

TRUST IN HEALTH CARE

AN AGENDA FOR FUTURE RESEARCH

Discussion Paper

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Key Points

- There is a rationale for examining trust from a patient, clinical, organisational and policy perspective.
- There is a considerable literature, based predominantly on research conducted in the US, that has explored patients' conceptual understanding of trust and measured levels of their trust in health care systems, physicians in general, and in a particular clinician. Research is needed to investigate whether and how clinical and managerial perspectives on trust vary from patients' views.
- There is substantial evidence that trust mediates health care processes but no evidence of a direct beneficial therapeutic effect on health outcomes.
- Trust is intrinsic to high quality consultations and is a marker for how patients evaluate their experience of health care. However, it is not known how clinician-manager relations and relations between clinicians affect patient-clinician relations and wider organisational performance.
- Levels of patient trust in specific clinicians continue to be high but there is lower public trust in clinicians in general and health care institutions. How this affects public/patient assessment of institutions and local providers and how this varies by model of health care delivery needs to be examined.
- Prospective studies need to be conducted to monitor changes in levels of patient and public trust.
- Research is required to explore how changes in the organisational structure of medical care and the culture of health care delivery have affected trust relations between patients, clinicians, and managers.

Introduction

The context

Trust in health care is currently high on the policy agenda, primarily because it is claimed that, for a number of reasons, public trust in health institutions and in providers is under threat. This so-called erosion of trust, at least in the UK, has been tied to the recent intense media scrutiny about scandals over medical competence, such as the enquiry into paediatric cardiac surgery in Bristol, the conviction of the GP Harold Shipman, and the removal of organs from children at Alder Hey Hospital. This has led to policies aimed at creating more effective accountability for health care professionals (Maynard and Bloor, 2003). However, the so-called erosion of public trust in health care has also been linked with how the NHS is run and financed and the increasing pressure on NHS budgets due to increased demand by an ageing population, the rising costs of technology, and increases in public sector pay (Taylor-Gooby and Hastie, 2003). Others have suggested that it might be associated with changes in public attitudes and expectations of health professionals brought about by wider social and cultural changes such as the overall decline in deference to authority and trust in experts and institutions and increasing reliance on personal judgments of risk (Giddens, 1991; Beck, 1992; O'Neil 2002) or the overall decline in social trust due to the breakdown of communities, social networks and cohesion (Putnam, 2000). In addition, the National Health Service as an organisation is believed to be characterised by a culture of 'low trust' brought about, at least in part, by the gradual introduction of the new public management with its emphasis on regulation, audit and monitoring (Gilson, 2003; Rowe, 2003).

The aim of this paper is to examine the conceptual issues and empirical research surrounding trust in health care with a view to setting out an agenda for further and future research. It will draw heavily on the literature review recently carried out by one of the authors (Rowe, 2004), see Appendix 1. The focus of the paper will be on trust in providers and organisations, rather than technologies, although clearly each of these elements are related ie the increased use of and apparent trust in complementary medicine and therapies might reflect the concerns about the harmful effect of orthodox medications (Calnan *et al*, 2004). However, before this analysis is presented it is important to consider what the concept of trust means and how it is defined.

What is Trust?

Trust has been characterised as a multi-dimensional concept primarily consisting of a cognitive element (grounded on rational and instrumental judgments) and an affective dimension (grounded on relationships and affective bonds generated through interaction, empathy and identification with others) (Gambetta, 1988; Lewicki and Bunker 1996; Mayer *et al* 1995; Gilson, 2003). Trust appears to be necessary where there is uncertainty and a level of risk, be it high, moderate or low, and this element of risk appears to be derived from an individual's uncertainty regarding the motives, intentions and future actions of another on whom the individual is dependent (Mayer *et al*, 1995; Mishra, 1996). In the context of health care the evidence suggests the concept seems to embrace confidence in competence (skill and knowledge), as well as whether the trustee is working in the best interests of the trustor. The latter tends to cover honesty, confidentiality and caring, and showing respect (Hall *et al*, 2001; Mechanic and Meyer 2000) whereas the former may include both technical and social/communication skills. Trust relationships are therefore characterised by one party, the trustor, having positive expectations regarding both the competence of the other party, the trustee, and that they will work in their best interests.

The nature and form of trust: empirical evidence

Ten studies have investigated the nature and form of trust, either through qualitative research to understand patients' understanding of the concept or through development of instruments to measure trust.

A number of scales measuring different trust relations (public trust in health care, trust in a particular physician, trust in the medical profession generally, and distrust in the health care system) have been developed that have been found to have high internal consistency and which are available for use in future studies.

