Maintaining Trust in the Surgeon-Patient Relationship

Challenges for the New Millennium

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Changes in the structure of the health care system have placed unprecedented stress on the surgeon-patient relationship. The essential trust placed in the surgeon by her patients has been weakened by changes in the structure and financing of the health care system. This article considers the historical and ethical foundation of the surgeon-patient relationship and proposes that the primary moral obligation of surgeons is to strengthen and earn patient trust. By improving communication skills, enhancing ethical education, serving as consistent advocates for patients, and conducting patient-focused outcome research, the surgical community can meet its moral obligation by increasing trust in the surgeon-patient relationship.


At the close of the last century, changing technology, health care infrastructure, and public sentiment resulted in a notable maturation in the discipline of surgery and the relationship between surgeons and their patients. Advancing technology and changing public understanding of disease had resulted in the dramatic move of patients from the home to newly expanded hospitals. There, patients underwent increasingly complex elective surgical therapy made possible by the development of antisepsis and anesthesia. Surgery was no longer confined to amputations and drainage of abscesses. By 1925, the most common operations performed in the Pennsylvania Hospital were tonsillectomies, hernia repair, and appendectomies. Modern surgery now offered physicians the opportunity to operate electively and restore patients to their pre-morbid state safely and with a minimum of pain. As a result, surgeons were no longer solely providers of last resort, to whom patients turned for life-saving but often morbid procedures. Moreover, surgical therapy was now practiced by a growing number of young, aggressive, especially trained physicians who offered patients surgical care for increasingly diverse conditions. The increase in the number and scope of elective, income-generating procedures led to an increased need for a professional code of ethical behavior. Hence, the pledge first taken by the fellows of the American College of Surgeons in 1913 called on surgeons to “place the welfare and rights of my patient above all else.” This code helped guide surgeons’ conduct and enhanced public confidence by assuring patients that the goal of surgical therapy was improved health, not enhanced professional income.

Changes in the technology and infrastructure of health care at the end of the current century have resulted in new, challenging ethical dilemmas for surgeons and their patients. Surgical therapy has been radically expanded by technological advancements such as organ transplantation, mechanical life-support systems, and novel diagnostic imaging technologies. Surgeons are now better equipped to care for older, sicker patients than ever before. The rapid expansion of an aging US population together with this technology has contributed to dramatically higher health care expenditures. While improved anesthetic techniques and minimally invasive procedures have allowed many more operations to be performed
with shorter inpatient stays or even on an outpatient basis, the overall economic cost of surgical care is increasing. Surgery, therefore, often to a greater degree than other medical specialties, has been the target of employer and government attempts to limit expanding medical costs by expanding utilization review and managed care programs. By using capitation, among other cost control strategies, managed care insurers often shift the financial risk of health services use to physicians and facilities as a means to encourage cost-effective care. This linkage between the financing and provision of services has many patients and physicians concerned that appropriate and effective services could be withheld, creating tension between a physician's financial interest and a patient's health interest. This conflict can undermine patients' trust in their physician's decisions, and represents a serious threat to the physician-patient relationship.3,6

Thus, despite the ability of surgeons and other physicians to prolong and/or improve life to a greater degree than in the past, the relationship between surgeons and their patients is strained as never before. Although most patients continue to have faith in their surgeons, public sentiment has largely turned against physicians and surgeons in general. Fueled by anecdotal reports of excessive salaries and managed care company profits, public opinion is turning against physicians, as reflected in a survey by the American Medical Association (AMA) that suggests that 69% of Americans are losing faith in physicians (although not necessarily their own physician). Within this milieu, it behooves surgeons to reflect on the moral underpinnings of the surgeon-patient relationship. This article will draw on the extensive literature on the physician-patient relationship, emphasize its particular application to surgeons, and further define the moral obligations and responsibilities surgeons have to their patients. Using an ethical framework grounded in patient trust, we will examine the impact of the recent changes in health care financing and provision and suggest ethical responses the surgical community should consider.

