

Trusting Under Pressure

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Abstract

This essay explores the idea that it is possible for a patient to feel ill at ease with a health care professional, even though there is no active ill will on the part of the professional. Noting that the relationship between the patient and the health care professional, especially in the case of the physician, is an asymmetrical one, I suggest that it is incumbent upon professionals to take extra steps to insure that the patient feels at ease in the staff-patient encounter, notwithstanding the good will that health professionals may be assumed to have toward patients generally. **Key Words:** Good will, ill at ease, active ill will, trust, hypertension, minority distrust.

NOTHING MAKES ONE PERSON MORE VULNERABLE to another than the absence of power. And nothing makes trust a more indispensable good than the absence of power. In important respects, the relationship between patient and health practitioner involves, as I shall specify below, a power differential which greatly favors the health practitioner. For this reason, the practice of medicine is a playing field for the virtue of trust. The absence of patient trust in the health practitioner may often be a factor when a patient feels ill at ease in an encounter with a nurse or a physician. My main concern in this essay is to show that rendering a patient ill at ease can be compatible with having generalized good will towards others. Indeed, just having good will toward others cannot achieve full equality for all members of society. Evil is opportunistic and does not require active ill will in order to bear fruit.

In the final section of this essay, I speculatively apply the considerations of the first two sections to the case of blacks and hypertension, suggesting the possibility that their blood pressure readings tend to be high because they often feel ill at ease in a health care facility. I then go on to make some general remarks about interaction across ethnic and class lines. I conclude with

some remarks about morally correct behavior in an asymmetrical power relationship.

Two final introductory points. First, health care practitioners include both nurses and physicians. In fact, in some cases, nurses may play a more vital role than do physicians. I shall often remind the reader of the role of both by referring to both nurses and physicians throughout this essay. Second, there are cases where the power differential between the patient and the health practitioner is diffused by the social standing of the patient. If the patient is Mother Teresa, a head of state, or some other figure of immense social standing, the power of the physician is diffused by the social standing of the patient. The arguments of this essay do not apply to instances of this sort.

Situating Trust

Characteristically, trust is a matter of voluntarily making oneself vulnerable to another person, who is both aware and accepting of this, with the belief that the person in question will not harm one, even though such harm could be done with impunity (1). Trust can be explicit or implicit. If I permit my child to visit your house in order to play with your child, I will have explicitly entrusted my child's care to your hands, which means a number of things implicitly. I will have implicitly trusted you not to poison her, to call me if she suddenly gets ill, to treat her fairly,

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and so on. I will most certainly not tell you not to poison her; indeed, it would surely be an insult if I did. Or, in any case, if I must make this request of you, then perhaps I should not be trusting my daughter to you in the first place. Or, to take another example, if I ask you to look after my mail while I am away, I am explicitly trusting you to gather my mail and put it in a safe place; I am implicitly trusting you not to read it or let someone else do so. Again, it would be odd if I were to ask you to watch after my mail, and then go on to implore you not to read it, though surely I expect you not to. Once more, if it were necessary to implore you not to read it, then that would be reason to suspect that perhaps I should not be trusting you to look after my mail in the first place.

It is difficult to imagine a case in which explicit trust does not involve implicit trust. There is nothing to be said for trusting you to save me from the lions if I know that you are going to throw me to the sharks. And so if I am explicitly trusting you to do the former, then I will be implicitly trusting you not to do the latter. Let us consider trusting you to be honest in speaking or writing on my behalf, when I have asked if you would do so and you have agreed. I am not asking you to speak the entire truth about me, for that may be considerably more than what anyone has a right to know. What is more, there are various ways of presenting the truth, not all of which are equally positive. While it may be true that I have not published much, this truth can be said in both flattering and unflattering ways. If I have trusted you to write a letter on my behalf, I will also have trusted you to present me in a positive light; doing that is more than a matter of telling the truth. In fact, it is sometimes a matter of not telling certain truths. After all, honesty is not an all or nothing virtue. That is, a person is not considered to be honest if and only if she tells everything she knows.

