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Trust in the Physician and in Medical Institutions. Modalities of Comprehension and Analysis

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Abstract

The issue of trust in the medical profession, in medical institutions, and in the healthcare system, implicitly, has been brought to the scientists' attention lately, taking into account the erosion of trust, determined by the aggressive display in the media of medical personnel migration, of medical malpractice cases, of underfunding and bad management, of the high pressure on the system due to population ageing and to the increase in chronic disease incidence. Other explanations include the modifications in the attitudes, values, and expectations of the public concerning the healthcare system, the emergence of private health insurances and of private institutions, and the erosion of trust in State institutions because of incertitude and economic crises.

This paper seeks to pinpoint, in the scientific literature, the definition of trust in the healthcare system, the determinants of trust in the patient – physician – institution – system relationship and the importance of social capital in these types of relationships, as well as the way in which the relationship between the patient and the actors within the medical system is created and influences the patient's quality of life in the context of chronic disease.

Keywords:

trust, institutional trust, healthcare system, chronic disease

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Why is the study of institutional trust in the context of chronic disease necessary?

According to World Health Organization (2002), chronic disease is defined as having one or more of the following characteristics: it is permanent, it can be accompanied by a disability, it is caused by irreversible pathological alterations, it requires the patient's special training for recovery, or it involves a long period for control and management. This definition highlights the need for the patient to access – on a long-term basis or for the rest of his/her life – one or several types of medical services. Chronic disease – governed by vulnerability, guarded prognosis, and incertitude – involves long-term interaction with different actors within the medical system. Whereas, from the perspective of the physician – patient relationship, trust is necessary because it facilitates compliance to treatment and it potentiates an effective self-management, from an institutional perspective, a relationship of trust between a patient and the medical system could lead to cost reduction (following relapses, aggravated health state, excessive use of medical resources), through an integrated management model. This model would also include other types of resources (including alternative resources) and it would increase the quality of health among the population through effective campaigns of prevention.

Chronic disease management can be very soliciting, because it involves several resources: information on the disease and the treatment, behavioural skills, defence mechanisms, soliciting support from others (social network of the patient, family, acquaintances, colleagues, and community), the medical system, etc. The permanent negotiation between the demands of the treatment, of the disease, and the personal wishes or interests is a process involving the adjustment to a new lifestyle, a process that some patients may manage easily, while some others may find difficult or even impossible to handle. The identification and prioritization of patient's needs must be corroborated with the physician's expectations concerning the patient and must be integrated within a systemic perspective. In this context, the issue is the way in which the relationship between the patient and the actors within the medical system is created and influences the patient's quality of life in the context of chronic disease.

Research on trust in the healthcare system has acquired significantly more importance in the recent period, starting from the

works of Hardin (2006, which attest a drop in the level of trust in important democratic systems – Canada, USA, UK, Sweden) and Fukuyama (1995; he divides societies in high-trust and low-trust societies). Empirical studies conducted until 2005 show a decrease in the degree of trust in medical institutions, which can be explained by epistemological challenges on the authenticity of knowledge (Popay et al., 2003), by the drop of trust in the power of science (Irwin, Michael, 2003), and by the increase in individual and social reflexivity (Giddens, 1994). On the other hand, bombarding the population with ever changing messages and often-conflicting messages on health suggest that we are all in a state of liminality or in “no man’s land” (Armstrong, 1993; Bauman, 1987; Gifford, 2002). The consequence of this behaviour is the public questioning the medical science and people comprising the medical system. In this context, according to Giddens (1991), trust in institutions no longer represents a datum, guaranteed and/or expected, but it must be earned through a laborious negotiation process.

Onora O’Neill (2002) describes mistrust as a cliché of our times. When public trust drops, political institutions begin taking measures for restabilising it. The rupture in the citizen – State relationship has also highlighted the passage from a paternalist patient – physician relationship to a contractual relationship. However, what is trust in the healthcare system and how can institutions in question restore the trust? In contrast with the vast literature comprising the concept of interpersonal trust (Mechanic 1998; Gambetta 1998; Fukuyama, 1995), research on institutional trust is relatively recent (Gilson 2006; Calnan, Rowe, Entwistle, 2006). The preoccupation for these studies originates, on one side, from the transfer of mistrust from the government and politicians to the healthcare system, but also from underfunding of the healthcare system, from inefficient and inequitable use of resources within the healthcare system, and from the publication of medical malpractice cases in the media (Calnan, Rowe, 2006; Connell, Mannion, 2006; Maynard, Bloor, 2003; Entwistle, Oliver, 2006). On the other side, lack of trust in the healthcare system can also reflect and influence the trust in other institutions, in the government, and the State in general.

