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Abstract

Historically, medical education has not adequately addressed racial and ethnic inequities in healthcare or prepared physicians to earn patient trust, especially among marginalized communities. While some curricula cover health inequities and cultural competency, they focus more on encouraging patient trust than on teaching physicians how to demonstrate trustworthiness. By distinguishing between mistrust, distrust, and trust, we highlight a crucial gap in medical training: current training promotes patient trust without equipping physicians with the skills to earn it. The focus must shift from encouraging patients to trust the healthcare system to directly training providers in behaviors and systemic changes that demonstrate trustworthiness in order to gain trust. We propose a reorientation of medical education: one that emphasizes promoting trustworthiness and directly addresses the systemic and provider-level factors that have contributed to the erosion of patient confidence in medicine and their medical providers.

Keywords: patient trust, healthcare inequities, health equity, medical curricula

1. Introduction

There is a growing recognition of the need for more well-rounded healthcare providers. In 2015, the Association of American Medical Colleges (AAMC) added psychology and sociology content for the first time to the Medical College Admissions Test (MCAT) to enhance future physicians' abilities to consider the patient as a whole person in the delivery of care[1,2] and understand how behavior affects health in an effort to better "serve a diversified patient population".[1,3] The addition reflects the AAMC's recognition of the importance of understanding the patient holistically, appreciating the wide range of factors that influence one's healthcare and wellbeing.[1]

Similarly, Metzl and colleagues have led efforts in building medical education around the notion of structural competency,[4,5] developing a framework for more holistically understanding how social and

political factors shape healthcare provision and patients' health. The medical curriculum rooted in structural competency consists of training in five core competencies: 1) recognizing the structures that shape clinical interactions; 2) developing an extra-clinical language of structure; 3) rearticulating "cultural" formulations in structural terms; 4) observing and imagining structural interventions; and 5) developing structural humility.[4] These skills are especially valuable in preparing future physicians to identify and connect patients with relevant social and support services.

Additionally, many medical schools are now integrating changes in their curricula to ensure a more holistic training of future providers, including units on social drivers of health.[6] However, surveys of medical students reveal that simply teaching these concepts is insufficient to prepare students to actually address health inequities. Here, health inequities are defined as differences in health that are unnecessary and avoidable and are considered unfair and unjust.[7,8]

In a notable attempt to improve medical education, Boston Medical Center delivered seven Health Equity Rounds (HER) from June 2016 to June 2018. This longitudinal curriculum utilized case-based discussions and evidence-based exercises to teach providers to recognize the historical context and present-day role of structural racism in medicine. While Boston Medical Center's training had a positive impact, with 88% of survey respondents indicating that HER promoted personal reflection on implicit bias, it primarily focused on educating providers about inequities rather than equipping them to actively demonstrate trustworthiness.[9] Ultimately, these improvements to medical education neglect to directly train physicians to actively address and confront the context that has hindered patient-provider relationships, particularly among racially-minoritized populations.

Before informed consent and other standard ethical practices today, there were numerous, well-documented instances of unethical research conducted on racial and ethnic minoritized populations and other historically marginalized groups.[10–13] Furthermore, increasing numbers of financial relationships between university scientists and industry have cast doubt on the objectivity of individual researchers, their institutions, and the larger system of academic research, fueling skepticism about research trustworthiness.[14,15] In an effort to set better standards for scientific integrity and ensure ethical human research, Congress passed the National Research Act and established the Office for Human Research Protections in 1974.[16] Though unethical practices still occur, there is now mandated implementation of regular training for clinical service providers and biomedical researchers.[17] While it is necessary for the physician workforce to understand this tragic history, there remains a need to equip current and future physicians with the tools to repair the damage caused to patient-provider relationships.

Although extensive research has examined patient trust, mistrust, and distrust, as well as structural racism and inequities in healthcare, this scholarship has not been translated into a coherent framework for medical education. Existing curricula do not explicitly identify trustworthiness as a teachable, assessable professional competency. As a result, medical education has not adequately prepared physicians to earn patient trust. This manuscript makes three key contributions to address this gap.

