The aim of this introductory chapter is to provide a rationale for examining trust in healthcare and a context for the different elements of trust examined in the following chapters. Definitions of trust are outlined and explored along with a discussion of some of the elements of trust which may be particularly important in the context of the provision of healthcare. First, however, it is important to consider broader discourses of trust, in which debates regarding trust specifically in healthcare are set, and in which there is currently a tendency to portray trust as a declining commodity, under threat from globalization and social change.

THE DECLINE IN TRUST: A DISCOURSE

The concept of trust appears to have become the focus of renewed interest both from academics and policy makers primarily because it is believed that existing bases of social collaboration and agreement are under threat or have been eroded (Misztal 1996). This is claimed to be a product of the increasing uncertainties associated with reflexivity, globalization and risk which are believed to be characteristic of high or late modernity (Giddens 1990; Beck 1992). This, according to Scambler and Britten (2001) has led to commentators emphasizing: ‘the significance of trust for post-fordist economics activities, for the invigoration of civil society and for face-to-face relations with friends, lovers and family’ (Scambler and Britten 2001: 58).

Trust, as will be shown, is fundamental in the provision of healthcare but according to some writers it too has not been immune from these wider social changes, with trust in doctors and in the
medical profession under threat from a number of different sources (Scambler and Britten 2001). The first of these is the rise in consumerism and the shift from organized to disorganized capitalism which has led to the so-called culture of ‘shopping around’ and cultural pluralism which has permeated the use of healthcare. The second concerns the shift towards a post-modern culture in which science, including biomedicine, has been deprivileged with active trust and citizenship becoming a more common feature of critical modern reasoning and professional expertise becoming increasingly contested. This is linked with the third concern; that is the decline in the status of modern medicine, which is witnessed by the discussion of the processes of deprofessionalism and proletarianization and the attendant threats to the cultural authority and clinical and economic autonomy of doctors. Finally, there is the marketization of healthcare and the more direct or overt link between financial and clinical considerations which may raise doubts about the altruistic motives of doctors (Scambler and Britten 2001) who are claimed to be working in the interests of organizations rather than patients. Thus, much of the renewed interest in trust relations in healthcare has developed in the context of the alleged decline in trust in medicine. These debates will be considered in more detail at a later stage in this book but what we turn to now is why is trust so important in the provision of healthcare?

**THE SALIENCE OF TRUST IN HEALTHCARE**

Trust appears to be necessary where there is uncertainty and a level of risk (Jones 1998), 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 reliant (Mayer et al. 1995; Mishra 1996). Thus, the salience of trust will vary from context to context as will the conditions for generating trust (Rose-Ackerman 2001) but it appears to be particularly important in relation to the provision of healthcare because it is a setting which is characterized by uncertainty and an element of risk regarding the competence and intentions of the practitioner on whom the patient is reliant (Titmuss 1968; Alaszeski 2003). For example, Titmuss (1987) suggests that the unique features of healthcare derive primarily from the prevalence of uncertainty and unpredictability and lists 13 distinctive characteristics that pervade modern health care systems. The need for interpersonal
trust relates to the vulnerability associated with being ill as well as the information asymmetries and unequal relationships which arise from the specialist nature of scientific medical knowledge (Calnan et al. 2004) as well as the social position of the medical profession. Scientific medicines’ expertise or claims to expertise appears to be the basic condition for generating trust in this context (Rose-Ackerman 2001) although the affective component may also have an influence (Hall et al. 2001).

Trust will probably be salient to healthcare irrespective of the system which provides it because of the uncertainty and unpredictability which characterizes it. However, in the UK NHS trust has traditionally played an important part in the relationship between its three key actors: the state, healthcare practitioners, and patients and the public. The arrangements, at least in the ‘old’ NHS, were that service users were to trust the judgement, knowledge and expertise of health professionals to provide a competent service which met their needs and they were to trust the state to ensure equity in the allocation of public goods and services. Thus, in the NHS we can distinguish between trust relations at the micro level between an individual patient and clinician, between one clinician and another or between a clinician and a manager, and those at the macro level, which include patient and public trust in clinicians and managers in general, in a particular healthcare organization, and in the NHS as a healthcare system and institution.

The former are broadly categorized as interpersonal and organizational trust relations while the latter constitute different types of institutional trust (see Figure 1.1). This simple classification of the different types of trust relationships will provide the framework for the theoretical and empirical analysis presented in the following chapters. This analysis should shed further light on the possible relationship between these different types of trust and whether other forms of trust relationship not covered by this classification are important in the context of healthcare provision.

A review of the literature of trust relations in healthcare (Calnan and Rowe 2004) highlighted that most empirical research has been mainly carried out in the USA where there is a more explicit link between economic incentives and clinical practice, and the consequent dangers of supplier-induced demand, and where trust in the altruism of doctors’ motives is not a given (see Figure 1.2).