How can we define and re(build) trust in the healthcare system?

Institutional trust is the trust in the system or in institutions. In the healthcare system, it refers to the trust in the medical system or in the social system that influences and interacts with the medical system. Trust is present in different types of relationships and it originates in a combination of interpersonal behaviours and in the institutions that determine these behaviours (Gilson 2005). Both the personnel within the medical system and the institutions must create an environment that provides trust. If they fail to do so, then they risk undermining the public trust in the healthcare system. A therapeutic relationship characterized by trust is built, supported or deteriorated by the face-to-face interaction with medical services providers and it is more apparent in a long-term physician – patient relationship, thus supporting the theories (Giddens and Luhmann) that trust in the system is determined by the individual's interaction with the representatives of the system. Interpersonal trust is defined as patient's trust in his physician, while institutional trust is defined as patient's trust in the medical profession, in hospital, insurers, medical organizations, and in the medical system as a whole (Hall et al., 2001; Rowe, Calnan, 2006).

The concept of trust has always been considered ambiguous and diffuse, hard to define and investigate. It has been defined in many ways and it comprises more definitions than similar terms, such as cooperation, faith, prediction (Hosmer, 1995, Taylor, 1989). A literature review (McKnight, Chervany, 2001) on the definition of trust identified 65 works, among which 23 pertaining to psychology, 23 to management and communication, and 19 to sociology, economy, and political sciences. Their analysis has concluded that the definition of trust concerns mainly the characteristics of the trustworthy person (including good will, honesty, morality, expertise, care, integrity, competence, and predictability) and the vulnerability. Consequently, the different definitions of trust have the following common elements: optimistic acceptance of vulnerability (the patient believes that the physician will act in conformity with his interests), dependence, support, and confidence. Vulnerability is inevitable in the medical relationship (determined by disease and invasive treatments), which means that accepting it is fundamental in the construction of a therapeutic relationship based on trust (Pellegrino and Thomasma 1993; Zaner 1991). Scepticism in the

therapeutic relationship will increase vulnerability and will diminish trust; however, the scientific literature in the field has also studied the reversed relationship: the more intense perceived vulnerability, the higher trust potential. This explains why some patients see their physicians as “demigods” and why they ascribe to them superhuman powers (Katz, 1984; Parsons, 1951).

An analysis of the way in which the term of trust is used in the literature brings to attention discordances between the definition, the characteristics, and the nature of trust. The multitude of meanings (confidence, reliability, faith, trust) creates confusions in the understanding and analysis of the concept. Furthermore, there is no consensus regarding the object of trust – is it a person, a group of persons or an institution? If both of them manifest at the same time, what is the difference between interpersonal trust and institutional trust, between horizontal trust and vertical trust?

The concept of trust has become an ample subject, heavily discussed in the medical literature. Although the articles proved very important in understanding the impact of trust relationships in health promotion and disease prevention, most of the articles failed to construct and adequately explain a theory of trust. For instance, social capital has been used in numerous studies for investigation the relationship between socio-economic status and health inequalities (Kawachi et al., 1997; Kim et al., 2006). Most of these studies regard trust as a variable, but they fail to analyze the concept as a process (Khodyakov, 2007). Trust is a complex and multidimensional phenomenon that consists in a mixture of strong connections, weak connections, and the institutions. The rigid distinction within social capital theory between high-trust societies and low-trust societies does not cover the complexity of the notion of trust.

The analysis of the concept of trust involves two such types: institutional (Luhmann, 1988) or abstract trust (Giddens, 1991), based on the system (Fukuyama, 1995) or “faceless” (Giddens, 1994) and interpersonal trust (Fukuyama, 1995). Authors define interpersonal trust as a negotiation between individuals and as an acquired personal feature. The two concepts are inter-correlated; hence, institutional trust is important for the patient, because it determines him/her to access healthcare services, to choose between various medical systems, to become involved in the therapeutic relationship, but also to develop a

trust relationship with the physician and with the healthcare staff. The patient needs to believe that the medical institution will protect him/her and will ensure a safe environment for healthcare services (Gilson, 2003), because they are the basis of patient's decision to access the services of a certain type of medical institution. The literature on institutional trust pinpoints that a State with low level of institutional trust is associated with a frequent change of physicians, with requests for a second opinion (Zheng et al., 2002; Balkrishnan et al., 2003), with weak trust in the physician's skills and a drop in the patient's level of satisfaction (LaVeist, Nickerson, Bowie, 2000). A high level of institutional trust is associated with improved physical and mental health, decrease in the number of emergencies, increase in the degree of acceptance and use of vaccines (Whetten et al., 2006; Altice, Mostashari, Friedland, 2001), and increase in the number of persons who agree to be donors (Boulware et al., 2003).

