Developing, Losing, and Regaining Trust in the Doctor-Patient Relationship

James K. Rustad, MD[a,b,‡,*]; Steven C. Schlozman, MD[a,‡]; Reuben A. Hendler, MD[c,‡]; Matthew J. Rasmussen, MD[a,‡]; Gerald L. Rader, III, MD[a,‡]; and Theodore A. Stern, MD[c]

LESSONS LEARNED AT THE INTERFACE OF MEDICINE AND PSYCHIATRY

The Psychiatric Consultation Service at Massachusetts General Hospital sees medical and surgical inpatients with comorbid psychiatric symptoms and conditions. During their twice-weekly rounds, Dr Stern and other members of the Consultation Service discuss diagnosis and management of hospitalized patients with complex medical or surgical problems who also demonstrate psychiatric symptoms or conditions. These discussions have given rise to rounds reports that will prove useful for clinicians practicing at the interface of medicine and psychiatry.

Prim Care Companion CNS Disord 2022;24(3):21f03184

To cite: Rustad JK, Schlozman SE, Hendler RA, et al. Developing, losing, and regaining trust in the doctor-patient relationship. *Prim Care Companion CNS Disord.* 2022;24(3):21f03184.

To share: https://doi.org/10.4088/PCC.21f03184

[a]Department of Psychiatry, Geisel School of Medicine at Dartmouth, Dartmouth Hitchcock Medical Center, Lebanon, New Hampshire

[b]Department of Mental Health and Behavioral Sciences, White River Junction VA Medical Center, White River Junction, Vermont

[c]Massachusetts General Hospital/Harvard Medical School, Boston, Massachusetts

‡Denotes co-first author.

**Corresponding author:* James K. Rustad, MD, Department of Psychiatry, Geisel School of Medicine at Dartmouth, Dartmouth-Hitchcock Medical Center, One Medical Center Drive, Lebanon, NH 03756 (james.k.rustad@dartmouth.edu).

Have you ever wondered how trust in the doctor-patient relationship can be facilitated and established? Have you reflected on when, why, and how that trust can be fractured or lost?

Have you deliberated on whether and how trust can be regained? If you have, the following case vignette and discussion should prove useful.

CASE VIGNETTE

Mr A, an undomiciled 34-year-old man with a substance use disorder (SUD), was admitted to the hospital with a forearm abscess, fever, anemia, and an elevated white blood cell count, as well as signs and symptoms of alcohol withdrawal. He described a 12-year history of intravenous (IV) heroin use, 10 years of heavy alcohol use (approximately 1 pint/day), and a 30-pack/year smoking history.

On his second hospital day, he requested to go outside of the hospital to smoke a few cigarettes. However, his medical team refused to grant his request, suspecting that he would use narcotics when unobserved. Mr A became irritated, and he stomped back into his room. Thirty minutes later, Mr A was "found down" in his bathroom. He had injected heroin into his peripherally inserted central catheter.

DISCUSSION

What Is the Basis for Trust in the Doctor-Patient Relationship?

With respect to our case and discussion, we will define trust between a patient and a physician as a bidirectional process through which certain *expectations and feelings* exist as a function of both explicit and implicit notions of what a patient expects from a doctor and of what a doctor expects from a patient.[1–3] Medical ethicists and educators have agreed that trust from patient to doctor and from doctor to patient rests on shared expectations, including competence, reliability, confidentiality, privacy, compassion, dependability, and communication.[2,4–7] In this sense, the expectation between the doctor and the patient is a type of social contract.[5] As is the case with the more common political definition of social contracts, these expectations are often not explicitly stated but are nevertheless agreements of the society in which the doctor-patient relationship exists.[5]

Trust varies from one doctor-patient relationship to another based on both emotional and cognitive factors. Some emphasize the affect that patients experience with doctors as the primary basis of trust,[4,6] whereas others argue that cultural expectations