First, we synthesize existing literature to clarify how trustworthiness differs conceptually from

trust, mistrust, and distrust. Trustworthiness determines trust and, therefore, must precede efforts to address patients' lack of confidence in the quality of care they receive. Understanding how trustworthiness influences these dynamics is essential for strengthening patient-provider relationships and preparing current and future healthcare providers to navigate these evolving challenges.

Second, we argue that trustworthiness should be understood as a set of teachable clinical competencies. By drawing on empirical evidence, we identify specific behaviors—transparent communication, empathic engagement, and reflective practice—that shape patient perceptions of provider trustworthiness. This approach reframes trustworthiness as a curriculum-worthy domain, grounded in documented mechanisms.

Third, we translate these insights into novel, concrete recommendations for medical school education. The curricular interventions we propose represent educational strategies that do not currently exist in medical training, but result directly from the evidence base. In doing so, this manuscript provides one of the first attempts to operationalize trustworthiness in a way that is both conceptually rigorous and practically actionable.

By articulating trustworthiness as a core competency and offering a framework for how it can be cultivated across medical training, this manuscript extends the literature beyond documenting the consequences of mistrust and distrust toward specifying what providers and institutions can do to meaningfully address it. The contribution lies not only in naming trustworthiness as an educational priority but by providing a structured pathway for implementing it—a shift that has the potential to transform the preparation of future physicians and strengthen relationships with communities historically harmed by medicine.

2. Background

In 2003, the Institute of Medicine, now the National Academies of Sciences, Engineering, and Medicine, garnered national attention when it published *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*.[18] The report reviewed over 100 studies documenting pervasive racial and ethnic disparities in the quality of healthcare, even when patients of different racial and ethnic groups had the same insurance status, income, and other access-related factors.[18] The extent of racial and ethnic inequities in healthcare was explained by factors rooted in systemic and structural racism. The report confirmed what Black Americans and other medically underserved populations had argued for decades: the quality of healthcare they received was poorer than that of other racial and ethnic groups.[18]

Numerous programs and policies were instituted following this report. Twenty years later, the National Academies of Sciences, Engineering, and Medicine appointed an ad-hoc committee to review the progress made since the initial report. Their goal was to assess and identify key drivers of racial and ethnic disparities in U.S. healthcare, evaluate past interventions, and propose scalable strategies to address gaps in the evidence base and promote health equity.[19] In 2024, this committee published *Unequal Treatment Revisited: The Current State of Racial and Ethnic Disparities in Healthcare*, reporting that most efforts to reduce healthcare inequities have been ineffective.[19] Additionally, they demonstrated that positive changes from diversity and implicit bias training tend to be small and short-term.[19] Given that many

physicians denied that bias and racism existed in medicine and the care that they provide, greater efforts to promote accountability for inequitable healthcare services are needed.

Given this context and the many well-documented instances of unethical research conducted on racially and ethnically minoritized populations,[10–15] it is essential to reframe notions of trust to recognize that patients are right to approach healthcare with some level of skepticism. Despite this, studies on patient trust often assume that patients have equal access to care, are likely to receive the same quality of care, and that their fears of inequitable care are unfounded or irrelevant.[11,20] Patient skepticism, suspicion, and distrust may be appropriate, reasonable, and highly adaptive approaches to healthcare institutions, particularly in the context of the history of racism and discrimination in medicine and healthcare.[20–22]

Many of the strategies and solutions proposed by the National Academies were changes to healthcare systems and societal structures beyond the control of individual healthcare providers. While these policy and structural changes in society and healthcare take time to become part of education, training, and practice, emphasizing trustworthiness is immediately within the control and purview of current and future providers.

This paper highlights a fundamental gap in medical education: existing curricula touch on concepts related to trustworthiness (e.g., cultural competence, implicit bias training), but fail to name and develop it as a distinct competency.[22] We argue for an explicit and intentional focus on trustworthiness in medical education, shifting attention from patient-centered interventions to provider accountability in mitigating distrust and mistrust. We propose this because it provides a tool for physicians to understand their role in operating within this history and context.

