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Trust matters in Health and Healthcare

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Abstract

The uncertainties, unpredictability's, and complexities inherent in health care configure trust as a key element and strategy in its effective provision across many national systems and organisational and clinical settings. It incorporates a number of different dimensions – such as macro-level policies, inter-professional cooperation and professional/patient encounters. Trust relations are significant in shaping and facilitating interactions and transactions between patients and professionals, amongst professionals, between professionals and managers and at the system or institutional level. This entry considers the salience and nature of trust relations at these different levels of the health system and the way they might interrelate and shape one another

Key words: Trust; Uncertainty; Patient; Doctor; Organisational; Institutional

Introduction

This entry begins by defining the concept of trust and identifying its key elements and showing how it is salient for managing increasing uncertainties and risks. It explains why trust is such a key concept in health care governance, organisation, provision and patient use. The analysis then considers the significance and nature of trust from the patient and doctors' perspectives. In relation to patient trust it discusses how the nature of trust might have changed and considers the difference between felt and enacted trust. The following section focuses on clinical perspectives on trust I which includes discussion of different levels of trust such as organisational/ workplace and system/ institutional trust. It concludes with an analysis of how these different levels might interrelate and might shape one another.

Trust and Uncertainty in Healthcare

It is argued that as life has become ever more uncertain trust is becoming increasingly important as a way of managing these enhanced risks in everyday lives (Beck ,1992) Adopting a macro-perspective, Beck (1992) suggested that global, potentially catastrophic risks would increasingly shape social reality .This has been clearly exemplified by the impact of the recent global Covid-19 pandemic (Calnan and Douglass, 2022) where some of the assumptions inherent in everyday life i.e the propensity to trust people, became disrupted with the perceived risk of infection In addition, the basis for establishing trust appears to be more precarious as there has been a change in relationships with experts whose expertise is no longer taken for granted (Elston, 2009) and which appears to have been exacerbated by the more recent emergence of the populist post truth culture (Muller, 2017).

Basically, trust relates to some responsibility for a social action being placed in a trustee by a trustor (Luhmann, 1979). This social relationship can take the form of placing or delegating responsibility for completing an individual task or it can comprise a longer-term relationship. Trust helps a trustor to overcome uncertainties in evidence and proof in order to maintain social relations (Barbalet, 2009) and has been described as a 'leap of faith' (Elston.2009). Zinn (2008) has described strategies which are used in decision-making to address uncertainty as 'in between' strategies – including emotion and intuition – which fall between rational (calculative and probabilistic) and non-rational strategies (belief, hope, faith and avoidance). Trust is another 'in between' strategy which is seen as an especially vital means of bridging over uncertainty (Möllering 2006) through judging the reliability of individuals' intentions and competencies.

Trust has been defined as a multi-layered concept which consists of a "*cognitive element (grounded in rational and instrumental judgements) and an affective dimension (grounded in relationships and affective bonds) generated through interaction, empathy and identification with others*" (Calnan and Rowe, 2008: 6). It is claimed to be made up of intentional and competence trust. Trust has therefore been characterised by one party, the trustor, having positive expectations regarding both the competence, knowledge and skills of the other party, the trustee, to do a good job and to be able to work in their best interests and with beneficence, fairness and integrity (Calnan and Rowe, 2008)

Trust is salient in managing settings where complexity and uncertainty are prevalent such as in healthcare and it is believed to be even more important because of the risks, uncertainties and vulnerabilities which are inherent in its provision not just for patients but also for clinicians. For example, Richard Titmuss (2004) suggested that there are various limits (he identified at least thirteen) to the adoption of illness actions by patients in relation to health care. Health care had distinctive qualities unlike other types of commodities, and these are all associated with uncertainty and unpredictability. For example, he argued that patients who are seeking health care do not know in advance how much they need, what it will cost and what specific types of care they need and that the consequence of delivering health care are usually irreversible. Trust has been recognised as significant for effective healthcare provision across many national systems and provider contexts (Mechanic and Meyer, 2001; van der Schee et al, 2007) and moreover as incorporating a number of different dimensions – such as macro-level policies, inter-professional cooperation and professional/patient communication Trust relations have been shown to be significant in shaping and facilitating interactions and transactions between patients and professionals, amongst professionals, and between professionals and managers (Calnan and Rowe, 2008).

Patient trust

At the level of interpersonal trust between patient-practitioner it has been argued that trust is important for its potential therapeutic effects although evidence to support such claims is limited mainly because of the lack of research examining the effect of trust on outcomes (Calnan and Rowe 2008, Cook and Stepanikova, 2008). However

there is a considerable body of evidence that shows trust appears to mediate therapeutic processes and has an indirect influence on health outcomes through its impact on patient satisfaction, adherence to treatment, and continuity with a provider. It also encourages patients to access health care and to make appropriate disclosure of information so that accurate and timely diagnosis can be made (Calnan and Rowe, 2008).