Qualitative research which has explored patients' understanding of the concept trust is limited but those studies which have done so have identified different types of trust. Dibben and Lena's study (2003) of patients attending nutrition clinics found that doctors sought to establish 'swift trust' early in the consultation by identifying areas of agreement and shared experience as the six monthly interval between consultations prevented frequent interaction and the development of trust over time. Lee-Treweek (2002) found that patients relied upon

‘network trust’, (the views of trusted family, friends or colleagues), in order to initially attend an osteopathic practice but that thereafter ‘experiential trust’ ensured their continued attendance. Thorne and Robinson’s study (1989) of patients with chronic illness distinguished between the ‘naive trust’ typical of the start of clinician-patient relations and ‘reconstructed trust’, trust which was re-established by patients after experiencing a period of disenchantment with their provider. The extent and way in which trust was reconstructed affected the type of clinician-patient relationship, varying from ‘hero worship’ when trust was re-established by designating an individual health care professional distinct from all others to trust, to ‘resignation’ when there was little evidence of any trust. Sobo’s study (2001) emphasised that trust has a non-rational dimension, anchored by patient dependence and hope. It is of note that all the qualitative studies which have explored conceptual understanding of trust have done so solely from the patient’s perspective. Research is needed to investigate whether clinical and managerial perspectives on trust vary significantly from patients’ views.

Does it matter? Trust as Process and Outcome

What is the case for examining trust in health care? Trust is believed to be particularly salient to the provision of health care because it is a setting characterised by uncertainty, and therefore risk (Titmuss, 1968; Alaszweski, 2003). Attaining and maintaining trust are believed to be important because of the benefits that such relationships bring to patients, clinicians and to health care organisations as a whole. For example, patient trust in the provider is believed to be important in its own right, meaning that it is intrinsically important for the provision of effective health care and has even been described as a collective good, like social trust or social capital (Hall *et al*, 2001). It is also important because it is claimed that it has a direct therapeutic effect (Mechanic, 1998), and there is a body of evidence that shows it has an indirect influence on health outcomes through patient satisfaction, adherence, and continuity with a provider and encourages patients to make appropriate disclosure of information so that accurate and timely diagnosis can be made (Hall *et al*, 2001; Safran *et al* 1998; Thom *et al*, 1999; Mosley-Williams *et al*, 2002; Kai and Crosland, 2001; Cooper-Patrick *et al*, 1997).

Trust has been identified by health service users as key to their experience and evaluation of medical care; high levels of trust are associated with high quality of care (Caterinicchio, 1979; Joffe *et al* 2003; Walker *et al*, 1998). Trust, although highly correlated with patient

satisfaction (Thom *et al*, 1999; Safran *et al*, 1998) is a distinct concept. Trust is forward looking and reflects a commitment to an ongoing relationship whereas satisfaction tends to be based on past experience and refers to assessment of provider's performance. It has been suggested that trust is a more sensitive indicator of performance than patient satisfaction (Thom *et al*, 2004).

Organisational benefits might include the facilitation of informed consent, ensuring more efficient use of doctors' time, reduction in the likelihood of complaints and law suits, and the fostering of effective health care relationships, heightening the quality of interactions and thereby promoting clinicians' job satisfaction (Fox, 1974). Other benefits that might be derived from trust as a source of social capital include the reduction in transaction costs due to lower surveillance and monitoring costs and the general enhancement of efficiency (Gilson, 2003). The rationale for examining public trust in the health care system is driven by political concerns regarding sustaining support for publicly funded services, as well as clinical concerns that relate to ensuring appropriate access and utilisation of services.

Trust might be of value in its own right but what evidence is available to assess the impact and consequences of trust? The effects of trust in patient-clinician relationships has been reported in 59 per cent of the studies included in the review. The importance of trust to the quality of doctor-patient interactions emerged spontaneously in a number of studies investigating patients' experience of health care (Goold and Klipp, 2002; Lings *et al*, 2003; Safran *et al*, 2001; Trojan and Yonge, 1993; Thorne and Robinson, 1988) with trust in doctors' expertise a key concern for breast cancer patients in the UK (Burkitt Wright *et al*, 2004) and AIDS patients in the USA (Carr, 2001). Trust appears to mediate therapeutic processes; higher levels of trust have been associated with acceptance of recommended treatment (Altice *et al*, 2001; Collins *et al*, 2002; Dibben and Lena, 2003; Hall *et al*, 2002; Jackson *et al*, 2004; McKneally and Martin, 2000; Paul and Oyeboode, 1999; Stapleton *et al*, 2002), lower treatment anxiety (Caterinnicchio, 1979) and adherence to treatment (Lukoschek, 2003; Mosley-Williams *et al*, 2002; Safran *et al*, 1998; Thom *et al*, 2002). For patients with mental illness trust facilitated disclosure (Repper *et al*, 1994) and helped them to take control of their mental health (Kai and Crosland, 2001; Svedberg *et al*, 2003), although it did not appear to moderate response to psychotherapy (McKay *et al*, 1997). Studies also suggest that trust facilitates access to health services (Booth *et al*, 2004; Cooper-Patrick *et al*, 1997; Matthews *et al*, 2002; Sharma *et al*, 2003).

Trust has also been associated with the performance of health services. Several studies suggest that trust acts as an indicator for quality of care and patients' experience of health services (Repper *et al*, 1994, Walker *et al*,1998) and is strongly correlated with patient satisfaction (Anderson, 1990; Baker *et al*, 2003; Hall, 2002 *et al*; Scotti and Stinerock, 2003; Thom *et al*, 1999). Trust levels have been associated with patients' loyalty to their provider (Arksey, 1999; Keating, 2002; Safran, 2001) and their evaluation of and willingness to recommend hospitals and medical care (Joffe *et al*, 2003; Caterinnicchio, 1979).