Trust can be best understood as a multi-faceted phenomenon, with distinct dimensions: cognitive, emotional, and behavioural; all of them should be seen as bearing various meanings for each individual (Lewis and Weigert, 1985). Understanding the way in which individuals acquire trust (based on experiences, knowledge, or hope) is important for increasing their trust in the healthcare system. Trust is a process and it can be founded on the notion of agency, which undermines the idea of temporality and which encompasses the role of past experiences, present action, and of expectations through expected results. The relationship trust is built in the present, based on past experiences (person's reputation), in order to obtain rewards (future actions), based on the belief that honesty and morality are attributes of both parties. Satisfaction and trust are closely connected, but the difference between them is the very dynamic of the trust process; hence, whereas satisfaction targets especially the past actions (history of the relationship), trust targets future actions. Therefore, a relationship based on positive experiences is a trust relationship that will make the patient remain involved in the therapeutic relationship and follow the physician's recommendations (Thom, Ribisl, Stewart et al., 1999).

Trust can also be defined as a process consisting in a variety of levels evolving in time, and it is based on mutual intentions, reciprocity, and expectations (Lynn-Mc Hale, Deatrck, J.A., 2000). Trust is the linchpin of social life, because it reduces the complexity of the way in

which individuals relate to the world and it provides the capability of acting and taking decisions (Pearson et al., 2005). Trust is a fundamental component of the physician – patient relationship, but also of the healthcare system in general, and it can be defined in the simplest terms as a patient's expectation according to which the healthcare provider will act in his interests. In the studies of Ensminger (2001) and Good (2001), the decision of having trust depends largely on previous experiences and on the reputation of parties involved in this relationship (Zucker, 1986). Whoever enters a trust relationship seeks to obtain both material and non-material rewards (Coleman, 1990; Gambetta, 1988; Tyler, 2001).

The social capital theory (Fukuyama, 1995; Putnam, 2000; Putnam et. al, 1993) conditions institutional trust on the development of social capital and of civil society. Fukuyama (1995, 1999) identifies general trust as a necessary factor for the development of trust in institutions: if there is no interpersonal trust, then institutional trust is impossible, but the relationship between interpersonal trust and institutional trust can be discussed both ways, because institutional trust can promote or, on the contrary, undermine the development of interpersonal trust. Parry (1976) posits that institutional trust is more likely related to the effective performance of the institutions than to the level of trust in the society and to citizens' participation to civil society. The author states that the development of trust in institutions depends on the State's capacity of consolidating the performance of institutions. However, when trust in State institutions is low, the degree of interpersonal trust is high (Khodyakov, 2007), because individuals create informal networks that represent coping strategies in periods of crisis and erosion of trust in State institutions. Institutional trust is often correlated with a person's belief, based on feelings of relative security (Williamson, 1993; Zucker, 1986). This security is due precisely to the structures that guarantee order.

Institutional trust refers to concepts such as political trust (Newton, 2001), used by researchers within the political sphere, or system trust, used by sociologists (Barber, 1983; Giddens, 1990; Luhmann, 1988). In Giddens's opinion, the difference between the two types of relationships – interpersonal trust and impersonal or institutional trust – is that, within the relationships with institutions, the individual does not interact directly with a person or with a group of persons responsible for this relationship in any way (Giddens, 1990: 83).

Institutional trust refers to (impersonal) structures, not to the persons comprising them. The analysis of the concept of institutional trust (McKnight, Chervany, 2001) has pinpointed two sub-constructs: structural assurance and situational normality. Structural assurance refers to the guarantees, contracts, regulations, promises, legal recourse, processes, or procedures provided by the institutions which are conducive to situational success; structural assurance involves the idea that trust is set up environmentally and that it concerns those processes and procedures that make things safe in a specific organizational setting. Situational normality refers to the fact that trust is the perception that things are normal, involving behaviours associated to trust, such as cooperation, information sharing, informal agreements, decreasing control, accepting influence, and granting autonomy. The impersonal nature of institutions makes it harder to create a trust relationship because it is more difficult to trust something abstract and anonymous (that does not express feelings or emotions), but it is the duty of institutions (through their own rules, regulations, and values) to increase the public interest in them and to enable trust relationship. Institutional trust affects positively interpersonal trust because it determines individuals to be more comfortable in their interaction with persons within these institutions.