ETHICAL UNDERPINNINGS

Until the mid-20th century, Western codes of medical ethics were largely derived from the Hippocratic oath. While the original oath offered a set of specific behavior guides to the ancient followers of Pythagoras (eg, it forbade sex with patients), the Hippocratic corpus has been refined through the centuries to provide a moral framework for medical decision making. The ethical precepts arising from the ancient tradition include beneficence (the obligation to help the patient), nonmaleficence (the obligation to do no harm through negligence or design), and confidentiality.6 These concepts served for 2500 years to guide physicians in their relationships with patients and their practice of medicine. Absent from the precepts espoused by the ancient Greeks and their Stoic and later Roman interpreters, however, was a recognition of individual patient rights. Their code of ethics explicitly valued a paternalistic medicine in which the physician's responsibility to act in the best interests of the patient was valued above the rights of his patient.3

The Hippocratic corpus eventually formed the basis of many modern codes of ethics including that of the AMA. The 1847 AMA code enumerated many of the values of the ancient physicians, including a prohibition against abandoning patients, and the obligation to place patient interests first. In keeping with classical tradition, in its section on “Obligations of Patients to Their Physicians,” the original AMA code called for total patient obedience.3 Thus, the patient who presented with a gangrenous limb was expected to permit surgery, without question, if prescribed by his surgeon. Critics further charged that the focus of the initial AMA code was too heavily focused on physicians' rights and responsibilities to other physicians rather than on their duties to patients. It was not until its final revision in 1980 that the AMA code explicitly prescribed respect for patients' rights and autonomy.3

In response to the paternalism in traditional medical ethics and the need for a practical code of ethics to use to make increasingly difficult real-life decisions in the early 1960s, professional ethicists proposed a new method of ethical deliberation. Most prominent is Beauchamp and Childress' Principles of Biomedical Ethics,7 which describes 4 prima facie principles: beneficence, nonmaleficence, autonomy, and justice. Prima facie principles are ethical precepts that must always be respected, unless there is a compelling, usually competing ethical reason to override them. The first 2 principles, beneficence and nonmaleficence, reaffirm the ancient ethical tenets to act in the patient's best interests and to do no harm. The last 2 principles, autonomy and justice, reflect modern theories of moral obligations not found in the Hippocratic tradition.

The principle of respect for autonomy requires that physicians recognize the right of individual patients to make their own health care decisions. This represents a clear departure from the Hippocratic corpus and can seem to conflict with the principle of beneficence. For example, faced with a patient with severe leg ischemia and gangrene who refuses an amputation, a surgeon finds the need to respect patients autonomy (by allowing him to refuse the procedure) at odds with the physician's perception of what is in the patient's best interest (assuming the patient prefers to continue living). In this case, the prima facie principles conflict and thus they provide the physician with no clear way to resolve this dilemma. Although widely used, principle-based theories have been criticized for, among other things, the lack of a defined hierarchy that can be used to resolve conflicting ethical obligations (ie, between the obligation of curing the patient through amputation and the obligation to respect the patient's right to refuse an operation).

The fourth principle, justice, has received increased attention owing to rising costs and a growing proportion of uninsured citizens. The progress of medical science and reliance on the market to allocate health care resources has placed issues of distributive justice in the spotlight of modern ethical thought. Physicians are being asked to participate, like others in the health care system, in efforts to control costs. These pressures are perhaps most dramatic for surgeons who control high-cost, limited resources such as organ transplantation and...
gamma knife neurosurgery, but are faced by almost all surgeons on a daily basis as they interact with insurers, utilization reviewers, case managers, and administrators. The reality of limited resources and the influence (some would contend interference) of third-party payers in clinical medicine has placed increasing strains on the surgeon-patient relationship, to which we will now turn our attention.

