Autonomy erodes doctor-patient trust because now the physician’s main goal is non- interference rather than providing the best treatment option. **Donnelly 14**[[1]](#footnote--1)

A second basis for normative critique is the cost to other values arising from the endorsement of a liberal conception of autonomy. Onora O’Neill argues that the important value of **trust between doctors and patients has been lost because of the** liberal **view of autonomy** ‘ simply **as independence from others’**. 161 **Contrasting** the different features of **trust and autonomy**, she notes, **‘[t]rust flourishes between those who are linked** to one another; individual **autonomy flourishes where everyone has “space”** to do their own thing’. 162 As O’Neill reminds us, ‘[t]rust is most readily placed in others whom we can rely on to take our interests into account, to fulfil their roles, to keep their parts in bargains’. 163 **If we do not believe in our** **healthcare professionals’** commitment to our welfare, our **trust** in them **will be** fatally **undermined notwithstanding** that **our** right of **autonomy is respected**.

That kills the ability to control disease and manage bioterror threats, and it only takes a tiny link to trigger the impact. **Jacobs 5[[2]](#footnote-0)**

To be sure, we will learn about the emerging science and clinical practice of cardiovascular disease over the next four days. But there is an internal disease of the heart that confronts us as scientists, as physicians, and as healthcare professionals. It is a threat to us all—insidious and pervasive—and one that we unknowingly may spread. This threat is one of the most critical issues facing our profession today. How we address this problem will shape the future of medical care. This issue is the erosion of trust. Lack of trust is a barrier between our intellectual renewal and our ability to deliver this new knowledge to our research labs, to our offices, to the bedside of our patients, and to the public. **Trust is** a **vital**, unseen, and essential element **in diagnosis, treatment, and healing**. So it is fundamental that we understand what it is, why it’s important in medicine, its recent decline, and what we can all do to rebuild trust in our profession. Trust is intrinsic to the relationship between citizens around the world and the institutions that serve their needs: government, education, business, religion, and, most certainly, medicine. Albert Einstein recognized the importance of trust when he said, “Every kind of peaceful cooperation among men is primarily based on mutual trust.”1 In our time, trust has been broken, abused, misplaced, and violated. The media have been replete with commentaries, citing stories of negligence, corruption, and betrayal by individuals and groups in the public and private sectors, from governments to corporations, from educational institutions to the Olympic Organizing Committee. These all are front-page news. Perhaps the most extreme example is terrorism, in which strangers use acts of violence to shatter trust and splinter society in an ongoing assault on our shared reverence for human life. Unfortunately, we are not immune in our own sphere of cardiovascular medicine. The physician-investigator conflicts of interest concerning enrollment of patients in clinical trials, the focus on medical and nursing errors, the high-profile medical malpractice cases, the mandate to control the cost of health care in ways that may not be aligned with the best interest of the patient—all of these undermine trust in our profession. At this time, when more and more public and private institutions have fallen in public esteem, restoring trust in the healthcare professions will require that we understand the importance of **trust** and the implications of its absence. Trust is intuitive confidence and a sense of comfort that comes from the belief that we can rely on an individual or organization to perform competently, responsibly, and in a manner considerate of our interests.2 It is dynamic, it **is fragile, and** it is **vulnerable**. Trust can be damaged, but it can be repaired and restored. It is praised where it is evident and acknowledged in every profession. Yet it is very difficult to define and quantify. Trust is easier to understand than to measure. For us, trust may be particularly difficult to embrace because it is not a science. Few instruments have been designed to allow us to evaluate it with any scientific rigor. Yet, trust is inherent to our profession, precisely because patients turn to us in their most vulnerable moments, for knowledge about their health and disease. We know trust when we experience it: when we advise patients in need of highly technical procedures that are associated with increased risk or when we return from being away to learn that our patient who became ill waited for us to make a decision and to discuss their concerns, despite being surrounded by competent colleagues acting on our behalf. Many thought leaders in the medical field understand the importance of trust.3 **When asked whether the** public health **system could be overrun by** public **panic over SARS and bioterror**ism, **C**enters for **D**isease **C**ontrol and Prevention **Director** Julie **Gerberding replied, “You can manage people if they trust you.** We’ve put a great deal of effort into improving state and local communications and scaled up our own public affairs capacity…we’re building credibility, competence and trust.”4 **Former Health and Human Services Secretary** Donna **Shalala** also recognized the importance of trust when she **said, “If we are to keep testing** new **medicines and** new **approaches to curing disease, we cannot compromise the trust** and willingness **of patients** **to participate in clinical trials**.”5 These seemingly intuitive concepts of the importance of trust in 21st century medicine actually have little foundation in our medical heritage. In fact, a review of the early history of medicine is astonishingly devoid of medical ethics. Even the Codes and Principles of Ethics of the American Medical Association, founded in 1847, required patients to place total trust in their physician’s judgment, to obey promptly, and to “entertain a just and enduring sense of value of the services rendered.”6 Such a bold assertion of the authority of the physician and the gratitude of the patient seems unimaginable today. It was not until the early 1920s that role models such as Boston’s Richard Cabot linked patient-centered medical ethics with the best that scientific medicine had to offer,6 and Frances Weld Peabody, the first Director of the Thorndike Memorial Laboratory at the Boston City Hospital, crystallized the ethical obligation of the physician to his patient in his essay “The Care of the Patient.”7 In one particularly insightful passage, Peabody captures the essence of the two elements of the physician’s ethical obligation: He must know his professional business and he must trouble to know the patient well enough to draw conclusions, jointly with the patient, as to what actions are indeed in the patient’s best interest. He states: “The treatment of a disease may be entirely impersonal: The care of the patient must be completely personal. The significance of the intimate personal relationship between physician and patient cannot be too strongly emphasized, for in an extraordinarily large number of cases both diagnosis and treatment are directly dependent on it.” Truly, as Peabody said, “The secret to the care of the patient…is in caring for the patient.”7 This concept that links the quality of the physician-patient relationship to health outcomes has indeed stood the test of time. Trust has been shown to be important in its own right. It is essential to patients, in their willingness to seek care, their willingness to reveal sensitive information, their willingness to submit to treatment, and their willingness to follow recommendations. They must be willing for us to be able.