We begin by defining and describing trust, mistrust, and distrust because they have been the primary focus of research to date (Table 1). These areas are important, but the emphasis is on changing characteristics of patients, not providers. We conclude by focusing on trustworthiness and propose integrating it into continuing medical education to address inequities in the quality of healthcare.

2.1. Trust

Trust is the defining characteristic that provides meaning and depth to patient-provider relationships.[23] Patient trust in their provider can be described as the patient's willingness to be vulnerable, honest, and transparent about their behaviors, symptoms, life circumstances, and other factors that may influence their health and well-being.[24]

Patient trust is believed to be an essential ingredient in effective medical care,[23] particularly in patient health and healthcare decisions.[24-26] According to Greene, over two decades of research show how patients' trust in providers promotes greater continuity of care, follow-through with clinicians' recommendations, patient satisfaction, and self-rated health.[27] While there is no universally accepted definition, patient trust implies that the healthcare provider or institution will act in the patient's best interest.[24-28] While a considerable amount of research documents the importance of trust, it has been difficult for physicians to earn and maintain the trust of historically marginalized people.

2.2 Distrust

Distrust is a transitive verb, meaning that it requires a direct object to clarify what or whom is

Table 1. Distinctions between trust, distrust, and mistrust

Construct & Definition	Root Cause
Trust: A patient's willingness to be vulnerable and transparent with their physician, based on patients' perceived belief in their provider's motivation and ability to care for them, given both direct and historical experiences and perspectives.	A patient's attitudes and beliefs are based on their assessment of a provider's competence. It is often assumed that the patient's perspective is based solely on the physician's characteristics, but this assumption fails to account for the historical, social, and political context of the patient-provider interaction.
Distrust: A lack of trust specific to an object or person.	A patient's skepticism or suspicion that a specific provider, health system, or other specific unit may not be providing them optimal quality healthcare. They base this assessment on personal or vicarious experiences.
Mistrust: A general lack of trust that is not based on a particular object.	A patient's general skepticism or suspicion that they may not be receiving optimal healthcare because the patient knows that there is a long history of unethical healthcare research and practice.

the object of the sentiment. This indicates a patient does not trust a provider, institution, profession, or something very explicit. Distrust, therefore, may be based on personal or collective experience or reliable information, and it can be directly instigated by the physician or institution itself. It could also be because a trusted friend, family member, or loved one reports a bad experience with a given provider, institution, or the healthcare system more generally. One of the cornerstones of distrust is a heightened skepticism regarding the quality of the treatment received.

The term also includes patients' efforts to contextualize their experiences, facts, and beliefs in historical, social, and political contexts.[23] In this case, distrust is the idea that the patient actively questions or doubts the motives of the specific provider, researcher, organization, or institution. Consequently, distrust affects patients' willingness to be vulnerable with or to depend on the provider or healthcare entity.[29] Historically and presently, marginalized communities may expect or have previously experienced racism, discrimination, and unethical healthcare that can infringe on patients' confidence in the quality of healthcare they are receiving.[10, 30–33]

To address distrust, it is critical to recognize that the suspicions, fears, and roots of distrust are logical responses to a history of inequity. Skepticism regarding the quality of the healthcare patients receive can be rooted in being well-informed about the history of racism, homophobia, and other structural inequities within healthcare.[34] For providers to successfully build trusting relationships with their patients, providers should explore and address why the suspicion that underlies distrust exists with an individual physician, practice, organization, or system, and match the measurement or intervention strategy to that level. Interventions aimed at addressing distrust must equip providers with an understanding of the

local history and the relationship between healthcare institutions and the communities they serve.[34-39]