**THE SURGEON-PATIENT RELATIONSHIP**

The invasive and potentially life-threatening nature of surgical therapy fundamentally shapes the relationship between a surgeon and his patient and requires an extraordinary degree of trust from the patient and, correspondingly, ethical action by the surgeon. Through the evaluation and therapy of a patient’s condition, the power and control of the clinical encounter is gradually transferred from the patient to the surgeon. Initially, it is the patient who controls the relationship by choosing to visit the physician and to enter into treatment. Ideally, the surgeon and patient discuss therapeutic options and decide together how to proceed. Eventually, it is the surgeon and her operating team who assume total control during the operation. This transfer of power and control differs substantively from the power dynamics between patients and practitioners in most other fields of medicine. Medical patients, in general, retain a substantial degree of control over their care. A patient with hypertension, for instance, may listen to her internist explain the risks and benefits of controlling her blood pressure with a variety of medications, but ultimately it is she who chooses to take her antihypertensive medication or modify her diet. The complete, unavoidable, albeit temporary transfer of autonomy to the physician inherent in surgical therapy makes it imperative that surgeons fully appreciate moral obligations implicit in the surgeon-patient relationship. Of course, these are generalizations, and the medical patient under heavy sedation for a colonoscopy or the surgical patient awake for a cystoscopy also require the patient under heavy sedation for a colonoscopy or the surgical patient awake for a cystoscopy also require the patient to cede some control to his or her physician.

Much empirical and ethical examination of the relationship between physicians and their patients has concentrated on the balance between the prima facie principles, autonomy and beneficence. Prominent physician-ethicists Emanuel and Emanuel, for instance, define 4 models of physician-patient relationships based on the primacy of either autonomy or beneficence. On one end of their spectrum, the paternalistic model, the physician asserts control of the clinical encounter by diagnosing and implementing treatment based on his interpretation of what is “best” for the patient. For the patient with gangrene who refuses surgery, for instance, a paternalistic physician would insist on surgery, perhaps by threatening to withdraw services unless the patient complied. At the other extreme, the informative model, the physician merely lays out the medical options without judgment and allows the patient to choose. This physician would merely state the risks and benefits of surgery compared with nonsurgical “treatment” of gangrene and passively accept the patient’s decision. Their preferred model, the “deliberative” model, lies in the middle. The physician helps the patient to identify pertinent health values and to choose among medical alternatives within a personal context. Thus, the physician should encourage the patient with the gangrenous leg to understand the risks of surgery and to try to overcome the fear of anesthesia. Furthermore, one should educate the patient about the potential of life after amputation, and the potential to return to a healthy, productive life. Through this process of education and discussion, the surgeon is able to establish or enhance the patient’s trust in the physician and his or her surgical judgment.

When a patient presents with a health problem to the surgeon, either emergently or electively, he seeks the skills and advice of an expert who possesses the knowledge and skills inaccessible to the nonsurgeon. The patient thus trusts the surgeon with his life, well-being, and private information. Moral obligations of the surgeon stem from the establishment of this trust-based relationship. A better understanding of trust-based relationships can serve as a practical guide for behavior in practice. Trust is related to the concept of fiduciary responsibility, defined morally and legally as a duty to “put aside self interest, focus primarily on the interests of the person for whom he or she serves as fiduciary, act to protect and promote that individual’s interests, and so earn the trust and confidence of that individual.” The surgeon-patient relationship extends the fiduciary responsibility by virtue of the interpersonal bond of trust that develops between physician and patient. This trust relationship has a moral content—fidelity to trust is morally praiseworthy, while betrayal of trust is morally blameworthy. On acceptance (implicitly or explicitly) of a patient’s trust by the surgeon, he incurs a moral obligation to strengthen and deserve that trust.