Clinical Points

- Trust between a patient and a physician is a bidirectional process through which certain expectations and feelings exist as a function of both explicit and implicit notions of what a patient expects from a doctor and of what a doctor expects from a patient.
- Patients whose identities place them in the crosshairs of oppressive forces (eg, racism, prejudice, and discrimination) may direct skepticism toward even well-meaning clinicians due to their position within a health care system that has been influenced by systemic forces.
- Dishonest communication can be understood as a strategy employed by mistrusting patients to convey their suffering, to muster a clinician's competence, to recruit a clinician's beneficence, to avoid the potential for harm, and to maintain their autonomy.
- Once the clinician and the patient have agreed that trust has been shattered, it is time to start working toward a solution, which requires time and cooperation.

are most important.[5] Interruptions of trust between a patient and a doctor can occur when either affective or cultural expectations fail to be met. A brilliant but off-putting doctor is not likely to be trusted, but neither is a warm, caring, but ill-informed one. In a similar fashion, a charming patient can fail to tell the truth and nevertheless still be trusted, whereas a highly informed patient might fail to garner the doctor's trust as a function of behavior that the doctor experiences as rude or belittling. Because of the influence of affect, trust can vary as a function of a patient's past experiences and biases that influence how they feel toward a doctor—and vice versa.[1]

The carryover of trust from a primary care provider (PCP) or influence of a break in trust with a PCP (which might be involved in the medical precipitant to admission) should be mentioned. Any rifts in trust when a relationship exists typically require inquiry and discussion. In hospital settings, trust relationships often involve house staff and attending physicians/consultants who the patient has never met before. Generally, it takes time to develop trust unless there is an "institutional transference" (eg, allegiance to a hospital/hospital system or group of practitioners). Inpatient care is multidisciplinary, and not all teams pull on the oars at the same time (or in the same direction) and are perceived as not being on the same page. This may be the reality or a manifestation of splitting by the patient. Open communication with a designated physician to run rounds (with the entire interdisciplinary team) and an "open dialog" approach can be beneficial (ie, identifying the members of the team). Continuity of care is often challenged by frequent team changes; this is an unfortunate reality. Chaos can be minimized by meaningful pass offs.

When Does Trust Develop During Development and Adulthood?

Bowlby (a family psychiatrist who investigated child development by studying the experience of young children who were removed from their homes and placed into the care of foster parents)[8–11] proposed that emotionally significant attachment bonds serve a basic survival function in human evolution. He defined secure attachment as a behavior pattern whereby a child becomes confident that their parent (or a parental figure) will be responsive and caring, especially when the child is under duress.[8] The child requires trust and confidence to explore the world outside of the parental attachment, and secure attachment provides that trust. Anxious resistant attachment is a pattern that develops when a child is uncertain about whether their parent will respond in a caring manner; the child becomes vulnerable to separation anxiety and a clinging dependency. Children with a pattern of anxious avoidant attachment come to expect rejection from parental figures, which leads the child to a strategy of avoidant withdrawal and predisposes them to the development of a borderline personality organization with its concomitant dependency-interdependency struggles.

Attentive care by a responsive mother in the first 6 months of life predicts secure behavior (ie, the child feels comfortable enough to explore their environment) in the second 6 months.[12] The mother's loving care creates an environment that involves basic trust through the experience of unconditional love; this serves as a paradigm for other caretaking relationships (eg, the doctor-patient alliance). In adult relationships (eg, marital interactions and therapeutic relationships), empathic failures and mis-attunements are common; however, repair of these ruptures forms the basis for healing and for psychological growth.[12,13]

Attachment-based social interactions that involve trust[14] are also affected by hormonal changes. Oxytocin enhances approach behaviors and likely serves as a neuromodulator for the mediation of trust.[15,16] For example, in a study of subjects engaged in a trust game with real monetary consequences, administration of intranasal oxytocin altered decision-making by enhancing trust and by facilitating prosocial approach behavior, even though it did not directly produce reciprocity.[17]