However Hall (2006) suggests a number of other reasons for this focus. First, it might reflect the ‘sanctity’ of the personal relationship that patients in the USA have with their freely chosen physicians.
Second, according to Hall (2006) the commercialization and the privatization of US medicine has led to the demand for the development of comparative performance indicators for evaluating providers so that US consumers can be more knowledgeable about what they are paying for. An interest in the USA in trust research has also

![Diagram: Trust relationships in healthcare]

**Figure 1.1** Framing trust relationships in health care  

![Bar chart: Research into trust by country]

**Figure 1.2** Research into trust by country  
stemmed (Hall 2006) from the perceived threat of managed care to the doctor–patient relationship. Trust in medicine was implicit but this changed as a result of concern that trust and the quality of the doctor–patient relationship may have been undermined by managed care insurance such as financial incentives to withhold care, restricted choice of doctors, and insurers’ oversight of doctors.

This research has addressed threats to patient–provider relationships although trust in healthcare systems from the patient’s perspective, at least in the USA, has been neglected. Hall (2006: 457) accounts for this neglect in terms of the highly fragmented and disorganized nature of the US health system ‘simply put, we have not put much effort into studying our system because there is no system’. Studies in the organizational literature, which is also still in short supply, suggest that trust relations in the workforce, between providers and between providers and managers, may also influence patient–provider relationships and levels of trust (Gilson et al. 2005). This approach suggests that trust is not primarily dispositional or an individual attribute or psychological state, but is constructed from a set of interpersonal behaviours or from a shared identity. These behaviours are underpinned by sets of institutional rules, laws and customs (Rowe 2003; Gilson 2006).

Research into trust has been conducted from a variety of disciplinary perspectives. Studies in social psychology and economics have tended to focus on the attributes of the trustor (beliefs about or calculations of trustees’ motives; past experiences of healthcare and providers) and the characteristics of the trustee (their ability, competence, benevolence, integrity, reputation and communication skills). Taking the rational choice economics approach, trust may be reduced to instrumental risk assessment by individual actors, that is a rational gamble that the personal gains from trusting will outweigh the risks and costs involved. For example, an economic analysis of why the public place trust in voluntary associations (Anheier and Kendall 2002) suggests that voluntary associations are run by those who have a stake in services provided to meet their needs and because they are non-profit-making and less likely to exploit user vulnerability. However, this ignores how trust may be constructed through the use of myths, images and other symbolic constructions. For example, Newman (1998) points to the use of informal social mechanisms such as gossip to communicate information through organizations, in the process contributing to the creation of trust and distrust. In this sense trust may be manufactured by the construction or manipulation of images rather than consideration of rational self-interest.
The sociological literature stresses that theoretical models must also consider contextual factors: the organizational context; 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; Zucker 1986; Mayer et al. 1995; Tyler and Kramer 1996). In this book we take a predominantly sociological approach, seeking to understand how the meaning and enactment of trust is influenced both by the micro- and macro-social context and in particular how changes in the organization and delivery of healthcare as well as broader social changes may have affected trust relations in the UK NHS.

Trust and Its Construction

Trust has been characterized as a multilayered concept primarily consisting of a cognitive element (grounded on rational and instrumental judgements) and an affective dimension (grounded on relationships and affective bonds generated through interaction, empathy and identification with others) (Rempel et al. 1975; Lewis and Weigert 1985; Mayer et al. 1995; Lewicki and Bunker 1996; Gambetta 1988; Gilson 2003). Trust appears to be necessary where there is uncertainty regarding the motives, intentions and future actions of another on whom the individual is dependent (Mayer et al. 1995; Mishra 1996). Luhmann (1979: 8) suggests that trust is necessary for us as it increases tolerance of uncertainty; trust ‘reduces social complexity by going beyond available information and generalizing expectations of behaviour in that it replaces missing information with an internally guaranteed security’. In this respect it is enabling as it encourages people to take risks when the outcomes are uncertain. Trust may vary in terms of its quality and quantity. For example, in elaborating on the nature of social capital (Putnam 2000) makes a distinction between ‘thick’ trust associated with close family relationships and ‘thin’ trust for more casual contacts. It is important to identify what people trust others to do as much as how much trust they have. For example, patients may have a lot of trust in nurses to monitor their long-term condition but trust them less when managing their medication. Misztal (1996) proposes a sociological approach to trust based on three assumptions. The first of these is that trust should be understood in terms of its functions for social order which relate to stability, cohesion and collaboration. The second assumption is that trust requires ontological security and
conditions under which social bonds can be promoted. The third assumption is that trust has a role as a social good or social capital.