Again, the literature providing the provider perspective on the value and impact of trust is very limited. Trust was identified as being necessary for the uptake of evidence-based medicine by Canadian family physicians and could change the amount of time spent with patients (Jackson *et al*, *in press*). In the four studies that considered the impact of trust on workplace relations in health care settings, trust facilitated commitment to the organisation (Laschinger *et al*, 2000), encouraged collaborative practice between clinicians (Hallas *et al*, 2004), was associated with job satisfaction and motivation (Gilson *et al*, *in press*), and where trust was low nurses spent more time assessing the communication behaviour of other nurses (Northouse, 1979).

In summary, there is substantial evidence that trust mediates health care processes, but no direct evidence of a beneficial therapeutic effect on health outcomes. It appears to be a key indicator of the quality of clinician-patient relations and patients have identified it as a marker for how they evaluate their experience of health care. Further research is required to investigate the impact of trust in clinician-manager relations and between clinicians on organisational and clinical performance and on patient-clinician relations.

Levels of Trust

A considerable number of studies, using cross-sectional designs and mainly conducted in the US, investigated levels of patient and public trust in clinicians, the health system, or health insurers. There is little empirical evidence that patients' trust in health professionals has eroded in recent years, with trust in clinicians in all countries remaining high. In the USA Joffe *et al*'s large survey (2003) of patients discharged from hospitals in Massachusetts reported that 77 per cent always trusted nurses and 87 per cent always trusted doctors, and

Mainous *et al* (2004) found in his study that most cancer patients had similarly high levels of trust. Levels of trust may, however, vary according to the type of illness, extent of risk, and the patient's experience of medical care. Although Mechanic and Meyer's qualitative study (2000) did not use objective measures of trust levels it was evident from patient narratives that these varied according to their type of illness. Patients with breast cancer appeared to have the highest level of trust, in part because the life-threatening nature of the disease made it more important for them to feel they could trust their physicians. In contrast Lyme disease sufferers who had experienced difficulties in obtaining diagnosis and treatment talked much more about loss of trust.

The impact of managed care on levels of trust appears to be mixed. Whilst HMO members have less trust in doctors as a group than in their own doctor (Goold and Klipp, 2002), (which supports Hall *et al*'s finding (2002) that interpersonal trust is on average 25 per cent higher than general trust), 85 per cent of members trusted their doctor all or most of the time (Grumbach *et al*, 1999) with similar high levels reported by members in another HMO, irrespective of the type of provider payment (Kao *et al*, 1998). In contrast Haas (2003) reported that in US communities with more than 50 per cent managed care individuals were less likely to trust their doctor to put their medical needs first, and young physicians in the US considered that trust in them had diminished over the past five years (Sulmasy *et al*, 2000). Haas' study comprised a survey of US households and it may be that lower levels of trust are reported when members of the public rather than patients are questioned, i.e. that whilst patient trust in clinicians remains high, public trust has fallen. In the one longitudinal study assessing changes in levels of trust, Murphy *et al* (2001) reported that trust in doctors among Massachusetts employees of a public sector organisation had significantly declined between 1996-1999.

In Canada patients from breast cancer, prostate cancer, and fracture clinics had varying levels of trust in clinicians: 36.1 per cent reported high trust and 48.6 per cent reported moderate trust with only 9.0 per cent having low trust (Kraetschner *et al*, *in press*). As in the US, patients have lower trust in the medical system generally and trust in policy actors may fall to particularly low levels during times of change to the health care system (Kehoe and Ponting, 2003). In the UK Calnan and Sanford (2004) also found that levels of public trust and levels of confidence in doctors is still high, but was low in managers (see figures 1 and 2). The low level of trust and confidence in service managers appears to be explained by responses to

items about trust in specific aspects of the service. The lowest level of trust was found in relation to the performance of the system, for example, 75 per cent said that they had little or very little trust in waiting times never being too long. Tarrant *et al*'s study (2003) of trust among GP patients also reported high trust levels, 66 per cent had overall trust scores of 8 or over (10 = complete trust). Given the uncertain impact of managed care in the US it is interesting that in a comparison of the US and the UK Mainous and colleagues (2001) found no significant difference in the levels of trust of patients in their family physicians, both were high (more than 44 points on a scale that ranges from 11 to 55).

With the development of instruments to measure trust in health care systems several studies have reported such data (Straten *et al*, 2002). The English and Welsh appear to be more trusting of their health care system than the Dutch or the Germans (Van der Schee *et al*, 2004) and Rose *et al* (2004) found that distrust of the health care system (arguably a different concept to low trust) was only moderate amongst prospective jurors in Philadelphia.

In summary, levels of patient trust in specific clinicians appear to continue to be high but there is lower public trust in clinicians in general and health care systems. Given the lack of longitudinal studies it is not possible to state whether this marks an erosion of trust, although evidence from regular national surveys (Appleby and Rosete, 2003) shows an overall decline in public satisfaction (not necessarily trust) with the NHS.