The developmental failure to achieve object constancy organizes much of the behavior and thinking of paranoid adults.[18,19] Paranoid people are convinced that caretaking and love relationships are unstable and dangerous because they fail to maintain attachment with an internal object representation.[20] Thus, paranoid adults, due to hypervigilant guardedness and attentional monitoring,[20] are unable to trust others. The paranoid cognitive style they manifest is characterized by a lack of flexibility and an unrelenting search to uncover the "truth" behind the face value of a situation (eg, as is the case with those who endorse conspiracy theories).[20] Suspicious individuals dread being surprised more than the danger itself.[21] Projection is a characteristic defense mechanism used by paranoid people, and it transforms internal threats that are created by the pressure of intolerable thoughts, feelings, and impulses into an external threat that is easier to manage.[21] Projection fails to distort the significance of the apparent reality;

instead, it warps the significance of events and overvalues their importance.[21] Paranoid people meet reality halfway by projecting internal tensions into the external world.[21]

What Contributes to Fractures of Trust?

Trust between a patient and a clinician rests on the therapeutic alliance, a mutual understanding that the clinician can be relied upon to understand their patients and promote their well-being in accord with the patients' own wishes. Patients come to mistrust clinicians when they doubt their clinicians' understanding, competence, beneficence, and respect for autonomy.

During early development, infants' elicitation of needed support relies on their caregiver's response to bids for attention (eg, crying) with manifestations of empathic connections and understanding. The same is true for adult patients, who need their clinicians to recognize and take their suffering seriously and to attempt to identify the underlying cause of their distress. Patients who have had good enough caregivers may assume that clinicians are able and willing to understand them. However, patients who have not been so fortunate may bring skepticism to their encounters and require repeated and authentic demonstrations of accurate empathy before they feel understood. Because arriving at a perfect understanding is nearly impossible and differences in perspective are inevitable, it is crucial to demonstrate empathy when addressing and repairing recognized ruptures in understanding.[22]

Understanding must be coupled with competent interventions if clinicians are to be effective. Here again, patients who have had helpful caregivers may readily assume that subsequent clinicians will be proficient. For these individuals, it may take blatant mistakes or demonstrations of incompetence to fracture trust in the therapeutic relationship. However, other patients bring a history of failed interventions, which have deeply ingrained a sense of futility; when this occurs, patients may not feel that there is reason for optimism.[23] For these individuals, an active demonstration of competence may be required. Patients are often unlikely to communicate honestly with a clinician whom they do not believe can help them.

Even if a clinician can be helpful, some patients may not trust that their clinician will try to help. Some patients see clinicians as being inherently self-interested and wonder whether their needs will be prioritized when struggles arise between the needs of patients and clinicians. In addition, clinicians often have responsibilities to, and pressures from, their employers, as well as from the settings in which they work, from public health mandates, and from commitments to teaching and conducting research.[24] When clinicians respond to these obligations, patients may fear being deprioritized and exploited, for example, as when one is asked to serve as a research subject or be examined for the benefit of trainees. Here again, some patients give clinicians the benefit of the doubt, whereas others assume ill will (due to unjustified paranoia or earlier experiences) until proven otherwise.

Unfortunately, health care is not immune to the influence of oppressive forces (eg, racism, prejudice, and discrimination), which operates both implicitly and explicitly at structural, interpersonal, and individual levels and contributes to inequities in health care outcomes.[25] Patients whose identities place them in the crosshairs of these issues may, justifiably, direct skepticism even toward well-meaning clinicians due to their position within a health care system that has been influenced by systemic forces.