In the context of healthcare, the most prevalent elements include 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 (Mechanic and Meyer 2000; Hall et al. 2001) whereas the former may include both technical and social/communication skills although the relative importance of these skills may depend on the organizational setting in which the care is provided. The vulnerability associated with being ill may specifically lead trust in the context of medical settings to have a stronger emotional and instinctive component (Coulson 1998; Hall et al. 2001). Trust relationships have therefore been characterized by one party, the trustor, having positive expectations regarding both the competence of the other party (competence trust), the trustee, and that they will work in their best interests (intentional trust). For example, as Davies (1999) suggests, all definitions of trust embody the notion of expectations: expectations by the public that healthcare providers will demonstrate knowledge, skill and competence: further expectations too that they will behave as true agents (that is, in the patient’s best interests) and with beneficence, fairness and integrity. It is these collective expectations that form the basis of trust.

However, for some writers (Giddens 1991) these trust relations are built on symbolic signs of expertise rather than altruistic principles and intentions and actual performance. Barbalet (2005) suggests that trust works as a ‘tranquillizer’ in social relations in which trust shuts down the trust giver’s uncertainty in the face of the trust takers’ freedom to act how they wish. Yet, the general point that these two writers allude to is that trust must be seen and understood within the context in which the relationships take place. This involves making explicit the social and cultural assumptions and expectations which are embedded in and emerge from these contexts. This is believed to be relevant to both interpersonal and institutional trust relationships (Gilson 2006). For example, Greener (2003), drawing on Luke’s three faces of power, has developed a power-focused taxonomy of trust which illustrates the influence of overt and covert forms of power. Greener’s first category of trust is voluntary which is characterized by an absence of calculation and the presence of mutual or shared trust such as in friendship. This can be manifest in interpersonal relations where there is a mutual understanding and a shared identity which might develop and be built up in a doctor–patient relationship.
over time, possibly in the context of chronic illness. It could also be manifest in trust in an institution such as public confidence in the NHS because of its reputation or through evidence from more visible performance information and trust in healthcare practitioners because of their standard of professional training. The second category of trust is involuntary where trust is forced on someone as there is no alternative and dependency or reliance is enforced. It is contingent on and constrained by power relations at either the interpersonal or institutional levels. This is manifest in the provision of healthcare by the power relations brought about, at least in part, by the asymmetries in clinical and system knowledge in the provider–patient relationship and the prevalence of uncertainty previously described by Titmuss (1987). Greener’s (2003) third category of trust is hegemonic which involves an unquestioning acceptance and subservience to a system such as the inherent trust in the NHS general practitioner system which led to a doctor such as Harold Shipman being trusted unconditionally.

The trust literature makes little explicit mention of risk, other than in relation to vulnerability (Connell and Mannion 2006). However, for many writers the concepts of trust and risk are closely related. For example, Jones (1998) in a philosophical review identifies risk as one of the key elements that should be accommodated in accounts of trust as trust involves risk because those who trust run the risk of letting those they trust near things that they care about (Jones 1998). The trustee may be unaware of or choose not to be aware of the risks such as in the case of blind trust. However, trust is not simply a vague or optimistic hope and does not require a denial of all risk (Jones 1998). For example, as Entwistle and Quick (2006: 407) argue when writing about trust in the context of patient safety, ‘... we should also accept that the placing of trust by a patient in a healthcare provider does not necessarily depend on the patient being ignorant of healthcare safety problems, being convinced that their healthcare providers have exceptional safety records (or prospects) or being totally convinced that no harm will befall them’.

DOES TRUST MATTER?

The case for examining trust in healthcare tends to hinge upon theoretical arguments sometimes complemented by empirical evidence. At the level of interpersonal trust between patient and practitioner, it has been argued that trust is important for its potential therapeutic
effects (Mechanic 1998) although evidence to support such claims is still in short supply mainly because of the lack of intervention studies or quasi-experimental studies (see Figure 1.3) examining the effect of trust on health outcomes (Calnan and Rowe 2004). 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, and that it encourages patients to access healthcare and to make appropriate disclosure of information so that accurate and timely diagnosis can be made (Calnan and Rowe 2004). For example, the importance of trust to the quality of doctor–patient interactions emerged spontaneously in a number of studies investigating patients’ experience of healthcare (Thorne and Robinson 1988; Safran et al. 2001; Goold and Klipp 2002; Lings et al. 2003; Trojan and Yonge 2003) 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 (Paul and Oyebode 1999; McKneally and Martin 2000; Altice et al. 2001; Collins et al. 2002; Hall et al. 2002; Stapleton et al. 2002; Dibben and Lena, 2003; Jackson et al. 2004), lower treatment anxiety (Caterinicchio 1979) and adherence to treatment (Safran et al. 1998; Mosley-Williams et al. 2002; Thom et al. 2002; Lukoschek 2003).

![Figure 1.3](image-url)

**Figure 1.3** Types of studies researching trust

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 (Cooper-Patrick et al. 1997; Sharma et al. 2003; Matthews et al. 2004) and the acceptance and use of new vaccines by patients (Rothstein 1998).