The determinants and the development of trust: evidence from the review

Given that trust is assumed to be important for an effective therapeutic relationship, over half of the studies have examined what factors are associated with high levels of trust and how trust can be built and sustained between patients and clinicians. Most of the data are derived from cross-sectional studies; although their findings do not show causal relationships a number of common themes emerge from the research. Most studies emphasise that trust depends on relationship factors more than patient characteristics (Calnan and Sanford, 2004, Goold and Klipp 2002, Tarrant *et al*, 2003, Thom *et al*, 1999), although others have reported that higher trust levels were found among older, less educated patients (Balkrishnan *et al*, 2003, Anderson, 1990, Freburger *et al*, 2003; Mainous *et al*, 2001, Tarrant *et al*, 2003; Kraetscher *et al*, *in press*). A number of studies emphasise that trust can be built if patient views are respected and taken seriously and information is openly shared with patients

(Arksey and Sloper, 1999, Burkitt Wright *et al*, 2004, Henman *et al*, 2002; Joffe *et al*, 2003, Johansson and Winkvist, 2002, Mazor *et al*, 2004, Mechanic and Meyer, 2000; Trojan and Yonge, 1993; Walker *et al*, 1998; Wilson *et al*, 1998; Zadoroznyj, 2001). As well as clinician's interpersonal skills, their technical competence is important for the development of trust (Burkitt Wright *et al*, 2004; Cooper-Patrick *et al*, 1997; Gibson, 1990; Gilson *et al*, *in press*; Goold and Klipp, 2002, Henman *et al*, 2002; Lee-Treweek, 2002; Lings *et al*, 2003; McKneally *et al*, 2001; Thom *et al*, 2002). Zadoroznyj's study of Australian women who have gone through childbirth suggests that if clinicians have good interpersonal skills then their technical competence is secondary in patient's judgement of their trustworthiness.

Several studies have examined the impact of ethnicity on variations in levels of trust in the US. In a large household survey Doescher (2000) reported that lower levels of trust in doctors were associated with African-Americans compared to white Americans and this finding was confirmed in Boulware *et al*'s (2002) survey in Baltimore. However, amongst African-American patients, as in Mosley-Williams *et al*'s study (2002) of Lupus sufferers, differences in trust by race disappeared.

The potential impact of managed care on trust has stimulated studies that have investigated the contribution of choice of provider, provider payment method, and continuity of provider to patient trust. The results have been mixed. In a cross-sectional survey choice of provider was associated with higher trust levels (Kao *et al*, 1998). But Hsu *et al* (2003) conducted an RCT to assess the impact of choice of provider and found that although it increased satisfaction and provider retention it did not significantly increase trust. Kao *et al* (1998b) reported that patient knowledge of payment method was not associated with lower levels of trust, possibly because physician behaviour mediates any impact of this knowledge. This was confirmed by Hall and colleagues (2002) in an RCT – using a letter disclosing payment method with explanatory follow-up call. However, if HMO members experienced difficulties (Keating *et al*, 2002), such as in accessing a specialist (Grumbach *et al*, 1999) or if they had sought a second opinion (Hall *et al*, 2002), this was associated with lower trust.

Other studies have addressed the importance of continuity of provider in building up trust over time as the clinician and patient increase their knowledge and understanding of each other. Kao *et al* (1998) reported that choice of physician and continuity with provider increased trust among HMO members in Atlanta and Mainous *et al* (2001), Jackson *et al* (*in*

press), and Baker *et al* (2003) found that continuity of care was associated with higher levels of trust. Carr's qualitative study of AIDS patients (2001) also found that trust was linked to provider continuity but participants emphasised that trust had to be renegotiated at various points. However, Tarrant *et al*'s study (2003) of English patients in primary care found no correlation between trust and continuity and Caterinicchio (1979) reported that the quality of interaction, not continuity was important. This was similarly shown in Dibben and Lena's study (2003) where the infrequency of consultations created little opportunity for trust to develop over time, instead doctors sought to build trust by sharing information, identifying areas of common ground and by emphasizing patient self-competence. Thorne and Robinson's research (1988 and 1989) with patients suffering from a variety of chronic conditions found that trust in clinicians developed when clinicians showed their trust in patient competence to manage their illness.

More recently studies have addressed the importance of patient participation in decision-making and its contribution to the development of trust between clinician and patient. For some patients trust was linked to the professional status of their clinician and they did not expect an active role in decision-making (Zadoroznyj, 2001; Trojan and Yonge, 1993; Johansson and Winkvist, 2002), Kraetschrner *et al* (*in press*) refers to this as 'blind trust'. Both Kai's study of patients with mental illness in the UK (2001) and Kraetschrner's research with cancer patients in Canada (*in press*) report that trust was associated with providing patients with the opportunity to express concerns and discuss and negotiate treatment options. Breast cancer surgeons and oncologists in Canada reported that they found trust facilitated shared decision-making (Charles *et al*, *in press*). But patient participation per se does not necessarily result in higher trust. Krupat *et al* (2001) found that trust was associated with value congruence regarding patient participation, patient centredness did not produce higher trust if this did not reflect patient preferences for involvement. In Caress *et al*'s UK study of adults with asthma (2002) higher levels of trust were associated with more passive decision-making, which reflects Anderson and Dedrick's study in the US (1990) that reported that patients with low trust wanted more control in medical interactions. The mixed evidence regarding trust and its association with shared decision-making and the uncertainty as to whether role preference determines trust levels or vice versa indicate that further studies which are not cross-sectional are required.