I have gone on about implicit trust precisely because it is difficult to imagine cases of explicit trust that do not involve implicit trust. Why is that? The answer has in large part to do with the fact that life is textured. That is, in order to perform the task with which one has been explicitly entrusted, there are, typically, an indeterminate number of other things that one has to do. Some of these things are knowable, because they hold generally. But others are not, because they are tied to the particular circumstances that come about, but whose coming about cannot possibly be predicted. That homes can catch on fire, it is knowable; when this will happen is not knowable,

and so the possibility is something that a person would typically take into account in asking someone to babysit for him.

There is more to be said about trust. We can bring this out by looking at what is perhaps the most dramatic expression of trust known to humanity, a trust that occurs between unequals, namely the child's trust of its parents. From the outset, parents have what amounts to complete power over the child, who is utterly dependent upon them for its well-being. There is very little that a 3- or 4-year old could do to prevent itself from being harmed by its parents, if they should desire to do so. If Freud is right, early experiences of parental power are very nearly decisive in determining how the child develops. In particular, they determine the motivational structures that the child comes to have. One of the most morally beautiful aspects of parenting occurs when parents successfully convey to their child that they will not abuse their power, that the child can trust them regardless of the extraordinary power differential between them. And surely it is right to characterize this as morally beautiful, for there is no set of laws on earth which could ensure that parents not abuse their power over their child.

Offhand, it seems natural to think that the parent-child relationship is the only social relationship involving unilateral trust. Not so, however. Systematic inequality can also be a basis for unilateral trust. What is more, wherever we have unilateral trust, considerations of implicit trust abound. This brings us to the field of medicine, to which I now turn.

Patient and Health Care Practitioner

It is a truism that the patient-health practitioner relationship is one of trust, in which the patient trusts the physician. As patients, we go to the physician to learn about ourselves, or to have complicated things done to our bodies that require considerable knowledge and skill. We are given information about things that are going on within our bodies and instructions to follow in order to ameliorate undesirable conditions. To put a finer point on the matter, physicians make authoritative utterances about the patient's body and may perform various procedures on it. They make this or that diagnosis and assert that this or that course of action is necessary to remedy or arrest the illness. To be sure, a patient may thank or compliment a health practitioner. But such actions or words are not tantamount to the patient making authoritative utterances about the health practitioner's body.

Nor, in general, is the patient in a position to make authoritative utterances about any other aspect of the practitioner's life.

Interestingly, our trusting a physician is not just a matter of whether his or her expertise is adequate. To be sure, we want this to be the case. But there is also something else that is absolutely necessary, namely feeling at ease with the physician. This embodies a cluster of notions. Among these are feeling comfortable with what the physician is doing and saying. This, in turn, is tied to the belief that one is being taken seriously by the nurse or physician.

Is the nurse or physician actually listening to what we say, to the nuances that we give to the description of our bodily pain and predicament? Does what we say matter to her or him? Or is the health care practitioner merely waiting for us to finish speaking in order to be able to get on with our physical assessment. Being taken seriously by a physician is of great importance, for obvious reasons. No matter how much knowledge the physician has, nothing whatsoever alters the fact that it is our bodies to which the physician is attending. Accordingly, how we feel about what is to be done to us matters, even if we are mistaken. A hostile, close-minded house painter is one thing; our walls have neither feelings nor preferences nor fears. As humans, we have all three, and a nurse who ignores them cannot possibly gain our confidence, no matter how great his or her expertise. It is not possible for the nurse to ignore us in this regard and, at the very same time, take us seriously. This is because no amount of expertise can render irrelevant our subjective perspective (2). Contrary to what the health practitioner says is supposed to happen, something may cause us pain and we do not want the practitioner to ignore our very real pain on the basis of professional expertise about what is supposed to happen.