Trust also appears to matter to patients as well as healthcare providers. In a number of studies investigating patients’ experience of healthcare, trust emerged spontaneously as a quality indicator, with patients suggesting that high-quality doctor–patient interactions are characterized by high levels of trust, for example see Safran et al. (1998). Trust, although highly correlated with patient satisfaction (Thom and Ribisi 1999), 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 past experience and refers to assessment of providers’ performance. It has been suggested that trust is a more sensitive indicator of performance than patient satisfaction (Thom et al. 2004) and might be used as a potential ‘marker’ for how patients evaluate the quality of healthcare. In addition, several studies suggest that trust levels have been associated with patients’ loyalty to their provider (Arksey and Sloper 1999; Safran et al. 2001; Keating et al. 2002;) and their evaluation of and willingness to recommend hospitals and medical care (Caterinicchio 1979; Joffe et al., 2003).

In contrast to the sizeable literature assessing trust from the patient perspective, studies examining either the value and impact of trust from the practitioner perspective and from a managerial or organizational perspective are very limited (see Figures 1.4 and 1.5).

From an organizational perspective trust is believed to be important in its own right: it is intrinsically important for the provision of effective healthcare and has even been described as a collective good, like social trust or social capital (Khodyakov 2007). Specific 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 and the general enhancement of efficiency (Gilson 2003).

In terms of the provider’s perspective, trust has also been 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. 2004). In studies that considered the impact of trust on workplace relations in healthcare settings, trust facilitated commitment to the organization (Laschinger et al. 2000), encouraged collaborative practice between clinicians (Hallas et al. 2004), was associated with job satisfaction and motivation (Gilson et al. 2005), and where trust was low nurses spent more time assessing the communication behaviour of other nurses (Northouse 1979).
A further broader potential benefit of why trust matters to healthcare systems has been identified by Gilson (2006) who suggests that a health system based on trusting relationships can contribute to generating wider social value. This argument is based on the understanding that health systems do not just produce healthcare and have the goal of improving health. In addition, as with other social and political institutions, they establish the social norms that shape human behaviour and so act as a repository and producer of wider social value. To the extent that these norms help establish a moral community whom you can trust, they may provide the basis for generalized trust (Gilson 2006).

In summary, there is substantial empirical evidence that trust mediates healthcare 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 healthcare. Little is known about the impact of trust in clinician–manager relations and between clinicians on organizational and clinical performance and on patient–clinician relations.

THE ‘DARK SIDE’ OF TRUST

What are the costs, dangers or the ‘dark side’ of trust? Gilson (2006) identifies at least three from the theoretical literature. The first is associated with shared identity which allows the development of a particularized form of trust that enables cooperation in pursuit of morally unworthy acts. She illustrates this through the activities of organizations such as the Mafia. Second, there is the abuse of power on the basis of trust which she sees as a widespread danger (Warren 1999) and as trust usually involves an asymmetrical relationship between trustor, trustee and a valued good, it sets up a potential power relation. Trust may provide legitimacy for the exercise of power but ‘blind trust’ without caution may also enable the abuse of power, in the form of exploitation or domination. The third and associated danger for healthcare is the vulnerability of patients from ‘deprived’ circumstances (Gilson 2006). For example, the consequences of misplaced trust can, particularly for groups living in poverty, threaten livelihoods and lives (Coulson 1998) and it may be easier to trust and take risks if you are powerful and wealthy. Similarly, wealthy as opposed to poorer people may be seen to be more likely to be trustworthy and less of a risk to ‘invest’ in. Thus, Gilson (2006)
argues that the poor may be further marginalized as a result of trust relations. Connell and Mannion (2006) explore this theme further by speculating on the negative aspects of high trust cultures in organizations. They suggest that trust may be difficult, costly and time-consum ing to create but once established may be easily lost through inappropriate actions. In addition, high trust cultures may offer the opportunity to exploit the lack of vigilance and assessment of performance and cozy relationships may stifle innovation and foster corrupt practice and exclusivity. Thus, given the potential benefits and costs of trusting relationships, there may be a need to explore what levels and forms of trust contribute to positive health outcomes and healthcare performance and what levels of distrust maybe necessary to counter the abuse of power (Gilson 2006).

RESEARCHING TRUST RELATIONS

Empirical research into trust relations (Calnan and Rowe 2004) has tended to explore: the nature and form of trust in terms of its different dimensions and types; levels of trust; the factors that build, sustain or detract from trust; and the effects of high or low trust.

The nature and form of trust: empirical evidence

Studies have investigated the nature and form of trust, either through qualitative research to understand patients’ understanding of the concept or through the development of instruments to measure trust. A number of scales measuring different trust relations (public trust in healthcare, trust in a particular physician, trust in the medical profession generally, and distrust in the healthcare system) have been developed that have been found to have high internal consistency and which are available for use in future studies (Hall 2006).