In chronic disease, trust oscillates between trust without reserves in the medical system and disillusion toward it, followed by re-establishing the limits of the relationship, and this time the point of reference is a person (the physician) or the institutions that proved to be trustworthy. Levels of trust describe the deepness of the relationship: it can be superficial or deep, weak or strong. The study conducted by Kirschbaum and Knafl (1996) concerning the relationships established between the persons who manages chronic disease and service providers found that there is trust where there is a reciprocal relationship, based on mutual respect. Trust does not emerge instantaneously, but it evolves in time. If the premises of a positive relationship are not present, scepticism and mistrust will govern the relationship; furthermore, in a climate of mutual lack of trust, weak are the chances for the participants to discover the knowledge and expertise of the other.

Conclusions

Trust can be related to a great number of the healthcare system objectives: access to the system, healthy behaviours, continuity and quality of care, improvement of lifestyle, and monitoring the health state. Trust is associated with increased access to healthcare services and to their effective use (Russel, 2005), to satisfaction with and loyalty to the physician (Safran et al., 1998), to self-monitoring of the health state (Wang et al., 2007), to the patient's desire of recommending the physician, to other persons, and to adherence to treatment (Hall, Zheng et al., 2002). The quality of interaction, the involvement in decision making regarding the treatment, the continuity of the treatment and the implication in behavioural change are determined by the trust between patient and healthcare provider. Socio-demographic factors, access to the healthcare system, use of healthcare services, and negative experiences with the medical system influence the type of patient – medical system relationship (Schwei, Kadunc, Nguyen, Jacobs, 2014). Professional norms, the quality of relationships between the categories of personnel medical institutions, and the way in which they reflect upon the patient are factors that can influence the relationship trust (Gilbert, 2005). A deep understanding of the factors that determine the creation of a relationship of trust in institutions will contribute to improving medical services provided by institutions; it could also reduce disparities within the medical system and increase the degree of individual responsibility concerning the health. Within medical relationships based on mistrust, the improvement of access to information facilitates the patient's self-care capacity and it enables the patient to find alternative solutions. In the same situation, the lack of access to information leaves patients with no alternatives and it forces them to depend on the physicians and on the treatment prescribed by them. Though, in most States, trust in institutions has recorded a descending trend, trust in physicians and in the medical profession is still high or very high, at least compared to other professions.

Healthcare system is an essential part of the society and it goes beyond providing medical care (Mohseni, Lindstrom, 2007). The differences – between countries – in the way in which institutions provide medical care can originate in the social capital defined as those structures of the society (such as interpersonal trust level, reciprocity, and mutual help) that represent resources facilitating interaction between

individuals or groups of individuals with public institutions and governments (Brehm and Rahn, 1997; Putnam 1993). Social capital can be equally important for improving governmental performance in order to make democracy functional and to improve economic performance (Putnam, 1993), to decrease the criminality rate (Kennedy, Kawachi, Prothrow-Stith, Lochner and Gupta, 1998), and to maintain population's health and a decreased mortality rate. The mechanisms through which social capital can contribute to the promotion of a healthy lifestyle among the population are as follows: self-esteem and mutual respect; increase in access to healthcare services; reduction of criminality rate by promoting prosocial behaviours.

Trust is supported by direct, face-to-face relationships and by engagements, and trust in physicians is necessary in the patient – healthcare system relationship, insofar as physicians are considered representatives of the healthcare system. Institutional trust involves and is determined by interpersonal trust and it can be understood as both an outcome and a response to the development and complexity of the society. Individuals are compelled to learn how to behave within a system and in relationships within the social setting. In other words, patients have to learn to trust the physicians (persons with whom they had not had connections and of whom they know nothing), the medical institutions, and the medical profession, and to understand that they all act in his/her interests (Russell, 2005). Determining the interpersonal trust and institutional trust relationship is essential for understanding the role of trust in the healthcare system. If trust is the outcome of complex interactions between physicians, the medical system, and other systems that influence the medical system, then we should improve trust at all levels in order to improve the degree of trust in the healthcare system.

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