

Talking About Declining Trust in Health Systems – and What to Do About It

Neil Seeman in conversation with Tony Sanfilippo

Our Quarterly Reflections columnist, Neil Seeman (NS), is in conversation with Anthony (Tony) Sanfilippo (TS), a Kingston, Ontario–based cardiologist, former senior advisor for Educational Expansion and Innovation at Queen’s Health Sciences and former associate dean at Queen’s Medical School. Tony sparked a national conversation with his popular 2025 book, *The Doctors We Need: Imagining a New Path for Physician Recruitment, Training, and Support*. That has inspired Tony to write a new, forthcoming book on trust.

NS: Why is trust declining in Canada’s health system? Is trust in providers also falling?

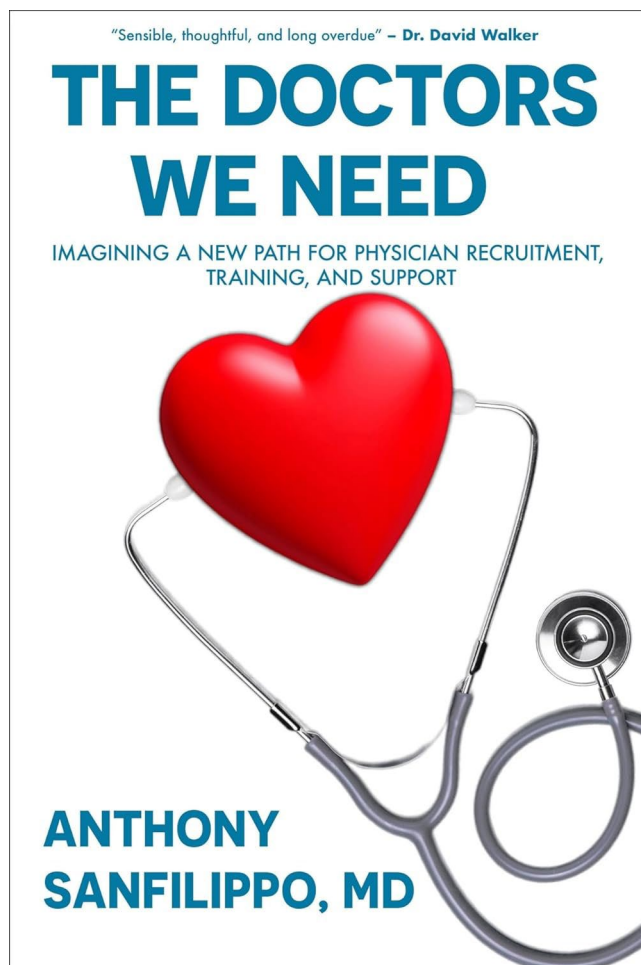
TS: I think we have to acknowledge from the start that those are two very different things. People seem to still have high (although reduced) levels of trust in their own healthcare providers, while their trust in the healthcare system has declined precipitously. This relates to one of the core themes of my work, which is that trust is an interpersonal phenomenon, developing in the context of a relationship. That gets to what I think is a key to your question about root causes. Our busy, highly stressed, technologically driven healthcare environment makes it much more difficult for those interpersonal relationships to develop and flourish. Single or short-term encounters between patients and doctors directed to single concerns are becoming the norm. At the system level, I do not believe people ever really place their trust in institutions or organizations, but they will if they relate to the people within them. Again, sheer size and diminishing consistency with respect to staffing make it very difficult for people to relate effectively.

NS: How does the erosion of trust differ across communities — urban, rural, youth and older adults?

TS: I think it is true that people have different inherent capacities to trust others. Some of that difference is simply hard-wired genetics and individual personalities, but much comes from our lived experiences and the environments in which we have engaged others. There is no getting away from the fact



Dr. Tony Sanfilippo



that there are dramatic generational differences with respect to engagement of common struggles, forms of communication and access to information. These affect both our need to trust and our willingness to engage others in a trust relationship. The same principles relate to the sort of communities in which

we spent our formative years. We learn to trust in small family and community units. Not everyone has the benefit of having experienced nurturing and caring environments during their formative years.

NS: How does transparency — communication and outcomes reporting — help rebuild trust?

TS: It is foundational. People must have faith that those they trust are fully honest and open with them. This adds to their sense of security in the relationship. But it goes deeper — they also need to know that those folks are committed enough to their welfare that they will put it before personal considerations or ego. In the medical context, it is very clear that full disclosure of adverse outcomes and even “near misses” do not diminish trust — they strengthen it.

NS: What can clinicians do in everyday practice to foster trust?