Qualitative research which has explored patients’ understanding of the concept of trust is limited but those studies which have done so have identified different types of trust. Dibben and Lena’s (2003) study 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 (1989) study 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 healthcare professional distinct from all others to trust, to ‘resignation’ when there was little evidence of any trust. Sobo’s (2001) study emphasized 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 and it is not known whether clinical and managerial perspectives on trust vary significantly from patients’ views.

**Levels of trust**

A considerable number of studies, using cross-sectional designs and mainly conducted in the USA, have 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 (2003) large survey 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 their 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 (2000) qualitative study did not use 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 a diagnosis and treatment talked much more about loss of trust.

The impact of managed care on levels of trust appears to be mixed. While 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 (2002) finding 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. 1998a). In contrast, Haas et al. (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 USA 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: that while patient trust in clinicians remains high, public trust has fallen. In a rare longitudinal study assessing changes in levels of trust, Murphy et al. (2001) reported that trust in doctors among Massachusetts employees of a public sector organization 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. 2004). As in the USA, 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 healthcare system (Kehoe and Ponting 2003). Given the uncertain impact of managed care in the USA it is interesting that in a comparison of the USA and the UK, Mainous et al. (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). Hall (2006) offers a number of possible explanations for the higher levels of trust that US patients and/or members of the public express in individuals as opposed to medical institutions. First, people typically have stronger trust in individuals than in professional systems or organizations. Second, people are generally inclined to have an optimistic view of themselves and their personal relationships. This is particularly important in the context of healthcare because of the patients’ position of vulnerability. Third, it could be a methodological artefact, reflecting a form of cognitive adjustment or social desirability bias in response to questions about trust (patients may have good reasons for not being overtly critical of their doctor). Finally, trust in individual health professionals may have a stronger affective component than trust in healthcare organizations, which may reflect a more critical
evaluation and a greater emphasis on the cognitive element of trust.

Little empirical research has been conducted to investigate the nature of trust relations within the UK health system; instead most studies have focused on assessing levels of trust. These studies confirm the familiar pattern that suggests that while patients retain high levels of trust in individual clinicians (‘your own doctor’) (Calnan and Williams 1992; Mainous et al. 2001; Tarrant et al. 2003; Calnan and Sanford 2004), lower levels of trust are found for healthcare institutions. For example, evidence from a recent postal survey (n = 1187) (Calnan and Sanford 2004), carried out in 2002/3, on a random sample of people (18+) living in England and Wales, showed that 76 per cent reported that they always or most of the time trusted NHS hospital doctors to put the interests of their patients above the convenience of the hospital (see Figure 1.6). The comparable figure for hospital nurses was 85 per cent, for general practitioners 83 per cent, and for general practice nurses 87 per cent. Similarly, when asked about levels of confidence in different healthcare practitioners, 89 per cent said that they either had a fair or a great deal of confidence in general practitioners, 87 per cent in hospital doctors, and 89 per cent in nurses.1

The reported average level of confidence and trust in today’s healthcare system was 6 out of a score of 10 and this declined to 5.6 when respondents in this survey were asked about confidence and trust in the healthcare system of the future. This lower level of trust in the healthcare system as an institution seems to be reflected in the

Figure 1.6 Levels of trust in health services staff: putting interests of patients above convenience of organizations

Source: Calnan and Rowe (2006).
levels of trust shown in health services managers. The survey evidence showed only 29 per cent reporting that they had a great deal of confidence (3 per cent) or a fair amount of confidence (26 per cent) in health service managers. Private hospital managers fared better than NHS hospital managers in that 59 per cent said that they think private hospital managers would always, or most of the time, put the interests of their patients above the convenience of the hospital compared with 38 per cent of NHS managers (see Figure 1.6).

This lower trust in health service managers also 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, that is 75 per cent said that they had little or very little trust in waiting times never being too long. The percentage for ‘cost-cutting does not disadvantage patients’ was 68 and for ‘patients won’t be the victims of rising costs of health care’ was 70. How important is this lower level of trust in aspects of the performance of the health system? The answer is that it has limited importance, at least according to results of the statistical analysis which explored the determinants of public assessments of confidence in today’s NHS care. This survey used 32 specific items measuring six different aspects of the process of healthcare: (a) patient-centered care; (b) macro-level performance and patient care; (c) professional competence; (d) quality of care; (e) communication and provision of information; and (f) quality of cooperation between healthcare providers/practitioners. Top of the league for explaining trust were whether patients are taken seriously and whether they are given enough attention (that is aspects of patient-centered care) followed by items assessing professional expertise (‘patients will always get the best treatment’ and ‘doctors always make the right diagnosis’). The bottom six predictors in the league table mainly consisted of items measuring aspects of macro-level performance such as waiting lists, waiting times and cost-cutting (see Figures 1.7 and 1.8; Tables 1.1 and 1.2).