**WHAT IS TRUST?**

Interpersonal trust relationships are typically found where there are conditions of risk and uncertainty—certainly present in surgery and all of medicine. The trusting patient is placed, sometimes unwillingly, in a position of vulnerability to the surgeon. The patient grants, sometimes reluctantly, discretionary power to the surgeon to achieve something the patient desires, usually better health or even the preservation of life. It is not only patients who trust the surgeon with their bodies and their health; spouses, parents, or others who care for the patient trust the physician with their loved one. Once trust, no matter how fragile or forced, has been established, patients hold several expectations. First, they have expectations of goodwill and beneficence, that their physician will act to pursue their (not the surgeon’s or another’s) interests. Included in expectations of beneficence are expectations of advocacy—that surgeons will advocate with third parties such as insurers or nurses to pursue the patient’s good. Second, they hold expectations of competence, and even of good outcome; they expect that their trust in the surgeon will lead to their own good because the surgeon is knowledgeable and skillful. Finally, they expect honesty and openness. Deception, even by omission, is a powerful betrayer of trust.

Trust between the patient and the surgeon may differ from other physician-patient relationships for sev-
eral reasons. In many physician-patient relationships, trust develops through a prolonged, continuous process of care in which patient and physician together reach a diagnosis and implement a care plan. This care plan can and should be continually revisited as the patient’s circumstances change. Patients thus retain control of the treatment process. In addition, the relationship has time to develop and mature. Trust-enhancing experiences (eg, of compassion or competent handling of previous medical problems) can strengthen the physician-patient bond over time. Unfortunately, patients often present with surgical problems needing urgent or emergent therapy, so the time to develop a strong bond is absent or short. Compounding this intense and urgent need to trust is the high risk of surgical therapy including death and permanent disability. Little and Fearnside argue that the more serious the disease, the greater the need for trust, as the vulnerability of the trusting patient increases with the threat to health or life. Intuitively, this make sense, as we have less need to trust the practitioner who prescribes antibiotics for otitis media than we do the physician who repairs our child’s heart defect. The nature of surgical therapy requires the patient to relinquish control completely during highly emotional and frightening life events. Patients are, in a way, forced to trust the surgeon’s knowledge, competence, and goodwill, and often need to grant this trust immediately. Action that enhances and justifies patient trust, therefore, is the principal ethical obligation of the surgeon.

Patient trust in the surgeon-patient relationship can be enhanced through individual and institutional factors. Individual surgeons increase trustworthiness through education, clinical skills, and peer review. The emphasis on normative behavior standards including honesty, integrity, and putting the patient’s interest first characterize the surgical residency training. Comprehensive sociological investigation has documented what many graduates of such programs appreciate, that the residency system forgiving technical errors but not moral failings. Moral failings, such as the failure to see and evaluate a patient promptly, are addressed more seriously by attending staff than deficiencies of technique in the operating room. In morbidity and mortality conferences required in surgical departments around the country, residents and staff review errors to, hopefully, minimize recurrence and correct failures in judgment. In practice, the surgeon’s fiduciary obligation includes the ability to perform careful, competent surgical procedures. Patients’ expectations of competence and skill, while present for all physicians, may be more important for surgeons because of the higher potential for long-lasting even irreversible damage (or its perception) and the immediacy of the need for therapy. Contrast this with the situation in primary care, where expectations of excellence in every category are unrealistic, and where multiple positive experiences of competence can be taken into account when a patient encounters a single bad experience. Although patient outcomes may vary, competent practice that nevertheless results in a bad outcome can morally justify trust even if the outcome itself weakens it. Finally, completion of national board certification, membership in professional societies, and attendance at continuing medical education meetings may enhance the trustworthiness of individual surgeons. The American College of Surgeons, for example, has at its core a commitment to provide high-quality ethical care to surgical patients.

Other more visible actions by surgeons can enhance the trust bond between the physician and the patient. Compassion strengthens expectations of goodwill, for instance, while arrogance may lead patients to doubt whether the power they have granted the surgeon will be used on their behalf, or whether the information they receive about risks and benefits is overly optimistic. The quality of communication affects perceptions of competence (so the patient can believe that physician knows what he is doing), beneficence, and openness. An openness (or even eagerness) to patients seeking a second opinion can strengthen trust in 2 ways: first by confirming the patients’ confidence in the surgeon’s opinion (if the second opinion confirms the first); second, by making patients confident that their surgeon is open, honest, and has their interest at heart. Acts of compassion and effective, open communication both justify and enhance patient trust in the surgeon. Finally, inconsequential actions, including public relations efforts, the quality of the surgeon’s dress and mannerisms, and the appearance of the surgeon’s office often result in higher levels of trust, but do not necessarily warrant it.