Taking another person seriously is very much a human phenomenon. It involves the presumption that a person has self-knowledge or, in any case, that where the person is mistaken about herself this may in fact be instructive. Inappropriate fears often reveal mistaken assumptions about things, especially in a context where a person is relatively underinformed. To some patients, 14 grams may sound like an awful lot, whereas one-half of an ounce does not. If we take a person seriously, we suppose that what he or she says has significance even if we do not fully grasp that significance. Our failure to grasp a remark should leave us wondering what the person really intended to say. If we take a person seriously, we

are less likely to challenge the plausibility of the person's statement than to try to fathom its meaning. By contrast, we do not take the drunk on the street seriously. One sure indication of this is that we spend no time whatsoever trying to make sense of the remarks he hurls at us.

Significantly, whether or not we are taking a person seriously is revealed almost entirely by our non-verbal behavior. To be sure, I can tell someone that I am paying attention to what she is saying. But whether she will actually be convinced by that utterance will depend on her assessment of my non-verbal behavior.

Human beings are better monitors of human behavior than we tend to realize. Two examples suffice to show this. Consider flirting, something which can take place in a matter of seconds. Yet human beings are remarkably accurate with respect to whether a person is flirting with them as opposed to just staring at them or looking past them. If flirting took hours, human beings would be very different creatures, indeed. The second example comes from the parent-child relationship. In a loving parent-child relationship, a child is utterly convinced that its parents love it long before the child can fully understand the words "I love you." From the standpoint of child development, if this conviction came only in the wake of the child's having mastered the language well enough to understand fully the words "I love you," then either human beings would be different creatures or it would already be too late.

In short, while a physician may tell us that he or she is taking us seriously, we are not likely to believe this if the physician fails to exhibit the appropriate behavior in his or her interactions with us.

Drawing upon J.L. Austin's classic work (3), another way of putting the point just made is that taking another person seriously is not a "performative utterance" in the way that promising is. When I say to you "I promise," I have thereby done so, in the absence of certain factors that defeat this (for example, I was ordered at gunpoint to say those words). When I utter "I promise," I may not even be sincere, in the sense that I may hope with all my heart that you insist that I not keep my promise, whereby I get the benefit of having promised without having to carry it through. An even better example in this regard is the utterance "Congratulations!" In so uttering, I thereby congratulate you, even if I deeply resent the fact that you won.

It is true that an actor could come across as taking another person seriously when in fact he is not doing so. And people can feign concern, even

going so far as to cry. It is instructive, however, that people who are capable of crying in the absence of genuine concern are said to be shedding crocodile tears. But feigning concern is exceedingly difficult to do at will without some foreknowledge that one will need to put on a show of concern. And that we have the name "crocodile tears" suggests that even so salient a show of concern as shedding tears may not be convincing if it is not done in just the right way. There is little reason to believe that the typical physician could systematically feign taking a person seriously.

A nurse or physician who has subtle contempt for this or that ethnic group, or for persons of a lower social class may fail to take a patient seriously if the patient comes from one of these social categories (4). And, most unfortunately, the health practitioner is apt to be greatly self-deceived in thinking that he or she has successfully concealed this contempt. In this context, it may be worth mentioning that people can be quite self-deceived about the extent to which their lives actually measure up to the high ideals of equality that they embrace. Specifically, people often make the fallacious assumption that their general sense of good will towards others—different ethnic groups, in particular—precludes their having any biases towards others. But this is not so. Good will is compatible with a multitude of moral failings. For example, good will is quite compatible with an absence of understanding, and an absence of understanding is very fertile ground for stereotypes and biases. Again, not understanding others is very fertile ground for having an irrational fear of them, fear being one of the seeds of hostility.

Good will is not enough. It is not enough to prevent the operation of biases and misconceptions. It is not enough to preclude feelings of contempt and disdain. It is not, in and of itself, a barrier to being misguided in one's thinking about people of other ethnic groups.