The results of this statistical analysis suggest that the relationships between the perceived performance of the healthcare system at the macro level and the perceived quality of healthcare provision at the macro level is a complicated one. Research needs to examine how if, in any way, institutional trust influences interpersonal trust and/or vice versa and also on what basis the public and patients assess levels of trust and confidence in health service managers compared with healthcare practitioners. There is evidence of a decrease
in satisfaction with the NHS over the last decade or so (Appleby and Rosete 2003) but there is no evidence available about whether there has been a parallel decline in public trust. However, evidence from a Dutch consumer panel survey (van der Schee et al. 2006), which monitored public trust in healthcare in the Netherlands over an eight-year period from 1997 to 2004 showed overall levels remained quite stable. This was in spite of marked changes in healthcare policy during this period along with intense media coverage of public and political discontent about these policy changes. There were some minor fluctuations and, for example, trust in medical specialists

### Table 1.1 Specific determinants of overall rating of trust/confidence – top six

<table>
<thead>
<tr>
<th>Rank order</th>
<th>Individual determinants</th>
<th>N</th>
<th>Mean change in overall trust rating per unit lost in trust in individual determinant</th>
<th>95% CI</th>
<th>p</th>
<th>R²</th>
</tr>
</thead>
<tbody>
<tr>
<td>27</td>
<td>F: Patients are not given conflicting information</td>
<td>1140</td>
<td>−0.383</td>
<td>(−0.48, −0.29)</td>
<td>0.00</td>
<td>0.05</td>
</tr>
<tr>
<td>28</td>
<td>Patients will show doctors respect</td>
<td>1143</td>
<td>−0.376</td>
<td>(−0.48, −0.27)</td>
<td>0.00</td>
<td>0.04</td>
</tr>
<tr>
<td>29</td>
<td>B: Waiting times are never too long</td>
<td>1137</td>
<td>−0.358</td>
<td>(−0.45, −0.27)</td>
<td>0.00</td>
<td>0.05</td>
</tr>
<tr>
<td>30</td>
<td>B: Cost-cutting does not disadvantage patients</td>
<td>1135</td>
<td>−0.343</td>
<td>(−0.43, −0.26)</td>
<td>0.00</td>
<td>0.05</td>
</tr>
<tr>
<td>31</td>
<td>F: High levels of specialization do not cause problems in the healthcare system</td>
<td>1129</td>
<td>−0.278</td>
<td>(−0.38, −0.18)</td>
<td>0.00</td>
<td>0.02</td>
</tr>
<tr>
<td>32</td>
<td>B: Patients will be able to pay for their own healthcare if they have to</td>
<td>1128</td>
<td>−0.081</td>
<td>(−0.18, −0.15)</td>
<td>0.10</td>
<td>0.01</td>
</tr>
</tbody>
</table>

*Source: Calnan and Rowe 2006.*
displayed an upward trend but, overall, general practitioners and specialists are highly trusted by the Dutch public. This pattern of results led the authors to raise doubts about whether trust should be regarded as a strong reflective indicator or predictor of healthcare performance.

With the development of instruments to measure trust in healthcare systems, several studies have reported such data (Straten et al. 2002). For example, there is evidence from an international study using the same core questions and comparing levels of public trust in

<table>
<thead>
<tr>
<th>Rank order</th>
<th>Individual determinants</th>
<th>N</th>
<th>Mean change in overall trust rating per unit lost in trust in individual determinant</th>
<th>95 % CI</th>
<th>p</th>
<th>R²</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>A: Patients are taken seriously</td>
<td>1140</td>
<td>-0.801</td>
<td>(-0.89, -0.71)</td>
<td>0.00</td>
<td>0.21</td>
</tr>
<tr>
<td>2</td>
<td>A: Patients get enough attention</td>
<td>1140</td>
<td>-0.742</td>
<td>(-0.82, -0.66)</td>
<td>0.00</td>
<td>0.21</td>
</tr>
<tr>
<td>3</td>
<td>D: Patients will always get the best treatment</td>
<td>1141</td>
<td>-0.703</td>
<td>(-0.78, -0.62)</td>
<td>0.00</td>
<td>0.21</td>
</tr>
<tr>
<td>4</td>
<td>D: Doctors always make the right diagnosis</td>
<td>1144</td>
<td>-0.687</td>
<td>(-0.78, -0.59)</td>
<td>0.00</td>
<td>0.16</td>
</tr>
<tr>
<td>5</td>
<td>A: Doctors provide their patients with good guidance</td>
<td>1137</td>
<td>-0.651</td>
<td>(-0.74, -0.56)</td>
<td>0.00</td>
<td>0.15</td>
</tr>
<tr>
<td>6</td>
<td>F: Healthcare providers are good at cooperating with each other</td>
<td>1136</td>
<td>-0.635</td>
<td>(-0.72, -0.55)</td>
<td>0.00</td>
<td>0.15</td>
</tr>
</tbody>
</table>

Source: Calnan and Rowe (2006).
different countries (England and Wales, Germany and the Netherlands) with different healthcare systems (van der Schee et al. 2003). Results showed that levels of trust in different healthcare practitioners were higher in England and Wales than in the other two countries. However, for different aspects of healthcare, levels of trust in Germany were consistently marked lower than in the other two countries.