TS: The single most important element is focus. I know how difficult that is to achieve these days, but I also know that it is absolutely essential. Focus is the commodity that sends the message that “you are more important than other priorities I may have at this moment.” We live and work in a world that conveys that the opposite is true — in other words, that there are more pressing needs. And that is the reality, much of the time. So it is incumbent on us to frequently communicate to those with whom we work (patients and colleagues) that they matter, even if it is not possible to spend as much time with them as we would like. In a busy clinic setting, it may not be possible to spend a great deal of time with everyone, but on the occasion that a patient has a concern or anxiety that requires a few extra minutes, we should provide it whenever possible. If that is not possible at the moment, we should make the effort to make it up — a phone call later in the day (or days later) is incredibly powerful and communicates that they are important. Similarly, in an emergency room/acute care environment, a minute or two before the shift starts to say “hello” to the nursing and ancillary staff can make an enormous difference in the sense of trust as part of a team. A quick check-in before leaving can have the same effect. These gestures are not simply “nice things to do” — they reliably lead to more patient-centred care and a safer system.

NS: What about trust within teams — across professions and roles?

TS: I think it is absolutely essential. All this talk about trusting relationships with patients is meaningless if we cannot demonstrate the ability to do it with colleagues and others with whom we work. We tend to think of trust in the context of a dyad — the two-person relationship. In reality, we work in

the broader context of a clinic, emergency department, operating room, ward and a larger ecosystem. Trust in that environment means that everyone feels their opinions and concerns are respected and valued. That comes from creating an environment where people feel comfortable expressing such concerns. There must be an understanding that all such concerns will receive a respectful hearing. More importantly, there must be follow-through — changes in care processes where necessary, communications with those expressing concerns (with feedback), and periodic consideration of the process and whether it is working. Importantly, those entering the environment must understand this is a core part of the culture and must be respected.

NS: What role does education play in cultivating trust?

TS: What we do in our educational environment is intensely dependent upon personal relationships, particularly those within clinical teams. As with all such relationships, trust is essential and is built upon common elements — communication, honesty, commitment and follow-through. More specifically, in the educational setting, we must add respect for the learner/teacher relationship and the associated responsibilities that go with those roles. The learner must come to the learning setting with a deep respect for the opportunity to learn and a commitment to personal and professional development through all the stages of training. Teachers must take seriously their responsibility to do everything possible to help learners attain their goals. They must always be sensitive to power imbalances that exist in educational settings and take steps to mitigate them. One of the most important elements in my view is the concept of co-learning, with the aim of achieving excellence as a team. Team members come to excellent and equitable clinical care with a variety of strengths and weaknesses. With committed and honest communication, these strengths can be leveraged. Similarly, with such communication, team members can work together to deal with and mitigate weaknesses. It is particularly important for leaders to appreciate that followers carefully watch their behaviour to ascertain what they value and what to emulate. I believe this is what lies behind the common adage that culture is set at the top. In reality, it is set by the everyday behaviour of leaders and their interactions with others and the norms that are thereby created. Those interactions speak louder than any policy pronouncement.

NS: Which personal experiences most shaped your views on trust?

TS: I have spent the past 40 or so years involved more or less simultaneously in two parallel worlds — the practice of medicine and medical education. Success in both, I have come to realize, is mainly determined by trust that may or may not

develop with patients, colleagues, co-workers and the wider medical/educational community. I have been able to observe first-hand instances of success and failure and, hopefully, learn from them. I have found the core elements of communication, truth and commitment to be consistent and reliable determinants.

NS: What leadership qualities restore trust when people see political vision or courage as lacking?

TS: As I considered the genesis and elements of trust, I came to appreciate more and more that leadership and trust are intimately intertwined. Effective leaders have a vision that resonates with those they lead. It resonates because they understand and are attuned to their needs and desires. They are able to effectively communicate that vision. All this is motivated by a deep commitment to the welfare of those they lead. Essentially, great leaders foster trust that is not artificially manufactured, but genuine. You use the term “courage,” and that is very meaningful. Effective leaders are motivated by principles that may or may not meet with the approval of every person or group at all times. The “courage” relates to maintaining focus on those core principles despite changing

circumstances. Not an easy thing to do in our turbulent and media-driven times. We can always find great examples from history – Lincoln’s adherence to the principles of national unity during the US Civil War and Churchill’s refusal to compromise during the early days of the Second World War show the value of visionary and principled leadership.

NS: How can artificial intelligence (AI) and digital tools improve trust – while addressing privacy, equity and access concerns?

TS: Evolving AI-driven technology has huge potential to facilitate patient care and allow physicians to be more efficient and effective, while at the same time feeling much more personal satisfaction in their work. But this only works if technical development is guided by real-life needs. It is not enough to simply develop an intriguing technical advance and drop it into the medical world. It must be developed with real consultation with users. AI scribe is a great example. It essentially “unchains” clinicians from their computers and allows them to focus on the patient with much less “afterwork.” Privacy, equity and access are all critical concerns, all best addressed proactively, not as an afterthought.

About the Author

Neil Seeman, JD, MPH, is a senior fellow and associate professor at the Institute of Healthcare Policy, Management and Evaluation and a senior fellow at Massey College at the University of Toronto in Toronto, ON. He is a Fields Institute fellow, publisher at Sutherland House Experts, and senior academic advisor to the Investigative Journalism Bureau and the Health Informatics, Visualization and Equity Lab at the Dalla Lana School of Public Health at the University of Toronto. Neil can be reached by email at neil.seeman@utoronto.ca.