Whilst there is a substantial literature on factors associated with the development of patient trust in clinicians, research into clinician-clinician and clinician-manager relationships is sparse. In Jackson *et al*'s qualitative study (*in press*) family doctors in Nova Scotia reported that trust between providers developed over time through positive experiences, and Hallas *et al*'s (2004) small survey found that open and honest communication was associated with greater trust and mutual respect between paediatric nurse practitioners and US paediatricians. Payne and Clark (2003) reported that systemic factors such as job specification as well as interpersonal variables affected trust levels; similarly Gilson *et al*'s study in South Africa (*in press*) suggested that management style and communication practices may increase workplace trust. These limited studies indicate the need for further research to identify how trust is built between clinicians, between clinicians and managers and how this might affect clinician-patient relations and patient trust in health care organisations and systems. Hall *et al*'s survey of HMO members (2002) found that system trust could help the development of interpersonal trust, without prior knowledge of the individual clinician, but it is not known how clinician-patient trust affects institutional trust. Medical errors and cost containment are associated with distrust of health care systems (Rose *et al*, 2004) and it appears that system-level trust may be linked to cultural differences (Van der Schee *et al*, 2004), but more research is required to investigate what influences trust in health care systems.

Towards a conceptual framework: explaining trust in the new NHS

A large body of literature has examined the antecedents or determinants that shape levels of trust. Research in social psychology and economics has tended to focus on the attributes of the trustor (beliefs about or calculations of trustees' motives; past experiences of health care and providers) and the characteristics of the trustee (their ability, competence, benevolence, integrity, reputation, communication skills). However, the sociological literature stresses that theoretical models must also consider contextual factors (the stakes involved, the balance of power within the relationship, the perception of the level of risk, and the alternatives available to the trustor) (Luhmann, 1979; Barber, 1983; Mayer *et al.*, 1995; Tyler and Kramer, 1996). In contrast to the rational choice economic approach which reduces trust to instrumental risk assessment by individual actors, sociological approaches suggest that the meaning and enactment of trust is influenced by wider social structures. Trust relations therefore need to be understood with regard to broader social changes associated with a late modern society which have produced a shift away from characteristic based trust, tied to knowledge of a particular person such as the family GP, to institutionally-based trust which is based on institutions such as certifications, regulations and legal constraints (Zucker, 1986). This perspective is reflected in Harrison and Smith's (2004) assessment of policy changes advocated in the UK government's modernisation programme. They argue that the new policy framework of clinical governance has sought to achieve a shift in focus from trust relationships between people to confidence in abstract systems, such as rules and regulations. The more behaviour is constrained by such systems, so uncertainty is reduced and the less we need to rely on trust (Smith, 2001).

Drawing on Zucker's analysis (1986) of the impact of wider social changes on trust relations, a framework has been developed that might explain the existence of different forms of trust in the 'new NHS'. It is hypothesised that changes in the organisational structure of medical care and the culture of health care delivery have changed the experiences of health care for individual patients and affected trust relations between patients, providers and managers. It is not proposed that these changes in health care delivery have cumulatively achieved a shift from trust in people to confidence in abstract systems. The provision of health care is still characterised by uncertainty and risk and there is evidence that not only are patients sceptical of institutional confidence building mechanisms such as star ratings, but that interactions between managers and clinicians continue to rely on informal relations and unwritten rules

rather than performance management (Goddard and Mannion, 1998). Rather, it is hypothesized that this new context of health care delivery may require new forms of trust relations, as patients, clinicians and managers become or are expected to become more active partners in trust relations.

For patients in the new NHS embodied trust (Green, 2004), arising out of an enduring relationship with the 'family doctor', may be less relevant due to new points of access to health care. It is hypothesized that provision of information and greater patient involvement in their care has produced greater interdependence between patient and clinician, making informed trust more relevant to the patient experience. For general practitioners, their relations with other providers have changed as other health care professionals become responsible for delivery of services, creating new relations in which trust has to be earned through collaboration rather than relying on professional status. The government's clinical governance policy has also created new trust relationships as its emphasis on institutionally based trust has required individual practitioners to develop much closer relations with managers. These emerging forms of trust relationships are exemplified in figure 3:

The framework suggests that trust relations in all three types of relationship in the 'new' modernised NHS might, in general, be characterised by an emphasis on communication, providing information and the use of 'evidence' to support decisions in a reciprocal, negotiated alliance. These new relationships may be particularly manifest in chronic disease management where trust is fundamental and where there has been considerable change in the nature of service delivery. Although studies in the USA have examined how patients experience trust in their relationships with clinicians and organisations (Mechanic and Meyer, 2000), to date such research has not been conducted in the very different setting of the UK NHS where the influence of economic incentives and constraints on professional decision making may not be so overt or direct (Mechanic, 1996). Certainly, trust appears to be seen as more of a 'problem' in the US, judging from the high proportion of research carried out on this topic.