The authors postulated four possible influences on variations in public trust in healthcare systems. Two of these characteristics are associated with the healthcare system itself; these are the extent and nature of institutional guarantees (for example extent of regulation and protection of patients’ rights) and the quality of care provided. The two others were media images, which can be positive and negative (the media tends to amplify a scandal on the one hand and ignore success stories on the other), and the influences of different cultural differences in public attitudes, that is people in different countries may differ in their general orientation or predisposition to trust institutions and people. The authors tentatively conclude that differences in public trust may strongly reflect cultural differences, which clearly affects the applicability of the concept of public trust in international comparisons of healthcare performance (van der Schee et al. 2007).
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 healthcare 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 in the UK shows an overall decline in public satisfaction (not necessarily trust) with the NHS which is believed to be paralleled in the USA (Mechanic and Schlesinger 1996). However, evidence from the Netherlands shows little change in recent years in levels of public trust in the health system.

The determinants and the development of trust

Given that trust is assumed to be important for an effective therapeutic relationship, it is not surprising that a large proportion of trust research has 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 emphasize that trust depends on relationship factors.

Figure 1.8 Trust in different aspects of healthcare: international comparison

Source: Calnan and Rowe (2006).
more than patient characteristics (Thom et al. 1999; Goold and Klipp 2002; Tarrant et al. 2003; Calnan and Sanford 2004), although others have reported that higher trust levels were found among older, less educated patients (Anderson and Dedrick 1999; Mainous et al. 2001; Balkrishnan et al. 2003; Freburger et al. 2003; Tarrant et al. 2003; Kraetscher et al. in press). A number of studies emphasize that trust can be built if patient views are respected and taken seriously and information is openly shared with patients (Trojan and Yonge 2003; Wilson et al. 1998; Arksey and Sloper 1999; Mechanic and Meyer 2000; Zadoroznyj 2001; Henman et al. 2002; Johansson and Winkvist 2002; Joffe et al. 2003; Burkitt Wright et al. 2004; Mazor et al. 2004). As well as clinicians’ interpersonal skills, their technical competence is important for the development of trust (Gibson 1990; Cooper-Patrick et al. 1997; Goold and Klipp 2002; Henman et al. 2002; Lee-Treweek 2002; Lings et al. 2003; McKneally and Martin 2000; Thom et al. 2002; Burkitt Wright et al. 2004; Gilson et al. 2005). 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 patients’ judgement of their trustworthiness.

Several studies have examined the impact of ethnicity on variations in levels of trust in the USA. 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, among African-American patients, as in Mosley-Williams et al.’s (2002) study 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. 1998b). 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 et al. (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. (1998b) reported that choice of physician and continuity with provider increased trust among HMO members in Atlanta and Mainous et al. (2001), Jackson et al. (2004) and Baker et al. (2003) found that continuity of care was associated with higher levels of trust. Carr’s (2001) qualitative study of AIDS patients also found that trust was linked to provider continuity but participants emphasized that trust had to be renegotiated at various points. However, Tarrant et al.’s (2003) study 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 (2003) study 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, 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 (Trojan and Yonge 1993; Zadoroznyj 2001; Johansson and Winkvist 2002). Kraetschner et al. (2004) refers to this as ‘blind trust’. Both Kai and Crossland’s (2001) study of patients with mental illness in the UK and Kraetschner’s (2004) research with cancer patients in Canada 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. 2003). 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 (2002) UK study of adults with asthma higher levels of trust were associated with more passive decision-making, which reflects Anderson and Dedrick’s (1990) study in the USA 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.

While 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 (2004) qualitative study 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 pediatricians. 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 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 healthcare organizations and systems. Hall et al.’s (2002) survey of HMO members 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 healthcare systems (Rose et al. 2004) and it appears that system-level trust may be linked to cultural differences (van der Schee et al. 2007), but more research is required to investigate what influences trust in healthcare systems.

FOCUS OF THE RESEARCH: STRUCTURE OF THE BOOK

This introductory chapter has presented a rationale for examining trust relations in healthcare from a patient, professional, organizational and policy perspective. This chapter has clearly shown, despite the considerable body of trust literature in existence, that there are still numerous unanswered questions for theoretical and empirical
research (see Calnan and Rowe 2004 for a more detailed research agenda). Trust is a complex concept with multiple domains and potentially different forms but very little research has been conducted to increase our conceptual understanding of trust relationships in healthcare or to develop methodologies for exploring such concepts empirically. Conceptually, there is a need to examine whether trust is still salient to relationships within healthcare and if so whether new forms of trust have developed as a result of the changing organizational structure of medical care and the culture of healthcare delivery. Has, for example, patients’ blind trust in healthcare practitioners been replaced by a more conditional, informed trust and if so what does this new form of trust look like and what are its implications for patients, practitioners and managers? What of the trust relationships between health professionals and between healthcare managers and health professionals which have been neglected in research up until now? In addition, there are particular methodological challenges to investigating trust; most notably reported expressions of levels of trust may differ from enacted behaviour. Research is needed to identify what beliefs and behaviour might indicate low or high trust in different organizational settings and in different relationships, between clinicians and patients, between patients and healthcare organizations, between healthcare practitioners, and between practitioners and managers.