2.3. Mistrust

Whereas distrust is specific to an object or person, mistrust describes a more general lack of trust in medicine, not based on a particular object.[23] The patient is not skeptical of something or someone specific, rather more generally apprehensive towards healthcare as a whole. Mistrust often stems from the patient's knowledge of the long history of unethical healthcare research and practice.[34] This feeling may originate from distinct historical experiences linked to group identity (e.g., the U.S. Public Health Service Study of Untreated Syphilis in the Negro Male, also known as the "Tuskegee Syphilis Study"), vicarious experiences, or oral histories.[23,34] Addressing mistrust requires interventions that train providers to acknowledge and compensate for past medical abuses of communities.[12] As highlighted by Dr. Chandra Ford, Professor at Emory University's Rollins School of Public Health:

> "Mistrust is really a symptom. Mistrust is not the root of the problem. And so if mistrust is the symptom, then we must deal with the problem, the need to make our institutions more trustworthy."[40]

2.4. Trust, mistrust, and distrust: A critique

Patients who lack trust are less likely to follow providers' guidance and recommendations.[24] The current focus of research, education, and training on trust, mistrust, and distrust often treats these psychosocial factors as abstract and theoretical, rather than as an intimate and essential component of a patient-provider relationship and as a key driver of healthcare quality outcomes. There is a need to determine tangible interventions regarding how to optimally train current and future providers to earn trust and promote trustworthiness.[22,25]

2.5 Trustworthiness

Physicians are often assumed to have a patient's trust by default, but trust must be earned, not presumed. Shifting the focus to trustworthiness places the responsibility on providers and institutions to address mistrust and distrust through meaningful changes in behavior, policy, and accountability.[39]

Dr. LaVera Crawley was among the first to name trustworthiness as a critical focus and competency in healthcare and healthcare inequities.[21] Almost 25 years ago, she argued that it was critical to begin shifting the responsibility from patients to healthcare systems and providers because of well-documented findings that not all providers deliver equitable quality of care. A trustworthy physician demonstrates behaviors and qualities that foster confidence, trust, transparency, and accountability of their words, skills, and professional acumen.[24,25] Trustworthiness is the expectation that a clinical encounter will be beneficial, based on the perceived likelihood that the provider will act in the patient's best interest.

Studies have shown that patients are more likely to perceive clinicians as trustworthy when they believe that they are competent, concerned with their welfare, and share their values.[20,21] Demonstrating trustworthiness requires transparent and accurate verbal and nonverbal communication that ensures the patient feels valued. Additionally, being a trustworthy provider requires a balance of probing for and sharing challenging and complex information with the patient.[20,21,23-25,27,39]

3. Emphasizing provider trustworthiness in medical education and training

To begin to address inequities in healthcare quality and outcomes, we propose that medical education and training move beyond simply teaching physicians about healthcare inequities to focus on training them in trustworthiness. Promoting

trustworthiness should be a core competency in medical education and training. In this section, we describe three strategies that can be incorporated into training. These strategies highlight skills that are fundamental to fostering trustworthiness, though they do not explicitly address the root causes of mistrust and distrust, nor are they exhaustive.

3.1. Communication

Compassionate, accessible patient-provider communication is a crucial foundation for trustworthy medical care. Research has shown that when physicians communicate with their patients using accessible, engaging language and actively listen, patients exhibit higher adherence to treatment plans and greater satisfaction with care.[20,21,23-25,27,39,41] For example, one study found that effective physician communication increased patient adherence by 19%, reinforcing its critical role in patient outcomes.[41]

Patient-centered communication has been shown to enhance patient engagement and increase positive perceptions of finding common ground,[42] a facet of perceived trustworthiness. Physicians who engage in feedback sessions, where they practice transparent communication, navigate difficult conversations, and address patient concerns, exhibit improved patient satisfaction and greater consistency in demonstrating trust-building behaviors.[42,43]

Furthermore, a study by Mazor et al. found that when physicians openly disclose errors and candidly discuss potential risks, patients are more likely to maintain trust in their providers, even in adverse situations.[44] Actionable strategies such as acknowledging uncertainty in medical decisions, admitting mistakes, and ensuring consistency in messaging are all essential components in promoting patient trust.[45-48]

