the ability to communicate with patients defines success, physical barriers cripple the interaction before it even begins. It's like being a sprinter coming off starting blocks with your shoes tied to one another. Even if you're Usain Bolt, you're going to stumble.

Over millions of years, natural selection has honed humans' ability to subconsciously assess the trustworthiness of others remarkably rapidly in one way: by looking them in the face. Cognitive neuroscientists have pinpointed this function to the amygdala, king of our limbic system and the factory of our fears. Studies evaluating our ability to judge the safety of others by looking at their face have shown that we need merely a few milliseconds before we've made up our minds about who to trust. However, when we cannot fully visualize a face, research suggests that we default to distrust. This makes sense. Those ancestral humans who erred on the side of blind trust in ambiguous situations probably didn't survive as much on average to pass on their DNA.

So how can we balance these competing priorities of responsible mask use and earning the confidence of our patients? Well, mask wearing may be an impediment to trust, but I believe the "either–or" assessment of this situation is a false dichotomy. A SARS-CoV-2 exposure, according to the Centers for Disease Control and Prevention, occurs when we are within 6 feet of an infected individual for longer than 15 minutes. Therefore, it is safe and reasonable, especially as a growing number of UC clinicians have been vaccinated, for us to show our faces from a distance for a moment as we greet our patients.

For some of you, depending on your personal level of concern for COVID-19, age, and health history, this may seem impractical or even reckless. We are all battling varying levels of burnout and COVID-19 exhaustion; certainly, I'm not advocating for any behavior that inspires significant concerns for your personal safety. However, hopefully, with vaccination, lower

"A simple gesture can help establish a connection with the patient, and more trust than you could expect to earn in 15 minutes of listening patiently and explaining."

rates of infection, and better understanding of transmission, our own amygdalas will quiet. After all, fearing those we care for is not a sustainable psychology for career longevity. Furthermore, studies to date on healthcare worker (HCW) infections have shown that with adherence to CDC guidelines for PPE and distancing, HCWs who contracted COVID-19 generally got sick because of a non-patient exposure.

I have experimented with this form of greeting and have found that it serves as a wonderful ice breaker. As I enter the exam room, I briefly reposition my mask and shield to show my face and, with a wide smile and eye contact, I greet them. "Hi, I'm Dr. Russell and I'll be your doctor today. I'll pull my mask up when I get closer, but I just wanted you to know there's a human being taking care of you." I'm almost universally met with a softening in body language—as if we are both transported, albeit momentarily, to a less chaotic time. The connection this simple gesture establishes is among the biggest efficiency hacks I've stumbled upon during the COVID era. In a few seconds, I'm able to earn more trust than I could with Mrs. Fletcher despite 15 minutes of listening patiently and explaining. And during fearful and uncertain times, ravaged by the parallel pandemics of burnout and exhaustion on both sides of the exam table, mutual trust—safely and quickly earned—may be the thing patients and providers alike need the most. ■

Resources

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