The major focus of this book is to explore the nature of trust relations between patients and health professionals, between healthcare professionals, and between clinicians and health service managers. Thus, the aim is to examine in some depth interpersonal trust relations, organizational trust and institutional trust, and if and how they may relate to each other. This is explored through a combination of theoretical analysis and empirical research. The later chapters in this book draw mainly on evidence from a recently completed study using qualitative methods to explore trust relations in different clinical and organizational settings in the NHS in England. This exploratory study compares and contrasts evidence from an analysis of two different clinical and organizational settings: treatment of type 2 diabetes in primary care and provision of elective hip replacements in secondary care. Trust may be particularly pertinent to self-management by patients with diabetes as patients need to play an active part in care management and thus are required to develop the necessary levels of competence and motivation for self-management (Skinner and Hampson 2001). Thus, the provider–patient relationship might be characterized by a need for mutual
trust with the patient trusting the provider to have the expertise and to provide care and support when required and the provider trusting the patient to develop the expertise and take responsibility for self-care. This case study provides the opportunity to examine how trust operates in the primary care setting and specifically how trust in a particular GP or practice nurse translates into trust in primary care generally and the wider NHS. In acute settings, which are characterized by greater levels of uncertainty and risk, patients’ higher dependence on their practitioners may require high levels of trust, and less need for mutual trust. This case study examines how trust operates in an acute setting and how trust in specific hospital clinicians translates into trust in the particular hospital and the wider NHS. The case studies also differ in the potential for patient self-management (greater for diabetes patients) and the extent of patient choice (potentially more salient to patients requiring hip replacements). (For full details of the methodology used see Appendix).

Before this empirical evidence is presented, there is a need to outline and discuss the theoretical perspective taken in this research and this is addressed in Chapter 2 which examines how and why trust relations in the NHS may be changing. It describes how changes in policy and professional discourses may have changed the nature of trust relations in the UK NHS and examines how changes in the organization and delivery of healthcare as well as broader social changes may have affected these relationships. A theoretical framework is presented for understanding the nature of trust relations between patients and healthcare professionals, between clinicians, and between healthcare professionals and managers. It concludes by a discussion of some of the methodological challenges involved with exploring the explanatory power of this framework empirically.

Chapter 3 examines the role of trust in relationships between patients and healthcare professionals, drawing on the published literature and the findings of the authors’ research study which seeks to explore how trust relations differ for patients with an acute condition from those with a long-term health problem. It also explores the relationship between ‘felt’ and ‘enacted’ trust and how the concept of ‘informed trust’ and ‘conditional trust’ manifest themselves in people’s accounts.

As the delivery of healthcare becomes more reliant on teamwork between health professionals, trust may be increasingly important to their relationships but inter-professional trust relations have
been neglected in empirical research. Chapter 4 addresses the role of trust in relationships between different clinicians, what is considered high and low trust behaviour and what affects levels of trust between professionals. Findings from the research study examine the similarities and differences in how trust operates between healthcare professionals in an acute setting compared to those in primary care.

Chapter 5 explores the role of trust in relationships between managers, clinicians and patients. The increase in mechanisms to enhance accountability and the use of performance management and financial incentives for meeting central targets have generated new dependencies between clinicians and managers in which trust may play an important role. The chapter presents findings on trust in managerial–clinical relationships and to a lesser extent between managers and patients.

With the growth of patient choice in determining selection of provider, institutional trust is increasingly salient for healthcare organizations. Public trust in the NHS as an institution is similarly relevant to the sustainability of a tax-financed and publicly provided healthcare system. Chapter 6 examines the nature of public trust in healthcare institutions (both organizations and healthcare systems). It considers what builds and sustains institutional trust, how interpersonal trust may be reflected in institutional trust, and how trust in the NHS as a system links to the individual patient experience.

Chapter 6, the final chapter, also summarizes the conclusions from the different elements of the book and identifies the policy implications that flow from the empirical evidence and the evaluation of the theoretical framework. It also sets out a new agenda for research into trust relations in healthcare in the light of the analysis presented in this book.

NOTES
1 The correlations between the questions on levels of trust and those on confidence were consistently positive and strong, for example

- general practitioners .60
- hospital specialists .48
- health service managers .69
- nurses .60
This may suggest that trust and confidence are closely related and, as Rose-Ackerman (2001) suggests, while there may be a logical distinction between trust (intentional) and confidence (competence) it might not prevent trust implying confidence or at least embracing it.