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Trust in GPs: Findings from Focus Groups

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Abstract

Trust is fundamental in relationships where there is an element of risk and unequal knowledge between parties, such as in the relationship between a patient and their GP. This paper forms part of a larger study which explored how judgements regarding the trustworthiness of GPs are formed using a range of different methods. It reports on findings from focus groups which were conducted with people experiencing particular conditions that an analysis of the 2012 GP/Patient Survey indicated are associated with lower levels of trust in GPs. Six focus groups were conducted with people experiencing: chronic pain; mental health problems; Parkinson's disease and visual impairment. The study sought to explore: what factors might explain why people with certain health conditions have lower levels of trust in GPs; their views on the services received in primary care; and, whether they felt that the 2012 NHS Health and Social Care Act (HSCA) was having an impact on their trust in their GPs. The study found that underlying patients' conceptions of the behaviour and characteristics of a trustworthy GP appears to be an ideal of the family doctor of the past. The many demands on GPs, exacerbated by the HSCA, mean that a return to this ideal of a GP as a 'family doctor' is unlikely. While there are many barriers in contemporary general practice that make it difficult to develop the sorts of relationships of trust that patients seek, some participants in this study appeared to have been able to forge a relationship of trust with their GP with which they were satisfied, demonstrating that such relationships are possible despite the constraints patients and GPs experience. Possible explanations for lower levels of trust associated with certain conditions are explored.

Introduction

Trust is fundamental to the patient-doctor relationship in that it can increase adherence to treatment and continuity of care (see e.g., McKinstry et al, 2006). While 'general' measures of trust in GPs in surveys demonstrate high levels of trust among populations, 'specific' measures of trust (in relation to particular experiences of health care) reveal a more sceptical picture, particularly among people with certain health conditions (see Stoneman, 2014). Various factors have been identified as challenging the trust that people have traditionally had in GPs. These include the increase in the availability of health information and support online (Hesse et al. 2005) which have enabled people to become more knowledgeable consumers of health care than in the past. This is coupled with an increase in the prevalence of chronic conditions, which have occurred as life expectancy has increased, meaning that people have repeated consultations with GPs about specific and long-term health problems about which they (patients) increasingly become experts.

These developments have occurred against a context in which there has been a decline in levels of trust in science and in public organisations in general, and in the medical profession in particular (Alaszewski, 2003). In relation to the medical profession, this has occurred partly in response to various medical scandals in the UK including the Alder Hey and Bristol Hospitals organ scandals and the case of the GP Harold Shipman who was convicted of murdering 15 of his patients in 2000¹. The decline in trust in the medical profession has resulted in greater governance and regulation of doctors aimed at restoring 'the trust that society and patients historically had in medicine' (Lugon & Secker-Walker, 1999, p1). However, Calnan and Rowe (2008), among others, note that such systems may have little impact on trust relationships between patients and their GPs because these are predicated on patients' *personal* experiences with their GP. The nature of patient-doctor interactions are further complicated by the Health and Social Care Act 2012. Various health care organisations have argued that the Act poses a further threat to trust between patients and GPs as GPs take on a major budgetary role (Guardian 2011).

It has been argued that these various developments have resulted in a change in patient-GP interactions. The relationship between GPs and patients has been characterised as changing from one of 'blind' or 'embodied' trust in GPs, in which patients unquestionably view their GP as trustworthy, to one of 'earned trust' (Calnan & Rowe, 2008). The earned trust model implies that patients trust their GPs when their personal experience with a GP indicates that they are trustworthy, that is, when they demonstrate their technical competence as well as a range of interpersonal skills. This model is associated with shared care or partnership working in which patient and doctor co-operate together in meeting a patient's healthcare needs in a 'reciprocal negotiated alliance' (Rowe & Calnan, 2006). Nevertheless, the desire for these sorts of partnerships of shared care have been found to vary across social classes, age groups, disease groups and cultural backgrounds (Coulter & Fitzpatrick, 2000).