Even when a patient trusts a clinician's inclination to help, a trusting therapeutic alliance may nonetheless be thwarted due to a fear of harm from the clinician that may arise as a "side effect" of treatment. These fears may be of physical harm (such as from treatment complications or medication side effects) or psychological harm (such as needing to perceive oneself and be perceived by others as sick, with attendant anxiety and stigma). Patients may believe that endearing themselves to their clinician will enlist the clinician's help and minimize the potential for harm; as a result, patients may lie to their clinician so that they will be liked. In such a relational context, patients may not communicate honestly with clinicians due to a fear of being judged. The judgment of clinicians can sting more because of their role as authority figures.

One harm that patients may reasonably expect from clinicians is restriction of autonomy. A therapeutic alliance requires clinicians and patients to share common goals; however, the values and priorities of clinicians and patients can conflict and create dilemmas. Even the most broad-minded of clinicians may prioritize health and safety, whereas those goals may be of less importance to some patients.[26] Clinicians set hospital rules, which generally involve restrictions of autonomy; for example, patients are expected to remain on the premises, to adhere to specific diets, to follow certain schedules, and to refrain from cigarette smoking or use of recreational drugs. In certain contexts, clinicians can compel patients to be brought to the hospital, to hold them there against their will, to monitor them around the clock, to administer medications that are unwanted by the patients, to physically restrain them, to restrict their access to possessions, and to limit their communications with loved ones—all of which may be understandable sources of irritation and apprehension. On occasion, clinicians collaborate with other controlling systems (eg, child protective services and law enforcement) that may see a patient as someone to be controlled or punished. Patients with a history of trauma and those who are from communities that have been subjected to structural racism may be particularly vigilant for, and fearful of, how clinicians may restrict their autonomy in the name of health. Trust and mistrust can flow from how clinicians align with their patient's values and negotiate power and autonomy when tensions arise.

Why Do Patients and Their Health Care Providers Lie to One Another?

Honest communication flows from and reinforces trust among patients and clinicians; conversely, dishonest

conversations often engender and reinforce mistrust. Dishonest communication can be understood as a strategy employed by mistrusting patients to convey their suffering, to muster a clinician's competence, to recruit a clinician's beneficence, to avoid the potential for harm, and to maintain their autonomy. Such behavior is ubiquitous, a point readily driven home by clinicians' reflections on whether they themselves have always been entirely forthcoming and honest with their physician, dentist, or psychotherapist. Dishonest communication can be divided into intentionally leaving out important information (omission) and communicating false information (commission). Familiar examples of commission include lying (making a false statement with the intent to deceive) and exaggerating, mischaracterizing, and feigning symptoms. Frequently encountered omissions include minimizing disclosure of problematic behaviors, neglecting to acknowledge stigmatized diagnoses, and avoiding sensitive questions or efforts by the clinician to engage with them.

In our case (Mr A), we could hypothesize about why he may have lied about having recreational drugs in his possession. He may have feared being stigmatized (given his substance misuse history), which is a common response by clinicians and one that can interfere with empathic understanding.[27] He may have wanted to remain in the clinician's good graces (to enlist their beneficent and competent treatment of his infection). He may have been trying to avoid restrictions on his autonomy (in the form of his property being confiscated and from being prevented from using drugs of his choosing). His experiences may not have provided him with the confidence that his in-hospital drug withdrawal would be adequately recognized and managed, and he may have wanted a safeguard against undue discomfort. He may have wanted the assistance of a drug to help him cope during a stressful time. Or, he may have simply felt embarrassed to disclose behaviors that he knew would be contrary to hospital policies.