Trust also appears to matter to patients as in a number of studies investigating patients' experience of health care trust emerged spontaneously as a quality indicator, with patients suggesting that high quality doctor-patient interactions are characterized by high levels of trust (Canan and Rowe ,2008) Trust, although highly statistically correlated with patient satisfaction is believed to be a distinct concept. Trust is forward looking and reflects an attitude to a new or ongoing relationship whereas satisfaction tends to be based on previous experience and refers to assessment of providers' performance. However, it has been suggested that trust is a more sensitive indicator of performance than patient satisfaction and might be used as a potential 'marker' for how patients evaluate the quality of health care (Calnan and Rowe,2008)

Trust also appears to be central to public participation in public health programmes such as those providing vaccinations. Analysis has shown that trust or the lack of it is a key element in understanding vaccine hesitancy. This is in part explained by the lack of trust in experts and/or the authorities seen to be associated with them but also by groups who align themselves with alternative values and favour the use of complementary medicine (Calnan and Douglass, 2020).

It has been suggested that there has been a decline in patient trust in professional medicine. A distinction needs to be made between trust in the health service and trust in medicine, although sometimes they become blurred together not least because the 'facework' carried out by clinicians (Willis and Pearce, 2015) can shape the patients' assessment of the organisation or institution. Survey evidence of public attitudes to the NHS in England suggests a generally high level of support and trust (Calnan, 2020). Similarly, with the medical profession, evidence suggests that despite the discourse of a decline in trust in medicine there are still high levels of trust in doctors particularly in high income countries (Welcome Trust ,2019). It might be useful here to make an analytical distinction between institutional and interpersonal trust although the relationship between the two is still contested (Willis and Pearce, 2015). There may have been a decline overall in the trust in medicine as an institution, but less so in trust in individual doctors, which might reflect the dominance of the new public management perspective founded on neo-liberal values of marketisation, and individualism (Knight et al, 2020). Also, while there may not have been a shift in the level of public trust towards increasing distrust it may be that the nature of trust has changed. The public and the patient now use a different notion of trust where trust has to be earned and is conditional rather than trust being assumed or taken for granted. So, while public or patient trust in the medical profession may still be relatively high doctors have to do more to earn the critical or conditional trust of the patients or to be worthy of patient trust (Calnan and Rowe, 2008).

An analytical distinction (Calnan and Rowe ,2008) can be made between felt trust and enacted trust and it cannot be assumed that one closely determines another. For example, a patient may have low levels of felt trust in their clinician but not act on it due to feelings of vulnerability and lack of control. Avoiding certain clinicians and seeking a second opinion are examples of enacted low trust practices although empirical evidence suggests that the former rather than the latter action tended to be favoured by patients at least in the NHS (Calnan and Rowe, 2008) but this may be different to practices found in private health systems where seeking second clinical opinions might be a more socio- culturally accepted practice.

The meaning of trust for clinicians

Clinicians' perspectives on trust have not, in the main, been problematised and thus there has been limited research, to date, that has explored this (Calnan and Rowe 2008; Sousa-Duarte et al ,2020). However, the extent to which clinicians trust their patients (felt trust) may influence how they treat and manage (enacted trust) them (e.g. a lack of trust may lead to defensive medical practice, asking for a second opinion and poor communication) which could in turn influence how patients respond and have consequences for subsequent, disclosure and adherence and may lead to a spiral of distrust. Certainly, the need for mutual, interpersonal trust appears to be important not least because of the apparent shift in the structure and nature of the clinician-patient relationship away from paternalism towards shared-decision making with an emphasis on patient involvement and self- care and conditional and earned trust rather than assumed or blind trust (Calnan and Rowe, 2008). This shift from blind and assumed trust to more earned and conditional or critical trust appears to be due to the dangers of blind trust embedded in high trust cultures where there is a lack of vigilance and a risk of corruption, exploitation, or domination particularly for those with a lack of resources (Calnan and Rowe, 2008). For example, those patients with limited economic and cultural capital might be forced to trust whereas those with more resources e.g., time, money and energy can afford to be critical and be more selective in who and where they consult.

The discussion has focused on how the nature of trust might have changed and its implications for both patients and clinicians. However, there are levels of trust which have been proposed that might impact on and shape clinical practice (Douglass and Calnan,2016). Two of these are at the micro level which are trust in patients and self-trust; one at the meso level which is organisational or workplace trust and finally one at the macro level which is system trust.