The SPIKES framework, for example, is an evidence-based protocol for how physicians can effectively deliver bad news, comprising of six key components: setting up an interview, perceptions, invitation, knowledge, empathy, strategy, and summary.[49] The provider must set up an interview to sit down with the patient and ensure they are emotionally present, assess their perception and understanding of their own conditions, invite them to determine how much of the details of their condition they are ready to process, and then deliver the pertinent information accordingly. This strategy ensures information is conveyed clearly and the patient has full knowledge of their condition. The empathy component involves validating the patient's emotions and acknowledging how they may be feeling. The summary requires ending the session by providing an actionable plan going forward and ensuring the patient feels supported and can ask questions.[49] While further studies are needed to examine the efficacy of this method on patient satisfaction and trustworthiness,[51] a systematic review found that providers trained in the SPIKES framework for breaking bad or difficult news had significantly better communication skills, as rated by observers, compared to those who were not.[52]

The BATHE (Background, Affect, Trouble, Handling, Empathy) framework is another interview technique, which is utilized to better understand the psychosocial factors affecting patients' health. It involves: background, to elicit the context of the problem affecting the patient; affect, to examine the patient's emotional response; trouble, to identify what is the most troubling aspect to the patient; handling, to learn how the patient is coping; and empathy, to validate the patient's feelings and offer support. The use of these strategies and similar tools strengthens the physician's ability to develop and employ crucial interpersonal skills.[53] It can also help diagnose cases of anxiety and depression before they escalate further.[53] For example, in an illustrative case, a 23-year-old single mother of two preschool children was seen by her family physician. When asking about her background, the physician learned

that her childhood had consisted of moving from foster home to foster home. When asked what was most troubling in her current life, she replied, "I know nothing about how to be a parent". The physician was accordingly able to empathize with her distress and discuss community resources available in the area.[54] Employing these communication tactics in a medical school curriculum can thus help future physicians with a framework for exemplifying trustworthy competencies to their patients.

3.2. Empathy and advocacy

Crawley also highlights that compassion, altruism, and empathy are central components of a trustworthy provider.[21] Demonstrating these skills may help patients and physicians build productive relationships.[46] A systematic review found that empathy training for physicians improves patient experience, increases patient adherence, and improves clinical outcomes.[47] Because studies suggest medical students experience a decline in empathy over time,[48] it is crucial to integrate relational skills early in training and reinforce them throughout medical education.

Research has shown that experiential simulations can increase empathy among trainees in health-related fields by offering a clearer understanding of the conditions faced by marginalized communities. One example is the Community Action Poverty Simulation developed by the Missouri Association for Community Action. In this exercise, nursing and education students participated in a two-hour structured simulation designed to represent the experience of navigating four weeks of poverty. Before the simulation, students' reflection journals commonly expressed themes such as discomfort, confusion, and the belief that poverty stemmed from individual choice. After the exercise, however, both groups reported greater empathy toward individuals and families experiencing poverty. Students described a new recognition that poverty

constitutes an "endless cycle" of "day-to-day survival" and noted a deeper understanding of social justice issues and structural barriers that shape patients' lives. In particular, nursing students expressed a strengthened commitment to advocating for adequate resources for their future patients.

Importantly, increased empathy was accompanied by a heightened willingness to participate in social advocacy on behalf of marginalized populations. These findings suggest that similar experiential learning opportunities could be highly valuable in medical education. By immersing medical students in structured simulations that illuminate the lived reality of their patients, educators may help cultivate empathy, a core component of trustworthiness, and foster a greater sense of responsibility to engage in systemic reform and address institutional contributors to inequity.[55]

Research has also shown that physicians with service-based experience are more successful at fostering connections with marginalized populations and addressing the social determinants of health in clinical settings.[56,57,58.] Institutionalizing these stimulation experiences and immersive service experiences can ensure that students are prepared to understand the realities their patients face and help cultivate more empathetic providers who are willing to advocate for their patients.