Fleshing out the differential diagnosis of dishonest communications, the diagnoses of malingering and neuropsychiatric pathology need to be considered.[28] Feigning or exaggerating medical or psychiatric symptoms with the intention to achieve secondary gains (eg, shelter, freedom from imprisonment) indicates malingering, whereas the unconscious desire to achieve the sick role reflects factitious disorder. In addition, some people make dishonest (false) statements because they do not know the truth and do not appreciate their cognitive limitations—for example, in neurocognitive disorders. In cases with confabulation, classically associated with Wernicke-Korsakoff syndrome, a patient may furnish false information to fill memory gaps without realizing that is what they are doing. Due to anosognosia, associated with certain types of strokes and psychiatric disorders, patients may deny that they have an illness, as they are unaware of their deficits. Another pathological source of what can appear to be dishonest communication is dissociation, wherein a patient's psyche is fragmented (such that conscious awareness is cut off from perceptions or memories). More broadly, the psychodynamic model of the mind posits that important aspects of the psyche are often kept out of awareness by psychological defenses, which may distort a patient's view of reality in the context of personality disorders. "Deceitfulness, repeated lying, use of aliases, or conning others for pleasure or personal profit" is among the diagnostic criteria for antisocial personality disorder, characterized by "a pervasive pattern of disregard for and violation of the rights of others."[29]

The psychological impediments to a patient's truth-telling can similarly interfere with a clinician's honesty. Clinicians generally want to be liked and respected by their patients. When clinicians make mistakes or fall short of being competent and beneficent, they may be reticent to acknowledge their shortcoming, especially if they fear retribution or other harms from the patient. Clinicians are also subject to psychological defenses that can distort their perceptions—for example, discomfort with death may hinder a clinician's recognition of a patient's decline. Clinicians may also intentionally present information in a favorable light to influence the patient beneficently, eg, to help the patient maintain hope or positive expectations about a treatment that may increase its efficacy through optimization of the placebo response. The ethics around physician disclosure are often less straightforward than patients expect, and controversy exists about how much physicians should disclose.[30]

How Can Trust Be Repaired and Reestablished?

Reestablishing trust among clinicians and patients requires more than a few simple words or deeds. Offering apologies can facilitate this endeavor, but this practice is often insufficient to restore a therapeutic alliance.[31] Acknowledgment that trust has been fractured is typically necessary before rebuilding of trust can proceed. Then, further steps can follow[32]; however, this process requires time and cooperation.

When trust is lost, it is often convenient to consider that a "patient is difficult," as this places the blame squarely on the patient. However, it is preferable to reframe the interaction and to view the encounter as difficult; this gives the clinician some responsibility for the rift[33] and creates an opportunity for problem-solving.

With difficult patients or situations, clinicians may seek evidence for why they should fire patients.[34] However, stigma (eg, related to substance use, minority status, sexual orientation) frequently underlies distrust and promotes less-than-professional care.[35,36] Clinicians who reflect on their unconscious biases and who consult with colleagues about their behavior can enhance their insight and interactions.

Clinicians should also recognize that their medical knowledge has limitations; this facilitates humility.[35] For example, seasoned clinicians generate hypotheses about their patients' behavior and think that they know why their patients act the way that they do (eg, using illicit drugs); however, assumptions are not equivalent to certainty. Acting humble allows for more active listening and for empathizing with a patient's story.

Empathy is essential for forming attachments (such as a therapeutic alliance) and for repairing disrupted rapport.[37] Demonstrating empathy (with verbal and nonverbal expression [eg, mirroring facial expressions, nodding, and "leaning in"]) can deescalate conflicts, validate a patient's distress,[34,37] and demonstrate a clinician's effort to understand a patient and their experience. Silence, on the other hand, in response to a patient's emotional expressions may be perceived as disinterest and engender erosion of trust.

Once the clinician and the patient have agreed that trust has been shattered, it is time to start working toward a solution. Several communication strategies can be considered during this problem-solving process to restore the therapeutic alliance. Collaborating on setting expectations and boundaries will provide a framework for reestablishing trust.[34] Remaining calm and speaking softly when conflict arises will allow for ongoing interactions. Reminding the patient about prior successes may help them regain confidence and composure.

As the trust-building process unfolds, less-than-optimal interactions may develop. Addressing these interactions honestly allows for problem-solving to continue.[33] Developing a consensus among members of the treatment team and designating a single spokesperson to communicate relevant information to the patient creates a united front and reduces splitting.

