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| **The Many Faces of Trust During the Pandemic****Panelists****Cynda Rushton, PhD, RN, FAAN (moderator)****Debra Mathews, PhD, MA****Ashly Nealon, BSN, RN****Rev. John V.P.R. Ponnala, MA, BD, BCC** **Gloria Ramsey, JD, RN, FNAP, FAAN**The February Ethics for Lunch involved the case of a 48-year-old African American woman who was admitted to the intensive care unit with COVID pneumonia. Her breathing worsened to the point of needing a ventilator. Her husband was her surrogate decision maker. He was approached about giving her investigational medications that might be beneficial to her, but he didn’t want to have her enrolled in any research trials. Over the next several weeks, she remained critically ill. Different members of the staff updated her husband periodically and arranged Zoom video conference so he could see his wife. After weeks of not being able to successfully wean her from the ventilator, the medical team reached out to her husband to talk about placing a tracheostomy in hopes of weaning her ventilator support and progressing her care out of the ICU. Her husband was anxious and expressed feelings of distrust toward the care team, and he was unwilling to consent to the procedure. His aunt had been hospitalized with COVID and had made a full recovery, and he had faith that his wife would do the same.**Summary of Key Points**1. The panel discussed ways that trust that has been broken during the pandemic. As the case illustrates, the disproportionate impact of COVID on African Americans and people of color brought into sharp focus historical transgressions related to structural and institutional racism (e.g. Tuskegee, Guatemala, Henrietta Lacks).
2. Health inequities related to access to services and treatment, protections, micro and macro aggressions, and examples of entrenched racism result in justifiable mistrust. This then leads to questioning science, such as whether to participate in research trials and whether vaccines are safe.
3. The case calls into question the mixed views of what is trustworthy. Clinicians may have higher trust of evidence than patients; science alone is insufficient to gain the trust of the patient/family. The benefits may seem clear to clinicians but are not valued in the same way by the family
4. Trust has also been compromised within the care team. Teamwork has been re-defined during the pandemic—trust is needed for team members to work together and honor and trust each other’s capability. Team trust is translated to patients and families--both positively and negatively. Frequent changes of the care team create confusion and conflict among members, contribute to miscommunication, and can erode trust.
5. Visitor policies during the pandemic have also had an impact on trust. This case illustrates the challenges of not having family members present to witness the condition of the patient, especially when it deteriorates. The team is unable to understand the narrative of the family without that direct contact, and the family is unable to grasp how critically ill the patient is

6. The panelists discussed ways to rebuild trust, including:* Connections with families using technology
	+ Listening to what families know instead of telling more information
	+ Attempting to have all relevant family members present
	+ Coordinating communication with the family by designating a spokesperson to share information
	+ Intensify communication among team and with patients/families
* Transparency—when questions are asked, avoiding defensiveness
* Managing expectations; sharing what is known and not known
* Exploring the patient's and family's faith tradition and involving chaplains
* During hand-offs, sharing patient-centered information about the patient as a person and what the family/surrogate is asking and how they are coping
* Managing assumptions—instead of assuming the patient/family doesn’t trust, shifting to “What can I do to restore trust in this moment?”
* Flexibility and consistency of communication and clinical team members
* Humility to engage in an authentic way with people who do not trust in order to achieve shared decision making
* Acknowledging clinician's own suffering and resilience
	+ Clinicians are not alone in their struggle
	+ Important to reach out to colleagues for support during cases that cause moral distress
* Building trust takes time; striving to demonstrate trustworthy behaviors over and over again
	+ Both individuals and an organization must be open to honest self-reflection and critique
* For some people, race concordance is important

**References**1. Snowden L, Graaf G. [COVID-19, Social Determinants Past, Present, and Future, and African Americans’ Health. Journal of Racial and Ethnic Health Disparities](https://nam02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fjhu.us1.list-manage.com%2Ftrack%2Fclick%3Fu%3D0f543d0b018f081433751de11%26id%3Dd35d7241a7%26e%3D30e14e2405&data=04%7C01%7Ccrushto1%40jhu.edu%7Cfef7d3fd483f42e7855608d8cf7378b1%7C9fa4f438b1e6473b803f86f8aedf0dec%7C0%7C0%7C637487442138228452%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C1000&sdata=nDh%2FDg2YjTw7hnGgOJCZGmWvdf%2BnU20xcCQ6MwZ%2BDSY%3D&reserved=0).
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