3.3. Shared reflection

Trustworthiness also requires a commitment to reflection, self-awareness, and redressing injustices in healthcare.[59] This process involves understanding the history of racism in medicine, recognizing persistent healthcare inequities, examining the institutional history of one's training and practice, and critically reflecting on biases that influence patient care. Such an approach aligns with anti-

racism principles and cultural humility, acknowledging the deep-rooted structural racism in both the U.S. healthcare system and wider society.[59]

Narrative medicine plays a crucial role in fostering relational trust by enhancing a physician's ability to understand patients' lived experiences.[60] Importantly, emerging work suggests that this trust-building potential is amplified when narrative practices move beyond student-only reflection and actively include patients as co-participants. Chou et al. demonstrated that patient co-participation in narrative medicine can promote meaningful patient and community engagement among future physicians while advancing a "patient-as-partner" approach to care.[61] In their study, pre-clinical medical students and patients recruited from a population with high HIV prevalence participated together in a shared narrative medicine workshop.[61] Using a community-based participatory narrative medicine (CBPNM) model, participants completed weekly writing of personal narratives, engaged in close readings of literary texts, and offered structured feedback on one another's narratives. Group discussions centered on participants' narratives before authors were invited to respond and reflect. Thematic analysis from participants who completed the study revealed reciprocal relationships and "a sense of community" among medical students and patients of different demographics, an increased ability to "reflect on formative life experiences" and feelings "that their experiences had been acknowledged", and a unique and rare opportunity for medical students to escape the "performance-driven culture of medical school" and connect on "a personal level with patients and…with each other". Following the workshop, both physicians and patients were better able to see each other as "complex, multifaceted individuals" and "as human beings".[61] These findings suggest that CBPNM offers a promising framework for cultivating reflective practice, relational trust, and shared vulnerability between patients and future physicians, which are key components of trustworthiness in healthcare.

By developing these competencies in medical education, future physicians may be better equipped to address mistrust and distrust, strengthen patient-provider relationships, and improve health outcomes.[59 62-64]

4. Integrating trustworthiness into medical education: Applying the evidence

The strategies reviewed in Section 3 collectively illustrate that trustworthiness is not a single competency but a set of teachable behaviors that influence how patients evaluate the integrity of individual clinicians and the broader healthcare system. Applying the insights from Section 3, we propose a novel set of curricular reformations to help cultivate trustworthiness among future physicians.

First, the communication behaviors described in Section 3.1 should become core components of early medical training. Medical schools can embed longitudinal practice that normalizes transparency and teaches students how candid disclosure, even of imperfect information, functions as a trust-building act. Evidence-based frameworks such as SPIKES and BATHES should be taught to provide students with structured approaches for building these skills. In simulated clinical encounters in the pre-clinical phase, as well as clinical encounters during rotations, we propose that performance evaluations should include measured indicators to score students' capacity to convey honesty, reliability, and respect for patients' perspectives. These skills, when introduced early and reinforced consistently, may help students internalize communication as a core component of their clinical skillset.

Second, the empathy and advocacy-building approaches described in Section 3.2 suggest a basis for experiential learning that centers the lived realities of marginalized patients. While community engagement exists in some programs, we propose

that medical schools develop mandatory multi-week experiential modules, such as immersive poverty simulations or social-needs navigation projects, that position students to better grasp the experiences and difficulties associated with navigating inequity firsthand. Furthermore, we propose students then reflect on how these experiences inform clinical responsibilities. Students would be expected not only to understand adversity but to imagine and articulate how physicians can help remediate structural barriers within clinical and institutional settings.

Finally, applying the insights from Section 3.3, a novel curricular approach would be to intentionally integrate these co-participatory narrative workshops into required coursework, allowing students to repeatedly encounter patients outside of clinical hierarchies and time pressures. Over time, these encounters reinforce the notion that meaningful patient-clinician relationships are built through openness, humility, and reflection. In this way, medical education can move beyond teaching students how to elicit patient stories toward helping them learn how to enter relationships where uncertainty and emotional risk are shared. This shift positions vulnerability as central to professional identity formation rather than something to be managed.

