

What to Do About Trust? A Source of Contradiction in Interprofessional Collaboration

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"In formal logic, a contradiction is the signal of defeat; but, in the evolution of real knowledge, it makes the first step in progress."

—Alfred North Whitehead (British mathematician, 1861–1947)

Whitehead's suggestion in the quotation above, that contradiction can launch the development of real knowledge, might provide some comfort to those advocating for increased interprofessional collaboration because this field is currently faced with a fundamental contradiction. This contradiction centers on the issue of interprofessional trust. In one conversation within our literature, this trust is hailed as a laudable goal because it facilitates and expedites interprofessional communication. But in another parallel conversation, it is also lamented as a perilous pitfall because it erodes the checks and balances supporting patient safety. Simply put, the contradiction is this: high levels of interprofessional trust can be viewed as both a benefit and a risk.

Consistent with theories of rhetoric, it has been suggested that increased interprofessional trust is a benefit because it will improve interprofessional communication. A high level of interprofessional trust allows a clinician's statements of knowledge or fact to be taken as true, demonstrating that the elaborate interprofessional relationships of community and power have been successfully negotiated.¹ When team members have earned the trust of others, their credibility (or ethos)² is established. A consequence of this trust is more efficient communication. Clinicians develop a specific kind of discourse—often realized as a communicative sort of shorthand—that is a reflection of a shared ideology, of common alignment, and

of cooperation.³ In other words, high levels of trust can create abbreviated communications, which in turn support more efficient interprofessional collaborations. Thus, from a rhetorically informed perspective, a high level of interprofessional trust is a laudable goal. Indeed, research has confirmed that increased levels of interpersonal trust can enable better collaboration and communication.^{4–6}

Standing in contrast to this is research that draws on theories of patient safety and crew resource management (CRM) studies. To ensure safety and buoy patient protections, this research also seeks to support improved interprofessional collaboration and communication. However, unlike the rhetorical perspective, the patient safety- and CRM-informed research identifies the assumptions that are taken for granted, the communicative shortcuts, and the reduced questioning that stems from high levels of interprofessional trust as problematic. These studies often identify weaknesses in interprofessional communication as being related to incomplete communication events, to missing information-sharing protocols, and to primitive forms of information transfer.^{7–10} To improve interprofessional communication, this research focuses on communication standardization and the development of (and adherence to) information-sharing protocols (eg, pre-surgery team checklists). From the patient safety and CRM perspective, the communication structures that evolve in teams with high levels of trust can be suspect. And this suspicion is grounded in evidence—research has indicated that safety-related risks and errors increase as levels of team familiarity increase.¹¹

In this issue of the *Journal of Graduate Medical Education*, the article by Chan et al, "Understanding the impact of residents' interpersonal relationships during emergency department referrals and consultations," illustrates this paradox.¹² The study demonstrates how communication between health care professionals is affected by perceptions of familiarity and trust. In examining the referral and consultation processes among physicians, these authors highlight the powerful influence of familiarity and trust on professional practices. They develop a model in which they describe the optimal referral-consultation relationship as one where communicating physicians share high levels of familiarity (generated through extensive collaborative exposure over time) and high levels of trust

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(based on perceptions of expertise, reliability, alignment of interests, engagement, affability, and reputation). In this way, Chan et al uphold the rhetorical conception that high levels of interpersonal trust contribute to improved communication practices. However, as a participant comment in the article's discussion illustrates, this ideal communication context enables the physicians to take some things for granted, to use communicative shortcuts, and to require less confirmatory questioning. These communicative practices can constitute a threat to patient safety. Indeed, the article's illustrative quote reflects both the rhetorical perspective (indicated with *underlined italics*) and patient safety perspectives (indicated with *bold italics*) associated with trust between communicators:

I find [trust and familiarity have] changed substantially from the beginning of my R2 year to the end of my R3 year... *now they're very quick encounters...*when I first started there was probably a little bit of a combination [because] *they don't know who I am, I don't know who they are, so we both are kind of asking each other a few more questions than we need to* or being a bit more defensive. *But once you know the people it's very fast... You don't need a new set of vitals. They just said stable; I'm OK with that.* [emphasis added by L.V. and G.R.]

Herein lies the conundrum. Advocates of interprofessional collaboration want to make communication as efficient and effective as possible, while simultaneously creating a culture of safety. So a question emerges: Is team communication improved when trust enables speed and efficiency, or is team communication worsened when trust begets less verification and more truncated communications? As this participant statement illustrates, trust can support communication, but that very same trust can erode safety.

So what do we do about trust? Will our interprofessional care teams be best served by valuing high trust relationships or not? It isn't clear from the literature that the health care community knows which goal to strive for. The 2 perspectives stand in contradiction to each other, and yet, both are equally valid. Is it possible to have teams with high levels of trust *that also* carefully and thoroughly vet each patient information-sharing communication? Or are these 2 perspectives mutually exclusive? Answers to these questions are not obvious but, as Whitehead suggests, if we can engage in the hard work of finding an answer, the promise of real knowledge awaits.

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