

Introduction

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ABOVE ALL, THE HIPPOCRATIC OATH (1) promises those who suffer from disease that their physicians can be trusted. Long before the contemporary elaboration of bioethical principles for medical practice, physicians appreciated the need for trust in the doctor-patient relationship and the moral necessity of physicians being trustworthy in the use of their special knowledge and skills. And before confidentiality was ever claimed as a right of individual patients and protected against the intrusive power of the state, the Hippocratic Oath made confidentiality a duty of the physician and trustworthiness a virtue of the Hippocratic practitioner:

Whatever houses I may enter, I will come for the benefit of the sick, remaining free of all intentional injustice, of all mischief, and in particular of sexual relations with both female and male persons, be they free or slaves.

What I may see or hear in the course of the treatment or even outside of the treatment ... I will keep to myself, holding such things shameful to speak about.

As medical knowledge has grown and as medical treatment has become more effective, health care providers have become more intrusive in their history taking and more aggressive in their diagnostic and therapeutic interventions. A medical history now routinely includes probing questions about sexual behavior, alcohol and drug use, psychiatric problems, familial and inherited diseases. Information about individuals' health and medical care is collected in patients' records and computerized databases that are shared with a wide range of

clinicians, researchers and, with the patients' consent, with insurers and employers. In its traditional sense, as physician Mark Siegler (2) has written, confidentiality may well have become "a decrepit notion." Yet, in the realm of treatment, where patients are subjected to invasive diagnostic procedures, where vital organs are removed and transplanted, and where known poisons are administered as chemotherapy, trustworthiness remains the central virtue of physicians and trust remains a central concern in the practice of medicine.

In a culturally and ethnically diverse society such as ours, the grounds for distrust are inevitably magnified. Health care for the poor is usually provided by physicians who are economically better off than these patients. Health care for patients from racial or ethnic minority groups is usually provided by white physicians who are well integrated into the cultural majority, so linguistic, educational, and cultural barriers may divide patients from practitioners. Some patients do not have adequate access to medical care. And physicians' health care decisions, increasingly dictated by the results of controlled clinical trials, may well clash with the culturally and religiously sanctioned beliefs and practices of the patients.

While the editors of this special issue are not enamored with the welter of alternative medical care modalities currently gaining official respectability, we are acutely aware that competing and incompatible beliefs regarding diagnosis and treatment, as well as their lack of a shared perspective on how to justify medical claims, often make trust difficult in the medical arena.

The thirteenth annual New York Regional Conference on Medical Ethics considered many of these issues in its meeting on "Hope, Distrust

and Allocation: Minority Distrust of Medicine.” This conference, sponsored by the Mount Sinai School of Medicine and the Ph.D. Program in Philosophy of the Graduate School, CUNY, brought together a multidisciplinary group of physicians, nurses, philosophers, lawyers, and health care advocates to consider the origins and implications of minority distrust of the health care system. Unlike misplaced trust, which may have no immediate impact on care, distrust often limits the ability of patients to seek, and of medical personnel to provide, health care.

Some of the papers from this conference, like those of philosophers Robert Baker, Leslie Francis, Howard McGary, and Laurence Thomas, and of lawyer Kenneth DeVille, offer broad perspectives on the role of trust in medicine, minority distrust and recent governmental and other efforts to correct past inequalities both in providing access to medical education and in delivering health care. Other papers, like those of physician Ian Holzman and philosopher Lance Stell, provide striking vignettes with commentary on distrust within the hospital-based acute-care setting. Still others, by physicians David Schonholz, Lynne Richardson, Cheryl Smith, Milton

Wainberg, and Millicent Sutton, nurse Lorna Canlas, and medical students Chen-Li Sung and Christine Kajubi, offer history and commentary on specific groups, e.g., recent Chinese or Latin American immigrants, African Americans, and patients with sickle cell disease. They describe the struggles of individuals from these groups to receive satisfactory care and to develop trusting relationships within our current health care system. As editors as well as organizers of the conference, we hope that this issue of *The Mount Sinai Journal of Medicine* will help encourage discussion about the experience of minority group members in their encounters with the health care system. We also hope that it will highlight the importance of trust in the doctor-patient relationship and alert physicians and other health care providers to the serious damage that can be caused by distrust.

References

1. Hippocrates. *Praec.* L. ix, 258.
2. Siegler M. Sounding boards. Confidentiality in medicine — a decrepit concept. *N Engl J Med* 1982; 307:1518–1521.