#### Extinction Yu 9[[3]](#footnote-1)

A **pandemic will kill off all humans**. In the past, humans have indeed fallen victim to viruses. Perhaps the best-known case was the bubonic plague that killed up to one third of the European population in the mid-14th century (7). While vaccines have been developed for the plague and some other infectious diseases, **new viral strains are constantly emerging — a process that maintains the possibility of** a pandemic-facilitated human **extinction**. Some surveyed students mentioned AIDS as a potential pandemic-causing virus. It is true that scientists have been unable thus far to find a sustainable cure for AIDS, mainly due to HIV’s rapid and constant evolution. Specifically, two factors account for the virus’s abnormally high mutation rate: 1. HIV’s use of reverse transcriptase, which does not have a proof-reading mechanism, and 2. the lack of an error-correction mechanism in HIV DNA polymerase (8). Luckily, though, there are certain characteristics of HIV that make it a poor candidate for a large-scale global infection: HIV can lie dormant in the human body for years without manifesting itself, and AIDS itself does not kill directly, but rather through the weakening of the immune system. However, for more easily transmitted viruses such as influenza, the evolution of **new strains could prove far more consequential**. The simultaneous occurrence of **antigenic drift** (point mutations that lead to new strains) **and antigenic shift** (the inter-species transfer of disease) in the influenza virus **could produce a new version** of influenza for **which scientists may not immediately find a cure**. Since influenza can spread quickly, this lag time could potentially lead to a “global influenza pandemic,” according to the Centers for Disease Control and Prevention (9). The most recent scare of this variety came in 1918 when bird flu managed to kill over 50 million people around the world in what is sometimes referred to as the Spanish flu pandemic. Perhaps even more frightening is the fact that only 25 mutations were required to convert the original viral strain — which could only infect birds — into a human-viable strain (10).

1. Mary Donnelly, pf of medical law @ University College Cork, "Healthcare Decision-Making and the Law" Cambridge Law, Medicine and Ethics series, November 2014 [↑](#footnote-ref--1)
2. (Alice, Director, Cardiac Catheterization Laboratory and Interventional Cardiology Professor of Medicine, Boston University School of Medicine) “Rebuilding an Enduring Trust in Medicine” Circulation. 2005; 111: 3494-3498 AT [↑](#footnote-ref-0)
3. **—**Dartmouth Undergraduate Journal of Science (Victoria, Human Extinction: The Uncertainty of Our Fate, 22 May 2009, http://dujs.dartmouth.edu/spring-2009/human-extinction-the-uncertainty-of-our-fate) [↑](#footnote-ref-1)