Together, these applications form a unified curricular approach that treats trustworthiness as a teachable, assessable component of medical professionalism. Rather than viewing lack of trust as a patient deficit, this framework positions trustworthiness as an active responsibility of clinicians and a structural goal of medical education. By anchoring their curriculum in communication, advocacy, and reflection, medical schools can apply an evidence-informed approach toward cultivating trustworthy physicians and addressing longstanding inequities in healthcare.

5. Limitations and next steps

Many of the strategies above fall short of addressing the institutional and historical breaches of trust that have shaped the relationship between marginalized communities and healthcare systems. For example, in the Tuskegee Syphilis Study, patients reported positive interactions with physicians and a sense of being cared for. Yet, they were systematically denied accurate information about their condition, care, and the effective treatment.[10] This history underscores that relational warmth and communication skills do not ensure ethical or trustworthy practice. Ultimately, isolated interventions focusing on proximal attributes that may contribute to trustworthiness are not sufficient on their own, particularly in the context of deep-rooted racial and ethnic inequities.[45,56,62,63] Therefore, the proposed strategies to foster trustworthiness are insufficient in isolation. Rather, they must be accompanied by efforts to address systemic betrayal.[4] Thus, another limitation is that we are not necessarily presenting an all-encompassing solution to achieve trustworthiness in care, as that has not yet been elucidated. Rather, our goal is to present interventions that are part of a broader multi–pronged solution that we must continue to work towards. Ultimately, these efforts must be continued and expanded.

Additionally, implementing the proposed frameworks is complex and requires restructuring the medical curriculum, making it unrealistic to assume these changes will occur soon. Instead, we hope this manuscript inspires steps in the right direction and provides a framework for medical education to build on existing initiatives.

Another limitation is the difficulty of measuring the success of these interventions. A proposed strategy to measure health care organizations' trustworthiness is to publicly report medical error rates stratified by race and ethnicity. This would increase transparency for patients from historically

marginalized groups and highlight areas where clinicians need to improve care processes to reduce inequities.[24] However, this measure cannot be used in isolation, as medical error rates can be attributed to a multitude of factors beyond trustworthiness, and trustworthiness similarly does not exclusively translate to medical error rates. This measurement would need to be paired with qualitative assessments of patients' perceived trustworthiness of providers, which would require a universally accepted, all-encompassing definition of "trustworthiness". Thus, it is difficult, if not impossible, to immediately assess the success of the proposed initiatives, and more work is needed to build consensus in medical education on what this term means.

Current medical education frameworks rarely explicitly provide physicians with tools to name, discuss, or address the implications of medical mistreatment's legacy. Thus, effective curricular reform must begin with medical education, acknowledging that we do not yet know how to fully overcome the long history of institutional betrayal in American healthcare. Yet, we should use the knowledge we have to begin explicitly grappling with these issues and focus on the roles current and future physicians can play in addressing these inequities.

We propose possible interventions to promote provider trustworthiness. Future developments in medical training should be co-designed with communities who have been harmed, centering on their definitions of what trustworthiness looks like and the actions necessary to earn their trust. Medical training must also emphasize recognizing when patient skepticism is justified and emphasize practicing humility and accountability.[62,63]

Conclusion

As the healthcare landscape evolves, medical education and training should prioritize ensuring physicians intentionally express trustworthy characteristics in their patient interactions. Such curricula should develop communication, empathy, and advocacy skills, and strategies to promote self-reflection. Moreover, this training should be implemented with the understanding that building competencies in trustworthiness alone is not sufficient to foster trust among historically marginalized communities. Physicians must also be aware of the historical and structural contexts that underlie patients' views and skepticism toward the healthcare system. Ultimately, building trustworthiness begins with acknowledging the legacies of systemic harm and recognizing that trust cannot be demanded by institutions that have yet to repair the damage they have done.

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