Institutional reputation and behavior may affect surgeon-patient trust in a variety of ways. Hospital credentialing committees certify a surgeon’s competence to perform specific operations, and this credentialing process may engender patient confidence in the individual surgeon. Nonsurgical staff who provide high-quality, state-of-the-art surgical equipment, competently assist surgeons during the operation (eg, operating room nurses), and facilitate a safe and comfortable operative experience (eg, anesthesiologists and recovery room nurses) all contribute to trust in the surgeon. Finally, clinical advances achieved through innovative research efforts, decreasing morbidity in surgical care, and advancing technology should and do enhance patient trust and confidence.

THE SURGEON-PATIENT RELATIONSHIP UNDER ATTACK

What is the source of the widespread perception that the surgeon-patient relationship has eroded despite rigorous individual and professional trust-building activities? A 1996 Gallup survey reported that only 15% of those questioned had a high opinion of the medical profession, substantially lower than a similar poll in 1983 in which 40% thought highly of the medical profession in the United States. While confidence in surgeons as a group is higher than for many other medical specialties, both surgical leaders and ethicists believe that the surgeon-patient relationship has been damaged by forces both internal and external to the profession.

Surgeons may have contributed to the decreasing level of trust from patients by emphasizing technical procedures over interpersonal relationships. While communication skills are of immense importance for establish-
ing and maintaining trust, especially when the clinical relationship needs to develop rapidly, they are not a key component of surgical residency training programs as they have been in the past. This gap is, perhaps, compounded by shortening inpatient stays. In the past, patients seen by residents were often followed from initial presentation through surgery and postoperative care. Now only the sickest (and hence the least communicative) patients are in the hospital for all 3 phases. This has affected residents’ exposure to the process of communicating bad news, risks, and reassurance. Increasing distance between patients and providers due to organizational patterns may have further weakened the trust bond. The current practice environment, in which physicians see an increasing volume of patients despite decreasing revenues, contributes to the problem by allowing patient communication to fall victim to economic pressures. The incentive under a global fee system is for surgeons to maximize time in the operating room, leaving less time to really talk with patients.20

Reports of greed, fraud, and abuse within the medical profession taint all of our relationships with patients, even though this represents the actions of a very small percentage of the medical community.11 Even high-quality research may lessen public confidence in the profession. Documentation of wide, but unexplained, variation by race and location in the rate of surgical procedures performed has led academic and lay critics to question the factors leading to disparate operative indications and performed has led academic and lay critics to question the factors leading to disparate operative indications and fueled the perception that in fee-for-service systems, surgeons may operate too often.21,22 Economic factors, including physician ownership of surgical centers in which they practice and to which they refer patients, have further undermined patient trust. This ownership creates a conflict of interest that, although not necessarily unethical, can act to undermine patient trust.5,23

Finally, surgeons have been reluctant to embrace solid patient-reported outcome studies that document the value of the work they do. While we actively report good surgical results from centers of excellence, surgeons have been reluctant to examine and report patient outcomes for many routine procedures. While the reluctance stems, in part, from the well-founded belief that the technology of risk adjustment is not adequate, it may engender distrust among patients if it creates the perception that surgeons are hiding or withholding information.4 Professional resistance may also reflect concern about the effect of this information on individual surgeon’s or hospital’s practices, despite its potential to improve overall patient care.