Clinicians trust in patients hinges to some extent on patient testimony which might be particularly relevant given the continued policy emphasis on patient centred care. Thus, there might be a degree of vulnerability for the clinician, which could be understood in terms of the risk of making a diagnostic error or risking a professional reputation by treating patients with ambiguous or psychosomatic symptoms in a specific way. Given the amount of unverifiable, descriptive information that a doctor must rely on from a given patient, a doctor is presented with a situation in which their trust in the patient could be called into question as they may or may not believe the symptoms being presented to them. This could be especially evident in contexts where a patient might be perceived as exaggerating their claims, which may alter how they are ultimately treated. Pilgrim et al (2011) expand on this in that they argue

that lay people might not be trusted by clinicians to act in their own interests because of perceived poor decision making. This is due to lack of knowledge (competence trust) and lack of care for their health (intentional trust) due to 'passivity, nihilism , fatalism , and fecklessness and at worst because they use help-seeking and illness presentation for manipulative reasons' .However, even when healthcare professionals and patients establish a trusting relationship, uncertainty over the honesty of the patient may become a problem because of the current norms of 'patient care' and the socio-legal context in which medicine is practiced. Fears and related vulnerabilities for clinicians are believed to include fear of deceit, fear of being manipulated, fear of contravening wider public norms and fear of litigation (Sousa-Duarte et al ,2020).

A further level is self-trust or intra-personal trust which Pilgrim and colleagues (2011) refer to as 'confidence in ourselves'. Self-trust may be particularly salient for less experienced clinicians who have clinical discretion but feel vulnerable as they do not have the confidence in their own competence, will be less willing to take risks and will follow protocols and rely on test results which may lead to a lack of personalised care and have consequences for patient trust.

One meso-level form of trust is organisational trust which is believed to be important in its own right and has been described as a collective good, like social trust or social capital. Organizational benefits that might be derived from trust as a form of social capital include the reduction in transaction costs due to lower surveillance and monitoring costs and the general enhancement of efficiency (Calnan and Rowe, 2008). A high trust culture in an organisation will mean that staff will be trusted 'to do the right thing and be professional' so there will no need for expensive audit processes. This is where the interrelations between managers and clinicians need to be considered and the extent to which there is cohesion and trustworthiness which might also have an impact on quality of patient care.

Systems trust at the macro level has number of different elements which might shape clinical perspectives on trust. One element of system trust facilitates the management of clinical uncertainty and complexity. The sources of the production of biomedical knowledge are researchers and commercial industry and those who serve to protect the validity of biomedical knowledge such as regulators. Despite having access to evidence-based data from critical appraisal, clinicians cannot be expected to have full knowledge /understanding of the technical and scientific processes that provide a rationale for the development and advocacy of a certain drug treatment, For example. proceeding with a particular drug treatment often involves the use of guidelines and thus system trust in the validity of the epistemic assumptions of biomedicine and the systems that facilitate and protect such validity (Douglass and Calnan, 2016).

The second element, which is linked to systems trust, relates primarily to trust in the institution of medicine at the macro level. This is referred to by some authors (Pilgrim et al, 2011, P9) as systems trust which relates to '*accountability and the checks and balances and systems that maintain fairness, preventing incompetence or malign intent'* This primarily involves the relationships between the regulators and the professional associations and practitioners who provide the service. This element has been increasingly important as in medical governance there has been a shift

away from self-regulation with a trust in professional values towards a culture of lack of trust with managerial control and tighter regulation and monitoring of performance (Calnan and Rowe, 2008).

Trust in institutions may also reflect a form of social trust or social capital. It is argued that health care systems are embedded in institutional contexts and do not just produce healthcare to improve health, but they can establish the social norms that shape human action and therefore act as a repository and producer of wider social value. These norms can help establish a moral community whom you can trust, and they may provide the basis for generalized trust. For example, while during the first wave of the Covid-19 pandemic there may have been some ambivalence in public attitudes towards government policy in England trust was enhanced by public loyalty to and support for the NHS as an institution which also reflected nationalistic values. Thus, the government gained political capital by tying itself to the NHS as an institution mirroring the campaign strategy previously adopted by the Brexiteers (Calnan and Douglass, 2022).

Interrelationships between levels of trust

Explanations for a possible link between different levels or layers of trust is more problematic. For example, patients may trust in the clinician that they know but have much less trust in the institutions or organisations in which these clinicians work. Theoreticians tend to agree that different levels of trust are interrelated but not how and why they might be related. The common distinction is made between the system and the individual. Luhmann (1979) makes a distinction between personal trust which is based on familiarity and taken for granted assumptions, and system trust, which is rooted in trust in the function of systems. Giddens (1990) similarly assumes the existence of two types of trust in late modernity, one that is disembedded (faceless trust in abstract systems) and an another that is re-embedded (trust in individuals). His broad argument is that both types interrelate and that trust in the system is mediated by trust in individuals – because individuals perform 'facework' on behalf of the broader system as they are the access points for the abstract system. However, Giddens (1990) argued that there is increasing need to trust in abstract systems as relations become more distanced. One key difference between Luhmann and Giddens appears to be that Luhmann (Barbalet, 2009) makes a distinction between confidence and trust, whereas Giddens sees trust as a particular form of confidence (Willis and Pearce, 2015). Luhmann (2000) argues that abstract systems are not trusted in the same way that individual persons are trusted, rather that there is confidence in systems, and thus proposes the notion of system trust. Unlike interpersonal trust, which is built on specific perceptions of individual competence, system trust requires continuing positive feedback (Luhmann, 1979), and it is only when this affirmative feedback discontinues that social action occurs, rather than with interpersonal trust, which shapes meaningful action as a bridge between present and future (Barbalet, 2009).