Trust in the treatment team is often impossible when there is a mismatch between a patient's developmental or education level and the treatment team's communication style. A shared vocabulary and minimal use of medical jargon allows for questions to be answered and for effective use of metaphors.[33]

Clinicians may be tempted to set strict rules with harsh consequences after a breach in trust (eg, when an individual with a history of IV drug use self-injects a narcotic during the hospital stay). While rigid enforcement sets a boundary, it challenges trust[32]; however, too lax a policy may fail to protect some patients from their use of illicit drugs. Institutions should seek to strike a balance between providing support to patients and protecting clinicians from liability. Providing opportunities for clinician well-being may also create a foundation for more open, honest, and flexible clinical interactions. Another strategy to rebuild trust resonates with a Russian proverb: trust, but verify (Russian: Доверяй, но проверяй, tr. *Doveryay, no proveryay*). (The phrase became internationally known in English after Suzanne Massie, an American scholar, taught it to President Ronald Reagan, who used it on several occasions in the context of nuclear disarmament discussions with the Soviet Union.)[38]

Should Health Care Providers and Patients Who Lie to One Another Be Given a Second Chance?

When trust is breached in the patient-doctor relationship (eg, when patients with a SUD use nonprescribed narcotics in the hospital setting, a problem reported in roughly 30%–40% of patients who have used nonprescribed narcotics in the prior 6 months),[39,40] it is reasonable to ask whether, when, and how the relationship can be repaired. Unfortunately, clinicians have had little guidance or expertise regarding the management of these situations.[41] As a result, clinicians often rely on their biases and beliefs about those with SUDs. However, developing a greater understanding of why individuals use drugs (eg, to avert or mitigate drug withdrawal, boredom, or pain) can improve health outcomes and reduce clinicians' distress.[41]

On occasion, when deciding what interventions are necessary to resolve complications of illicit drug use, clinicians must consider how health care resources are being allocated (eg, payment for a valvular replacement for a second episode of injected-associated subacute bacterial endocarditis)[42] and whether the resources should be invested in those with persistent problems. The decision should be considered in various ethical frameworks. Expensive procedures (eg, valvular replacement) tend to be withheld after the patient has demonstrated repeatedly the inability to avoid reinfection, and, thus, the expected benefit is at best short term. Care that the decision-making is framed in consideration of beneficence and not simply utilitarian (ie, maximizing resource use) or through the lens of judgment and punishment is critical.

Whether patients or clinicians will benefit from a second chance after betraying trust is not a simple decision. Factors to consider involve whether the professional treatment relationship can improve, whether treatment will be beneficial, whether a second chance allows for an appropriate allocation of health care resources, or whether continued treatment will be futile.

What Happened to Mr A?

After Mr A was successfully resuscitated, his medical team placed him on constant observation for the remainder of his 6-week antibiotic course; they believed that he was not to be trusted again. Psychiatric consultation was requested to identify strategies to enhance adherence with the negotiated treatment plan, to recognize and treat withdrawal from alcohol and narcotics, to facilitate discussions about obtaining stable housing, to arrange for a room search for illicit drugs and syringes, and to manage tense interpersonal conflicts between Mr A and his health care team. Multidisciplinary efforts allowed Mr A to complete his course of antibiotics and develop workable linkages with outpatient providers.

CONCLUSION

Clinicians are often challenged by breaches of trust (a bidirectional process involving expectations and feelings) that are manifest in the doctor-patient relationship. Trust is important for the care of inpatients and outpatients, and warm handoffs are often beneficial to facilitate transitions to outpatient care and rehabilitation programs. Strategies to recognize, understand, address, and manage the fallout from affectively intense interactions, impaired adherence with treatment recommendations, and rifts in the doctor-patient relationship, are essential to the provision of effective and satisfying care.

Submitted: November 2, 2021; accepted January 11, 2022.

Published online: June 21, 2022.

Relevant financial relationships: None.

Funding/support: None.