Agenda for future research

It is clear that the bulk of research into trust in health care has focused on patient trust in health care professionals. These studies have been predominantly carried out in the United

States and have tended to focus on processual aspects of health care using cross-sectional and qualitative designs and methods. However, there are a number of questions which do not appear to have been examined, some of which we outline here.

First, there is the question of whether trust is an outcome in its own right or is a part of the process of health care which may impinge on health outcomes. Certainly, there are those who believe that trust should be seen, like social capital, as providing benefits to patients, providers and organisations in their own right. Patients value trust in their relations with providers but there is little evidence about providers and organisational perspectives. There is some evidence that trust influences other aspects of process or intermediate outcomes, such as adherence to advice and treatment. However, the direct therapeutic benefits of trust, such as its relationship with the placebo effect, needs to be examined. A review is currently being carried out examining the interventions for improving trust in doctors (Car *et al*, 2004).

Second, there seems to be a mismatch between the overall decline in trust in medicine and health care institutions, particularly erosion of public trust, and the evidence that trust and confidence, at least in medical practitioners, remains relatively high. This might be an artefact of the methodology in that data on levels of trust are derived from public opinion surveys which are unable to elicit the critical reasoning used by patients in their evaluation. Alternatively, it might reflect the difference in views about institutions compared with local providers. Thus, there may have been an erosion of trust in health care and medical institutions but not at an individual level. The interrelationship between public/patient assessments of institutions and local providers needs to be examined. Clearly, there is a need for prospective studies to be carried out to monitor changes in levels of public and patient trust and to examine the consequences of any changes.

There is also the related question about how complaints and grievances about providers relate to overall assessment of performance of health care. Does the increase in complaints about providers reflect a general decline in trust in health care or do complaints reflect a distinct and separate type of problem? How do the nature of complaints and their presentation affect public levels of trust in clinicians in general and the wider health system?

Third, the relationship between trust and performance needs to be examined. These investigations might include whether trust is a more sensitive indicator of performance than

satisfaction, at least from the public/patients point of view. There is a need to examine how different levels of trust contribute to organisational performance, the quality of care provided and the effectiveness of services delivered. Organisational research in other settings has shown that trust is important for group cohesion, team working, job satisfaction and organisational efficiency but no studies have investigated how trust contributes to the effectiveness of health service delivery. Are high performing health care organisations characterised by high trust relations between doctors and other health care providers and between doctors and managers, and if so how have they sought to build and sustain trust? A related question is how trust contributes to implementing change in service delivery, contexts where doctors may be particularly dependent on other providers and managers and vice-versa.

Fourth, in what context are trust levels more or less important and are different relationships of trust found in different treatment settings? Innovations in service delivery, such as walk-in clinics and the expert patient programme, may undermine patient provider trust relations, traditionally based on continuity of care. Successful management of many chronic diseases (eg diabetes) depends at least as much on changes that the patient can make as it does on specific interventions, as a result it requires a partnership between patient and health care practitioner. Evidence suggests that trust in clinicians depends not just on a provider's demonstration of care and concern for the patient as an individual, but it also requires providers to show confidence in a patient's ability to manage their disease. Being viewed as competent by a health care professional encouraged patients to feel more confident in their ability to control and manage their illness and at the same time increased trust in the provider. The current UK policy on chronic disease management has important implications for trust relations: requiring providers to increase their trust in patient's ability for self-care, encouraging more integrated approaches to service delivery between providers involved in disease and care management, and involving managers from primary care organisations who are responsible for assessing and rewarding practices' standards of activity in this area (Department of Health 2002). In more acute contexts, such as treatment of cancer, patients may take a more passive role and higher levels of trust may be required as there is considerable uncertainty about outcome. Trust may be particularly pertinent for patients with mental health problems because of the need for integrated care and because trust in modes of treatment (eg psychotherapy) may be critical to health improvement.

Fifth, the trust relationships between providers, for example in the NHS general practitioners and hospital doctors, and between providers and managers appears to have been under researched. It is not clear why this area has been neglected although one possible explanation is that the relationships are not seen to be problematic or important in terms of consequences for care. The change in manager-provider relations arising from the clinical governance initiative and the developing role of clinical managers makes research into trust between managers and providers and its potential impact on quality of care highly pertinent. The strains and tensions between GPs and hospital doctors, and doctors and managers, have been well documented although how central trust, or the lack of it, is in these relationships is yet to be discovered.

Sixth, research into public trust in health care systems and their performance is sparse. Do different models of health care delivery, eg market based or NHS type, generate different trust relationships, particularly relationships between public and patient trust? For example, public trust might be more salient for nationally organised, tax-financed system whereas patient trust may be more important in the competitive pluralistic market based system with its emphasis on choice and where providers need the loyalty of patients.

Finally, there are the more 'normative' questions of what levels of trust and what kind of trust relations are appropriate? The conceptual framework suggests that recent developments in the NHS require a move away from 'blind trust' to 'informed trust'. However, the type of trust relationships the public or different patient groups prefer needs to be examined and how far groups who lack resources (time, energy, finance) are able to attain their preferences also needs to be investigated. Informed trust does not necessarily mean low trust or mistrust but it implies that trust cannot be taken for granted. Nor should high levels of trust always be assumed to be desirable, in certain contexts lower levels of trust may be understandable and appropriate. Research is required to examine what levels of trust contribute to positive health outcomes and effective health care delivery.