The surgeon-patient relationship has likely also been eroded by more general changes in society, as trust in professionals of all kinds has eroded. Lawyers, teachers, and prominent scientists (e.g., the researchers in Canadian breast cancer trial scandals) have been the subject of harsh criticism. The proliferation of news magazines and the success of investigative journalism have made sensationalized investigations of many institutions, including hospitals, a highly successful and profitable enterprise. While the profession, which suffers from inadequate self-policing, is not completely innocent, the focus of the media on money, mistakes, and mistrust clearly undermines public confidence.24 Finally, the economic success of the health care industry, particularly the pharmaceutical companies, medical device makers, and health insurance companies, has generated a public perception that patients' care and their medical interests have been sacrificed to achieve higher profits.

The process of “managing care” to control medical expenditures of resources through alternative payment systems has fundamentally altered the environment in which the patient-physician relationship is formed. Mechanic and Schlesinger18 argue that managed care has weakened patient trust through 3 mechanisms: financial incentives, utilization review, and care structures. Managed care pays frequently inject the economic consequences of treatment options into the clinical decision-making process. Increased regulation of practice decisions repeatedly generates additional work for surgeons and creates difficult ethical dilemmas. Physicians who challenge a managed care company’s decision to require same-day discharge for laparoscopic cholecystectomy, for instance, risk being deselected and suffering economic consequences for reasonable clinical practice. Surgeons are pressured to discharge patients quickly, thus shifting the burden of care onto the patient’s family and friends, who then blame the surgeon or distrust his motives. Furthermore, surgeons are faced with economic credentialing in which cost analysis of their practice patterns are used to determine hospital privileges, creating clear conflicts with their fiduciary responsibilities.5

Utilization review leads patients to question their physician’s decisions and can lead to the perception that physicians have lost the power to act on the patient’s behalf. While attempts by some insurers to prevent frank discussion of possible alternatives and choices with patients through gag rules have largely been made illegal, insurers continue to attempt to shape the scope and content of surgeon-patient interactions by other mechanisms. By developing internal, proprietary, and non-peer reviewed guidelines and care plans and then hiring care managers to enforce them, the utilization review companies attempt to shape clinical care and limit physicians’ choices and options for their patients.

Finally, Mechanic and Schlesinger18 argue that changes in the structure of health care have dramatically weakened the physician-patient relationship. Surgeons who are employees no longer work for the patient, but rather for the integrated health system or managed care firm. While self-employed physicians are not immune from financial conflicts of interest, the threat of the economic cost resulting from being “deselected” from an insurer’s list of “preferred providers” can be a stronger incentive than the relatively small gain incurred by the performance of an additional, question-able procedure in the fee-for-service arrangement.5,20 Furthermore, from the patient’s perspective, while the fee-for-service system certainly provided financial benefits to the surgeon that might influence recommendations, it was, arguably, more open and obvious. Patients re-
tained the right to refuse treatments they felt might be unnecessary. In contrast, in prepaid systems, patients may fear that expensive options are not being made available to them. Another cost control strategy, limiting a patient’s choice of physician, can influence the confidence patients have in the physicians they are “forced” to see. Similarly, controlling access to specialists by requiring primary care referrals, although primarily placing a strain on primary care physician-patient relationships, can engender distrust of all physicians.

A final point to consider is the effect of the weakened surgeon-patient relationship on those involved. For the surgeon, these ethical conflicts can diminish the essential pleasure of being a physician. Faced with angry patients, hostile insurance companies, and the gnawing worry that clinical judgment is clouded by economic and other forces when it is not being overridden altogether by a third-party payer, surgeons are retiring at an exponentially increasing rate.27 The decline in the strength of the surgeon-patient relationship may also contribute to expensive malpractice litigation. Most important, however, is the strong clinical effect of the surgeon-patient relationship. In a recent survey of patients after surgical treatment for pancreatic cancer, 33% reported needing the surgeon-patient relationship. In a recent survey of patients after surgical treatment for pancreatic cancer, 33% reported needing more emotional support from their surgeon.28 During times of great personal stress and turmoil, patients are in vital need of a strong trust relationship with their surgeon. We therefore have an ethical obligation to ourselves and our patients to strengthen and merit the trust that our patients have placed in us.