REFERENCES

1. Pearson SD, Raeke LH. Patients' trust in physicians: many theories, few measures, and little data. *J Gen Intern Med*. 2000;15(7):509–513.
2. Armstrong K, Rose A, Peters N, et al. Distrust of the health care system and self-reported health in the United States. *J Gen Intern Med*. 2006;21(4):292–297.
3. Hermesh B, Rosenthal A, Davidovitch N. The cycle of distrust in health policy and behavior: lessons learned from the Negev Bedouin. *PLoS One*. 2020;15(8):e0237734.
4. Petrocchi S, Iannello P, Lecciso F, et al. Interpersonal trust in doctor-patient relation: evidence from dyadic analysis and association with quality of dyadic communication. *Soc Sci Med*. 2019;235:112391.
5. Cruess RL, Cruess SR. Expectations and obligations: professionalism and medicine's social contract with society. *Perspect Biol Med*. 2008;51(4):579–598.
6. Huynh HP, Dicke-Bohmann A. Humble doctors, healthy patients? exploring the relationships between clinician humility and patient satisfaction, trust, and health status. *Patient Educ Couns*. 2020;103(1):173–179.
7. Iott BE, Campos-Castillo C, Anthony DL. Trust and privacy: how patient trust in providers is related to privacy behaviors and attitudes. *AMIA Annu Symp Proc*. 2020;2019:487–493.
8. Fricchione GL. Separation, Attachment, and Human Development. In: Fricchione GL, ed. *Compassion and Healing in Medicine and Society: On the Nature and Use of Attachment Solutions to Separation Challenges*. Baltimore, MD: The Johns Hopkins University Press; 2011: 207–224.
9. Bowlby J. The making and breaking of affectional bonds, I: aetiology and psychopathology in the light of attachment theory. an expanded version of the Fiftieth Maudsley Lecture, delivered before the Royal College of Psychiatrists, 19 November 1976. *Br J Psychiatry*. 1977;130(3):201–210.
10. Bowlby J. The making and breaking of affectional bonds. II. Some principles of psychotherapy. the fiftieth Maudsley Lecture. *Br J Psychiatry*. 1977;130(5):421–431.
11. Bowlby J. Developmental psychiatry comes of age. *Am J Psychiatry*. 1988;145(1):1–10.
12. Fricchione GL. Separation, Attachment, and the Life Cycle. In: Fricchione GL, ed. *Compassion and Healing in Medicine and Society: On the Nature and Use of Attachment Solutions to Separation Challenges*. Baltimore, MD: The Johns Hopkins University Press; 2011:225–237.
13. Blatt SJ, Behrends RS. Internalization, separation-individuation, and the nature of therapeutic action. *Int J Psychoanal*. 1987;68(Pt 2):279–297.
14. Fricchione GL. Evolution of the Brain. In: Fricchione GL, ed. *Compassion and Healing in Medicine and Society: On the Nature and Use of Attachment Solutions to Separation Challenges*. Baltimore, MD: The Johns Hopkins University Press; 2011:109–143.
15. Gintis H, Bowles S, Boyd R, et al. Explaining altruistic behavior in humans. *Evol Hum Behav*. 2003;24(3):153–172.
16. Damasio A. Human behavior: brain trust. *Nature*. 2005;435(7042):571–572.
17. Kosfeld M, Heinrichs M, Zak PJ, et al. Oxytocin increases trust in humans. *Nature*. 2005;435(7042):673–676.
18. Auchincloss EL, Weiss RW. Paranoid character and the intolerance of indifference. *J Am Psychoanal Assoc*. 1992;40(4):1013–1037.
19. Blum HP. Object inconstancy and paranoid conspiracy. *J Am Psychoanal Assoc*. 1981;29(4):789–813.
20. Gabbard GO. Cluster A Personality Disorders: Paranoid, Schizoid, and Schizotypal. In: Gabbard GO, ed. *Psychodynamic Psychiatry in Clinical Practice*. 4th ed. Washington DC: American Psychiatric Publishing Inc; 2005:401–426.