We conclude that, while there is a considerable literature on the development and consequences of trust in the doctor-patient relationship, there are many aspects of trust relationships between patients, clinicians, and managers at both the micro and macro level which merit further examination.

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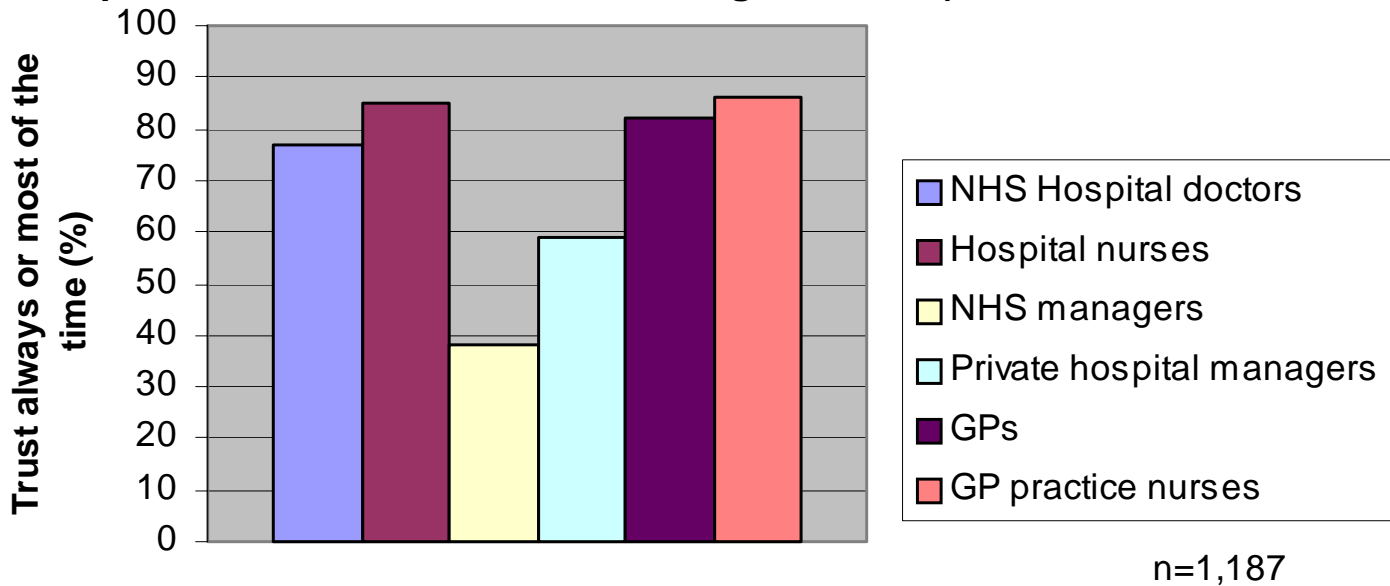
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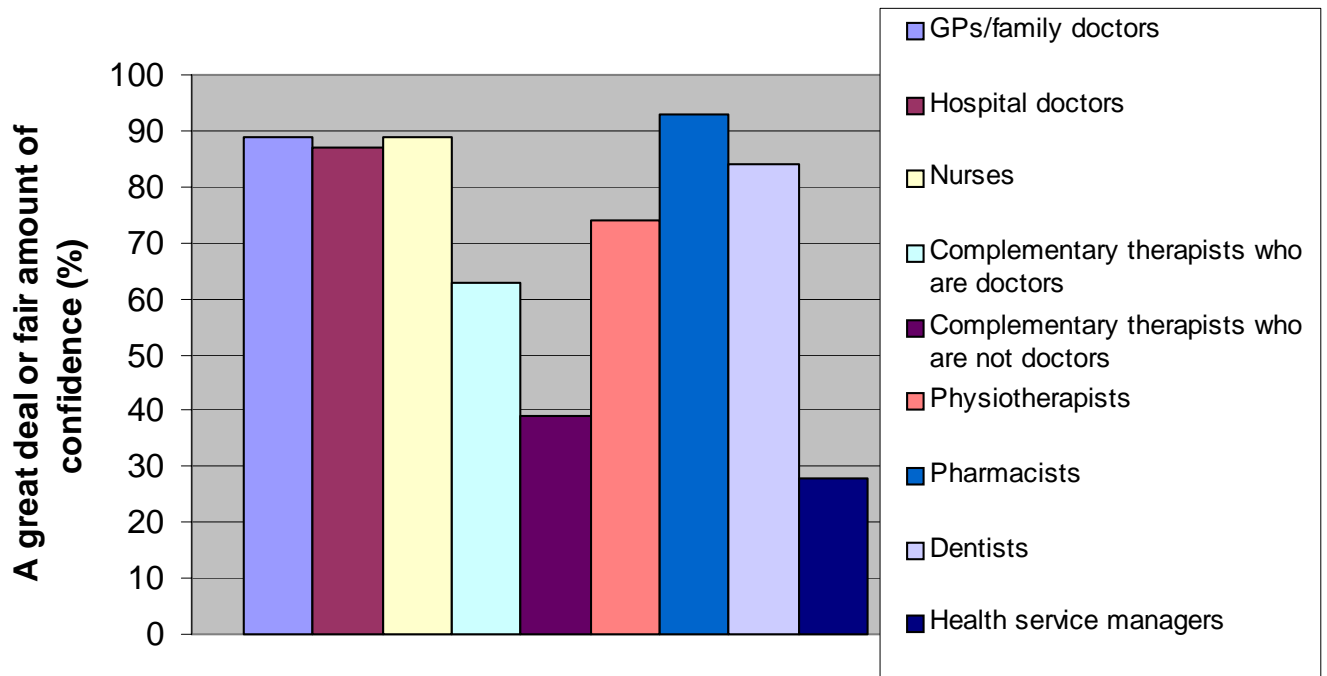
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Figure 1: Trust in health services staff (putting interests of patients above convenience of organisations)