Being Seen as an Other

I would like to begin this section with a particular case. The claim is that the percentage of blacks who suffer from hypertension is significantly higher than for people in other groups. No one quite knows why. There has been talk about the kind of foods people eat. Decades ago, this consideration might have seemed plausible enough, but not nowadays. Chips, dips, and fast-food, all of which help contribute to hypertension, have become an American lifestyle. Certainly,

nowadays, neither blacks nor any other group has a monopoly on poor eating habits. Yet hypertension remains more prevalent for blacks than for those in other groups. In what follows, I offer a speculative explanation in line with my reasoning thus far.

Here is a general principle: In any context where we feel at a disadvantage, we feel ill at ease. A quite neutral illustration of this would be an adult trying to speak the foreign language of the country that he is visiting.

In a language that we speak fluently, people may say the most unexpected things when we approach them with a question. While we may be stunned or puzzled by the response or even at a loss for words, we at least know that the response is utterly irrelevant. But when we barely know the spoken language, we are thrown by the smallest departure from the script that we have prepared. For example, we ask for french fries at a McDonald's in Paris. Indeed, we do this with flair, putting "S'il vous plaît" (please) at the end of our request. But the counter person comes back with "Sur place ou emporter?" and we suddenly have no clue as to what the appropriate response should be, discovering along the way that neither "oui" or "non" works, since what we have been asked is whether we want to eat the food there or take it with us. We had not anticipated that particular question and do not know what it means.

Unless one has the self-consciousness of a fly, it is impossible to feel completely at ease in social contexts in a country where one does not speak the language, as the most routine conversations are anything but that. Good will, of course, is of the utmost importance. Still, it is no substitute for a vocabulary, the absence of which makes one feel somewhat ill at ease. Why? Because one cannot participate in even the most routine conversation without running the risk of making a blunder; what is more, one cannot easily recover from a blunder once made. This example shows that even with good will very much in place, there are social contexts in which we can feel ill at ease if there is merely an impediment to our being a participant in a conversation. We need not have been wronged or feel threatened. Nor need we be of inferior social status. All the same, I would imagine that if one were to take our blood pressure in social contexts where we do not speak the language, it would be somewhat higher than normal, simply because we feel somewhat ill at ease. In a word, then, active ill will is not necessary to render a person ill at ease.

I have suggested that there is a correlation between hypertension and feeling ill at ease,

pointing out that it is possible to feel ill at ease even in contexts of good will. In view of the discussion in the preceding sections, the relevance of this suggestion to the issue of hypertension among blacks is perhaps obvious.

To begin with, it is generally agreed that stress contributes to hypertension. Second, an environment in which individuals feel ill at ease is conducive to stress in those individuals. Next, individuals are most certainly likely to be ill at ease, and so to experience stress, when they are not being taken seriously by someone who is making authoritative assessments and judgments that they may not fully understand, concerning their health and bodies, and that individual has a certain degree of power over them and their bodies. Finally, notwithstanding enormous goodwill, it is possible for physicians and nurses who embrace ideals of equality to have untoward feelings towards blacks, as a result of which they (the health practitioners) fail to take blacks seriously. So, health centers may very well be a variable in blacks' displaying high blood pressure.

Two caveats are now in order. The first one is that, of course, I most certainly have not meant to suggest that there are not any physiological factors which are relevant to hypertension being prevalent among blacks. There are undoubtedly a multitude of factors that contribute to hypertension. But if indeed stress is one of them, then the consideration that I have advanced (of feeling ill at ease with the physician) must certainly be taken into account.