21. Shapiro D. Paranoid styles. In: *Neurotic Styles*. *Basic Books*. New York, New York;1965: 54–107.
22. Lewis JM. Repairing the bond in important relationships: a dynamic for personality maturation. *Am J Psychiatry*. 2000;157(9):1375–1378.
23. Maier SF, Seligman MEP. Learned helplessness: theory and evidence. *J Exp Psychol Gen*. 1976;105(1):3–46.
24. International Dual-Loyalty Working Group. Dual-Loyalty and Human Rights in Health Professional Practice: Proposed Guidelines and Institutional Mechanisms. In: Allhoff F, ed. *Physicians at War: International Library of Ethics, Law, and the New*. Vol. 41. Dordrecht, Netherlands: Springer; 2008:15–38.
25. Jones CP. Levels of racism: a theoretic framework and a gardener's tale. *Am J Public Health*. 2000;90(8):1212–1215.
26. Kontos N. Ethics of Incongruity: moral tension generators in clinical medicine. *J Med Ethics*. 2019;45(4):244–248.
27. Kelly JF, Westerhoff CM. Does it matter how we refer to individuals with substance-related conditions? a randomized study of two commonly used terms. *Int J Drug Policy*. 2010;21(3):202–207.
28. Beach SR, Taylor JB, Kontos N. Teaching psychiatric trainees to "think dirty": uncovering hidden motivations and deception. *Psychosomatics*. 2017;58(5):474–482.
29. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. Fifth Edition. Arlington, VA: 2013.
30. Palmieri JJ, Stern TA. Lies in the doctor-patient relationship. *Prim Care Companion J Clin Psychiatry*. 2009;11(4):163–168.
31. Hills L. What to do when trust has been breached in your practice. *J Med Pract Manage*. 2013;29(3):199–203.
32. Reyre A, Jeannin R, Larguèche M, et al. Care and prejudice: moving beyond mistrust in the care relationship with addicted patients. *Med Health Care Philos*. 2014;17(2):183–190.
33. Stephens AL, Bruce CR, Childress A, et al. Why families get angry: practical strategies for clinical ethics consultants to rebuild trust between angry families and clinicians in the critical care environment. *HEC Forum*. 2019;31(3):201–217.
34. Dudzinski DM, Alvarez C. Repairing "difficult" patient-clinician relationships. *AMA J Ethics*. 2017;19(4):364–368.
35. Buchman DZ, Ho A. What's trust got to do with it? revisiting opioid contracts. *J Med Ethics*. 2014;40(10):673–677.
36. Miller J. The other side of trust in health care: prescribing drugs with the potential for abuse. *Bioethics*. 2007;21(1):51–60.
37. Cabaniss DL, Cherry S, Douglas C, et al. *Psychodynamic Psychotherapy: A Clinical Manual*. West Sussex, UK: John Wiley & Sons; 2017:94–100.
38. Trust, But Verify. Wikipedia website. Accessed October 27, 2021. https://en.wikipedia.org/wiki/Trust,_but_verify#
39. Ti L, Voon P, Dobrer S, et al. Denial of pain medication by health care providers predicts in-hospital illicit drug use among individuals who use illicit drugs. *Pain Res Manag*. 2015;20(2):84–88.
40. Parmar GS, Hayashi K, Nolan S, et al. Non-medical prescription opioid use and in-hospital illicit drug use among people who use drugs. *Drug Alcohol Rev*. 2021;40(6):959–963.
41. Strike C, Robinson S, Guta A, et al. Illicit drug use while admitted to hospital: patient and health care provider perspectives. *PLoS One*. 2020;15(3):e0229713.
42. Lane H, Sarkies M, Martin J, et al. Equity in healthcare resource allocation decision making: a systematic review. *Soc Sci Med*. 2017;175:11–27.