See Calnan M, Montaner D and Horne R (2004)

Figure 2: Confidence in health care practitioners



See Calnan M and Sanford E (2004)

Figure 3: Conceptual framework for explaining trust relations in the new NHS

Relationship	Trustor		Trustee		Context	Type of Trust
	Affect based	Cognition based	Reputation	Communication		
Traditional clinician – patient	X		X		Paternalistic medicine	Embodied trust
Traditional Clinician-clinician		X	X		Autonomous self-regulation	Peer trust
Traditional clinician-manager		X	X		Prof autonomy/expertise	Status trust
New NHS clinician-patient	X	X	X	X	Expert patient	Informed trust
New NHS Clinician-clinician		X		X	Shared care	Earned trust
New NHS Clinician-manager		X		X	Clinical governance	Institutional trust

APPENDIX 1

Trust in health care: a review of the literature

Rowe R

Background

Attaining and maintaining trust in health care are believed to be important because of the benefits that such relationships bring to patients, to clinicians, and to health care organisations as a whole.

Objectives

The objectives of this review were to examine the level and effects of trust, to investigate how it varies between patients and clinicians, between clinicians, and between clinicians and managers, and to identify what influences the development and maintenance of trust.

Search Strategy

The search strategy covered eight electronic databases: the full Cochrane Library (to Issue 21 April 2004), Embase (1980-2004), Medline (1966-2004), Dissertation Abstracts International, the Applied Social Sciences Index and Abstracts, PsychINFO (1984-2004), Sociological Abstracts and the Web of Science on ISI Web of Knowledge. Bibliographies of review articles were hand searched and references of references yielded further papers.

Selection Criteria

Studies were included that reported on empirical research; had been undertaken in health care settings; and had examined the role of trust in relationships or had investigated interventions that influenced levels of trust or had reported trust as an important outcome or had examined the consequences of trust. Study participants could include patients, carers, clinicians, and managers. Quality criteria for inclusion were broad given the paucity of randomised or longitudinal study designs. All studies were carefully appraised for methodological quality.

Data Collection

Data were abstracted by the author using a standard data extraction form and each study was appraised using critical appraisal checklists developed by Greenhalgh *et al* (2004), including those based on the Cochrane Effective Practice and Organisation of Care Group. A random sample of 10 per cent of the studies were independently reviewed and appraised and the findings compared with appraisals conducted by the author for quality control.

Main Results

A total of 88 studies were included in the review. Only 3 randomised controlled trials and one uncontrolled intervention study have been conducted. Of the remaining observational studies six were prospective longitudinal investigations and 45 were cross-sectional. Thirty-four papers reported the results of qualitative research. The majority of work has been completed in the USA (59 per cent) followed by the UK (15.9 per cent) and Canada (11.3 per cent). An overwhelming majority of the literature (94.3 per cent) has focused on examining trust in the patient-provider relationship. Levels of patient trust in specific clinicians appear to continue to be high but there is lower public trust in clinicians in general and health care systems. The majority of papers investigated the effects of trust between patients and an individual clinician. Such studies suggest that trust has an indirect effect on health outcomes through encouraging patient access to health services and disclosure of information and assisting acceptance of and adherence to treatment. Trust has been identified by patients as key to the quality of clinical encounters and their experience of health services. It is closely associated with levels of satisfaction, loyalty to provider, and willingness to recommend health care institutions. The development of trust appears to depend more on relationship factors than patient characteristics and in particular clinicians' interpersonal skills and respect for patient views. Evidence as to the importance of continuity of care in building trust over time is mixed. Patient participation in decision-making processes and disease management is associated with a higher level of trust, but it is not clear whether greater participation increases trust or vice versa. There is very limited evidence as to levels of trust between clinicians and between clinicians and managers and how trust is built in such relationships.

Conclusions

Patient trust in clinicians remains high although levels of public trust are lower. Trust is intrinsic to high quality patient-clinician relationships; it mediates health processes and increases patient satisfaction. It can be developed through clinical inter-personal skills and respect for patient views. Further research is needed to examine the role of trust in relationships between clinicians and between clinicians and managers.