**STEPS TO ENHANCE TRUST IN THE SURGEON-PATIENT RELATIONSHIP**

Surgeons should act to limit the effect of economic forces on the patient-physician relationship by minimizing the unavoidable conflicts of interest present in reimbursement mechanisms, and by acting as consistent patient advocates.11,20 By acting as advocates for patients, surgeons enhance trust and strengthen the therapeutic relationship. While there is no clear standard (eg, how many calls per patient must be made to a medical director?) regarding the extent to which one should go to meet this obligation, some attempts must be made even if it places the surgeon at financial risk. Successful advocacy enhances the surgeon’s power in the patient’s eyes; even unsuccessful advocacy shows the patient the surgeon is working for him. By working with professional organizations to create standards and develop guidelines, instead of merely responding to the ones created by insurers, surgeons can become stronger advocates for their patients’ needs. In cases in which insurers refuse to cover expensive but potentially beneficial technology (eg, transplantation and extracorporeal membrane oxygenation), surgeons need to pursue, when feasible, outcome studies to demonstrate both clinical effectiveness and cost effectiveness.

While individual surgeons should continue to enhance personal trustworthiness and strengthen their surgeon-patient relationships, additional action may be required through educational initiatives, changes in credentialing practices, and increased funding for patient-focused outcome research. The foundation of a strong surgeon-patient relationship is the surgeon’s ability to elicit and enhance patient trust. Excellent communication skills, strong clinical and technical abilities, and sound ethical judgment are the crucial elements in facilitating the transfer of trust from patient to surgeon. Unfortunately, while we currently provide excellent clinical training, residents often lack formal and informal education in ethical decision making and communication skills.29 Formal ethical education consisted of one lecture or less in 76% of American surgical residencies despite survey data indicating that 85% of residency directors favored additional discussion of the ethics of end-of-life decisions, managing ethical conflict, and informed consent. While initiatives such as the AMA’s educating physicians in end of life care (EPEC) program and the recent article3 on ethics from the American College of Surgeons may help to meet this goal, a stronger national focus may be needed.30 Similarly, recent changes to require more outpatient clinic time during training should provide for better mentoring for surgical trainees in communication skills. Hopefully, an increased emphasis on building relationships with patients will be reflected in higher levels of patient trust in the graduates of surgical training programs.

To address the public’s loss of trust in professionals in general and physicians in specific, surgeons need to build on the strong tradition of credentialing and self-policing. By ensuring that practitioners have achieved a high level of competence, instances of poor medical and surgical practice can be minimized, thereby justifying enhanced patient trust. This should include, for instance, recertification initiatives that ensure that surgeons have incorporated state-of-the-art knowledge into their practice.3 Hospital credentialing committees should require board certification and technical excellence from the practitioners who practice in that institution. Practitioners also have a fiduciary obligation to patients at large to identify and report other surgeons who are not technically adequate whether owing to age, substance abuse, carelessness, or other impairment.30 We, as surgeons, are uniquely qualified to assess our colleagues and must protect the public trust by ensuring the highest quality of surgical care. While this is a difficult obligation to fulfill, especially when it is needed close to home, it is absolutely essential to maintain patient trust.

Finally, to enhance patient trust, surgeons need to critically evaluate the outcome of surgical therapy, particularly through patient-reported outcomes research. By embracing this type of research, surgeons demonstrate to their patients a commitment to improving their life and health rather than merely to achieving technical successes. Furthermore, with this information the patients are able to make a more fully informed decision about surgical therapy. This attention to the wishes and preferences of patients generally, and to individual patients at the time of decision making, enhances trust both by showing respect and by valuing their definition of “benefit.”

The surgeon-patient relationship is grounded in ancient ethics and has been shaped by historical, scientific, and social forces. For the last hundred years, surgeons have been fortunate to practice in an environment that generously supported surgical therapy. The profes-
sion established strong ethical standards to protect our patients and warrant their trust. We must meet the challenges of the current health care environment by focusing on the cornerstone of our practice, the trust our patients place in us.

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REFERENCES