The empirical evidence about the implications of trust relations within organisations and between professionals and healthcare workers for patient care is in short supply, although some authors (Gilson, Palmer and Schneider, 2005; Brown and Calnan

2016) have suggested certain ways that relations and levels of trust may be interconnected in healthcare. In the context of mental health care. Brown and Calnan (2016), argue that chains of (dis)trust provide an explanatory link between trust relations at the organisational level with the quality of patient care. They attempted to specify the processes and procedures which accounted for the nature and structure of theses chains of trust relations. Their empirical work was carried out in the clinical setting of the management and treatment of people diagnosed with psychotic mental health problems where there is considerable uncertainty and vulnerability, and thus trust relations tend to be fragile. This research showed how relational - communicative and instrumental- strategic approaches shaped the extent to which trust chains could be characterised in terms of a vicious spiral of distrust or a virtuous cycle of trust. For example, poor trust relations between managers and clinicians, which may result over a conflict between organisational and professional interests, not only can lead to the provision of poor quality of patient care but can influence job satisfaction and work stress. This in turn can lead to high levels of staff sickness absence which limits the building of trust relations with clients and with the clinician's team. Hence a spiral of distrust may occur.

In relation to healthcare delivery in South Africa, Gilson, Palmer and Schneider (2005) put forward a conceptual framework that suggests that relations and levels of trust are interconnected. The authors argue that workplace trust shapes the attitudes and behaviours of healthcare workers towards patients which subsequently shapes patient (dis)trust in healthcare workers. Workplace trust is based in micro and macro level trust relations, including trust in the employing organisation, trust in supervisor and trust in colleagues. Patient trust in healthcare workers is grounded in interpersonal trust, including, attitudes and behaviour but also individual characteristics of the healthcare worker. Patient trust also reflects institutional trust, which is rooted in various elements that ensure healthcare workers are able to provide care (for example, qualifications, professional codes). Whilst the authors are cautious about confirming the interconnectedness of workplace and patient-healthcare worker trust, their empirical examinations as guided by this conceptual framework suggest that the two might be related.

In the context of vaccination supply and uptake the focus of the 'problem' has tended to be portrayed in terms of the latter rather than the former (Calnan and Douglass,2020). However, the interconnectivity between the supply side of vaccine development and take up should also be explored. This could build on the work which has studied vaccine trust relations between parents and professionals (Brownlee and Howson 2006) and which has also tried to extend the understanding of the shape and nature of trust relations to wider influences including the role of the media in relation to vaccination programmes (Brownlee and Howson ,2006). These authors show how the media may be significant to the relations of governmentality and trust that inhere in immunisation work. Health care professionals in the study by Brownlee and Howson (2006), such as doctors and health visitors, perceived the media's biased nature as undermining their trust-building work with clients. Certainly, social media appears to have a significant influence in shaping the publics, or at least some sections of the public's, trust in and uptake of the Covid- 19 vaccination programme (Calnan and Douglass,2022).

A broader framework for illuminating a 'chain' of different bases of trust, which together produce knowledge and assumptions upon which patient and public trust is grounded is provided by Brown and Calnan's (2012) analysis of trust relations in relation to the pharmaceutical industry. A similar approach might be applied to public perceptions of vaccination through an examination of the interrelationships between the practitioner, the public health system, the safety regulator and the manufacturer in the construction of knowledge into vaccines which could provide the basis for the analysis of trust in this setting (Calnan and Douglass, 2020; Calnan, Zinn and Douglass, 2022).

In conclusion trust has been and continues to be a key concept in the context of health and health care as it is one strategy for bridging uncertainty, unpredictability and complexity. Much emphasis and research have, understandably, focused on patient and public trust but the analysis needs to be broadened to understand different forms and perspectives on trust such as those of the clinicians and concepts such as organisational and systems trust. It also important to develop theories and find evidence to show how these different elements might be interrelated and shape one another. The Covid -19 pandemic has raised awareness of the salience of other relations of trust not least the relationship between scientific and medical expertise and government policy and with public trust which also need further exploration (Calnan and Douglass, 2022).

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