Secondly, while I have used the case of blacks as a specific illustration of the way in which feeling ill at ease with a nurse or physician may be a factor in persons showing signs of hypertension, it should be obvious that the argument can be extended to other groups and to persons from a lower economic class. Nor does my argument presuppose that only whites can make persons feel ill at ease. That is preposterous. A black health practitioner could render an Asian patient ill at ease. Or conversely, where the health practitioner is Asian and the patient is black. An Indian nurse or physician could render a Latino patient ill at ease. Or conversely. And so on. What is more, even if the physician and the patient are of the same ethnic background, it is possible for the physician to render the patient ill at ease; for members of the same group, as defined by some external feature, can have misunderstandings of other members of that group where there is a division along class or cultural lines. The categories of black and Asian, for instance, include a multitude of peoples. It is

surely not a given that all blacks or all Asians understand one another, as there have been histories of strife between different black groups and different Asian groups.

Now, I should point out that sometimes it is not in any way the health practitioner's fault that a patient feels ill at ease with the practitioner. Sexist attitudes among patients, regarding who might properly serve as their physician come readily to mind here. But the same holds equally well for racist attitudes regarding who might properly serve as a physician. That there are men who hold that a woman cannot be a first-rate physician, and whites who hold the same regarding blacks, hardly needs pointing out. The patient, too, may bring biases to the office of a health practitioner. That having been said, however, we must not lose sight of the fact that (as I remarked earlier) the physician-patient relationship is an asymmetrical power relationship that mightily favors the physician, because it is the physician who makes the authoritative utterances about one of the most personal aspects of a person's life—namely, the person's body.

Conclusion: Moral Goodness Beyond Rights

Rights talk is all the rage nowadays. Nauseatingly, there are rights and counter-rights to just about every imaginable activity. In some cases, it is far from clear what it even means to have the right in question. What could it mean to have a right to be stupid or wrong, as some have claimed? But one thing that is clear is that the focus on rights skews the moral landscape. Does anyone have a right to be greeted with "Good morning"? Surely not! Yet a world in which people did not so greet one another in their social interactions would be a much less desirable place in which to live. The language of rights does not always make for a morally richer world.

Do patients have a right to a physician who understands their background and experiences? Does a physician have a moral duty to learn these things about his or her patients? In general, does a physician have a moral duty to put her or his patients at ease? Whatever the answer to these questions might be, a physician does an immeasurable moral good in learning about her or his patients, and doing as much as possible to put them at ease. Being at ease with another is an intangible moral good of enormous significance, to which the language of rights cannot begin to do justice. In fact, even if there could be such a thing as a right to be put at ease, it would hardly be a right that one would want to claim against

others. For only purity of heart and depth of conviction could make it possible for one person to succeed in putting another at ease. But these are traits of character, and traits of character cannot be legislated.

If nurses and physicians are to succeed in making the patient feel at ease, this has to be done because they want to do so. But if good will is not enough, then it follows that, in order to put the patient at ease, physicians must cultivate a concern for others that extends beyond good will—a concern which, though it cannot be demanded as a right, constitutes a recognition of the humanity of the other. For we are not just formless human beings. Each of us is a human being with particular qualities and needs. And while it may be a contingent feature of life that we came to have one set of particular characteristics rather than another, these particulars nonetheless become a constitutive feature of the life that we live. Thus, to be indifferent to these particulars is to be indifferent to a person's humanity as it has taken expression in his or her life. And this no morally decent person should want to do.

I believe that each of us has the moral resources to inspire trust and put others at ease, if only we would find doing so desirable, if only we should so choose. For this is a choice that we must make; it will not just happen. It is possible to be harmful in our interactions with others without having active ill will. So if health practitioners choose not to be informed about the particulars of a person or a group of persons with whom they interact regularly, if they steadfastly insist, evidence to the contrary notwithstanding, that good will suffices for the tasks at hand, then it may be legitimately asked whether their resolute unwillingness to alter their behavior is itself a species of ill will. In the name of just doing their

job with good will, every health practitioner—every nurse, every physician and every social worker in the health professions—would do well to bear this consideration in mind. After all, trust is a moral virtue in its own right, a moral virtue that is not reducible to good will.

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