

EDITORIALS

Trust, Distrust and Trustworthiness

Lessons from the Field

The study of trust in healthcare is growing, paralleling its rise in other applied arenas¹⁻⁶ and in more theoretical disciplines like sociology and philosophy.⁷⁻¹¹ Studying trust and trustworthiness in the healthcare context, as illustrated by 4 papers in this issue, is imperative for several reasons. First, the ill are vulnerable emotionally, physically, spiritually, and, often, financially. The trusting patient is placed, sometimes unwillingly, in a position of vulnerability and grants, sometimes reluctantly, discretionary power to doctors, other clinicians, and numerous organizations in order to achieve something the patient desires, usually better health or even the preservation of his/her life.¹² An imbalance of knowledge and power characterizes health care relationships to a unique extent, while the importance of health to achieve one's life goals¹³ makes vulnerability greater and the choice to trust rhetorical.¹⁴ To pursue the patient's good, the patient must trust the physician (or clinician, or organization) with private information and with his/her body.¹⁵ Trust in the healer is essential to healing itself.¹⁶ Trust, at least to some minimal extent, is undoubtedly a prerequisite to seeking care at all.¹⁷⁻¹⁹

Trust is, of course, essential to both physician and patient. Without trust, how could a physician expect patients to reveal the full extent of their medically relevant history, expose themselves to the physical exam, or act on recommendations for tests or treatments?^{20,21} Trust promotes efficient use of both the patient's and the physician's time. Without trust, the process of informed consent for the most minor of interventions, even a prescribed antibiotic, would become as time consuming as that needed for major surgery. Presumed consent is a critical manifestation of trust that makes possible much of routine doctor visits.²² Trust may even have therapeutic value, enhancing the efficacy of prescribed treatment.²² Most importantly, trust in the doctor caring for them is of great importance to patients. Patients who trust their doctors rate their care more favorably, as demonstrated by Keating et al.²³ in this issue, as well as by others.^{20,24} Numerous open-ended studies of patients' views about their care, in a variety of contexts, most of which did not include specific hypotheses about trust, have found that patients spontaneously discuss trust and its importance, adding to the evidence that trust is important to patients.²⁵⁻³⁰

A variety of tools to study trust are gradually becoming available, including the straightforward single ques-

tion used by O'Malley and Forrest³¹ and similar single items about trust in health plans³² and hospitals.³³ More complex measures, including that used by Keating et al.,²³ measure trust in a specific doctor,³⁴⁻³⁷ trust in doctors generally,³⁸ and trust in health insurers.^{39,40} Again, this parallels changes in the way trust is measured in other domains.²

A caution is in order, however, since it is vital that the challenging task of defining and measuring trust and related concepts—distrust, skepticism, trustworthiness, confidence, vulnerability, and satisfaction, for instance—be approached rigorously. Although the definition of trust is itself far from straightforward,² a few key features can be asserted.

First, trust as a sociological construct refers to people's expectations, typically for goodwill, advocacy, and competence (and/or good outcome). As such, it is future-directed; although past experiences and other forms of knowledge influence the degree of current trust in another, measuring trust itself requires measuring beliefs of the person who trusts about the trustee's behavior. In measurement, it can be difficult to separate trust from other beliefs (especially those heavily influenced by past experiences) that can influence trust. The measurement of perceptions about a doctor's integrity, honesty, or commitment to confidentiality, for instance, may reflect actual trust, beliefs about behaviors or characteristics that influence trust, or, possibly, both.

Second, trust takes different forms. Expectant or presumptive trust refers to the predisposition a patient brings to a first encounter, while experiential trust develops with knowledge of the one trusted over time, and identification-based trust is based on a sense of shared values.⁴¹ Keating et al.²³ demonstrate convincingly that negative experiences, particularly those related to communication, lower trust in primary care physicians. The doctor's willingness to listen, and the content and delivery of information to the patient were more important to patient ratings than were perceived involvement in decisions, a finding that expands on other work⁴² and has important implications for the current emphasis on autonomy and shared decision making. Listening demonstrates concern and a certain amount of humility. Communicating well openly demonstrates respect, allows the patient to judge motivations and identify any shared values, and provides a means to judge the physician's competence. A shared narrative depends on and strengthens trust of

patient for doctor and doctor for patient, at least in the primary care context. Trust in other types of doctors (surgeons, radiologists) might not depend so heavily on, say, listening skills.⁴³

Expectant trust can be heavily influenced by trust in general, through previous experiences, secondhand knowledge from others, or general trusting tendencies. It can also be influenced by organizations; who would trust a surgeon's sterile technique if her office is filthy, or that one's private information is secure if errors in billing or scheduling are frequent? O'Malley and Forrest³¹ demonstrate that organizational "aspects of caring,"⁴⁴ including accessibility, availability and continuity affect trust in one's doctor. In hospitals, respectful treatment and courtesy is associated with trust in the doctors.⁴⁵ Without the presumption that trust may be invested in total strangers, influenced by trust in organizations and groups, a patient might well avoid essential medical care. These intriguing findings should catalyze additional studies that relate the organization and financing of health care to trust; indeed organizational changes may be the most fruitful ways to enhance trust in doctors.⁴⁶

Third, trust (or distrust) occurs in a relationship. Perceptions, beliefs and expectations are directed toward the one trusted, and are not merely the outcomes one hopes will occur via that relationship. Thus, "I trust my doctor to take care of my illness" is not a belief about the care, but about the doctor. Similarly, expectations directed toward health care organizations (e.g., "I trust my insurer to be there for me if I get ill.") are future-directed and about the organization, not the services the organization may deliver or the outcomes one expects. Although it can be tempting to concentrate on expected outcomes rather than on perceived motivations, there is evidence that the assessment of intent, character, or values is more important to trusting parties than are the outcomes of the decisions of those who are trusted.^{41,47,48} Doctors may steer patients toward or away from capitated health plans because of a spectrum of conscious and/or subconscious motivations, from concern for patient well-being to economic self-interest.⁴⁸ How patients (or the public) would judge these actions, and what impact this might have on trust in doctors is an intriguing research question.

Finally, although trust has inherent as well as instrumental value for patients, clinicians, and healthcare institutions, trust can be misplaced, and distrust can be unjustified. Thus, if a physician reveals truthfully to a patient how s/he is paid, trust in the physician may diminish as a result of this trustworthy behavior.⁴⁹ Disclosure of medical error could have the same effect. In contrast, the physician who is less open about his/her financial arrangements, especially if this is done knowingly, is acting in a less trustworthy manner even if patient trust stays the same or increases. Trust occurs where one party is vulnerable to the other, where motivation or intent or competence is often poorly assessed. Trust and distrust

can be foolish, misplaced, or unjustified, despite care on the part of the trusting party to trust wisely. Clinicians and healthcare organizations have obligations to both seek and deserve trust, but these two goals can conflict.⁵⁰ Important as it is to measure trust in individual clinicians and the actions and circumstances that affect it, it is equally important, in today's health system, to study (empirically and normatively) trust and trustworthiness in organizations and institutions.

Just over a year ago, Pearson wrote that there were "many theories, few measures, and little data" about trust in physicians.⁵¹ Measures of trust in doctors and in some health care organizations have now become available. If these are chosen and used with careful attention to theory, drawing upon insights and research outside of healthcare, we can expect additional lessons from the field about the predictors and correlates of trust. — **SUSAN DORR GOOLD, MD, MHSA, MA**, *University of Michigan Medical School, Ann Arbor, Mich.*

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