The Study

The aim of the focus groups was to explore patient's perceptions of what makes a GP trustworthy. Drawing on the findings from surveys of trust in GPs, we intended to convene focus groups of participants who had experience of specific conditions that have been correlated with low levels of trust in GPs. By doing this we hoped to be able to shed some light on why people with particular health conditions might have lower levels of trust in GPs. Analysis of the 2012 GP-Patient Survey data conducted by Stoneman (2014) as part of this project found lower levels of trust were associated with patients with the following conditions: long-term neurological problems; long-term back problems; long-term mental health conditions; arthritis or long-term joint problem; epilepsy; kidney or liver disease. In addition to these

¹ While Harold Shipman was convicted in 2000 for killing 15 of his patients, an enquiry found he was probably responsible for 215 deaths.

conditions, Stoneman's analysis also found an association with people with visual or hearing impairment and dissatisfaction with their GPs in some of the behaviours, such as giving time and listening, that have been associated with relationships of trust between patients and GPs.

We wanted to explore what characteristics, behaviour or attitudes people with some of these conditions² wanted their GPs to have in order to view them as trustworthy; in other words, we wanted to explore how they conceptualised trust in relation to GPs. We also wanted to explore what their experiences of their own GPs were in relation to notions of trustworthiness. We viewed it as important that people's views on GP trust should be located in the context of the GP services they use. For that reason we also wanted to explore their views on the services they received and whether the NHS Health and Social Care Act 2012, which became operational in April 2013, was having an impact on patients' trust in their GPs. Various commentators on the Act have noted that the greater role given to GPs might lead to an erosion of patient trust as a result of the conflicts of interest experienced by GPs (Iacobucci, 2013; Campbell, 2013; Toynbee, 2013).

Methods

We recruited participants to the study primarily through health support groups for specific conditions. We felt that health support groups would be appropriate groups from which to draw focus group participants as participants would be likely to have an established condition, extensive experience of health care and to be repeat users of GPs. Using established groups also meant that members would be known to each other which we felt would mean that participants in groups would feel relaxed with each other and make discussion in the group easier. Participants were recruited through the group organiser, generally by one of us attending a group meeting, talking about the project and inviting participants to participate in a subsequent focus group. This approach was used with a chronic pain support group, a Parkinson's Disease support group and a visually impaired support group. A mental health user researcher worked with us to identify people with mental health conditions through various mental health user groups in London³.

Six focus groups were convened, these comprised two groups for people with chronic pain, two for people with mental health conditions, one for people with visual impairment and one for people with Parkinson's Disease. The groups were facilitated by a researcher (Rose Wiles or Dorothy Gould) and observed by a second researcher (Jaimie Ellis or Rose Wiles). A total of 38 people participated in the focus groups overall with numbers for each group ranging from 4-10 participants. Participants were asked to complete a brief pro-forma prior to the focus group to

² We were not able to include focus groups covering the range of conditions identified by Stoneman (2014) due to difficulties accessing health support groups for these conditions.

³ Dorothy Gould, a mental health user researcher recruited participants to the two mental health focus groups and also facilitated these two groups.

provide information on their personal characteristics. Table one provides details of the characteristics of participants.

Table 1 Focus Group Participants

Number of participants per group	
Chronic pain group 1	10
Chronic pain group 2	5
Mental health group 1	6
Mental health group 2	5
Visual impairment	8
Parkinson's Disease	4
Number of participants overall	38
Gender	
Males	9
Females	29
Age	
26-30 years	0
31-40 years	4
41-50 years	6
51-60 years	10
61-70 years	7
71+	11
Length of time registered with GP	
0-5 years	8
6-10 years	6
>10 years	14
No information given ⁴	10
Number of consultations per year (approx.)	
0-5	3
6-10	11
>10	13
No information given	11
Ethnicity	
White British	33
Asian	3
African Caribbean/black British	2

Participants were also asked to provide information on the pro-forma on their main condition or diagnosis. A range of health problems and conditions were identified. The conditions reported by participants to the mental health focus groups were: depression; anxiety; post-traumatic stress disorder; obsessive-compulsive disorder; bi-polar disorder; and, personality disorder. Participants to the chronic pain focus

⁴ It was not possible to obtain some information on characteristics for the visual impairment group

groups reported, in addition to 'chronic pain': repetitive strain injury (RSI); back pain; endometriosis; fibromyalgia; and, arthritis. As well as the primary condition, participants in all groups (including the Parkinson's Disease and visual impairment groups) also reported a number of other chronic conditions, most commonly, diabetes, high blood pressure, asthma and anaemia.

We acknowledge that people who attend health support or user groups may have specific characteristics and may differ from those with similar conditions who don't attend such groups. They are (probably) likely to be more knowledgeable about their condition and to be informed, and perhaps assertive, health care users or even activists in relation to their condition. There was certainly some evidence from the focus groups that this was the case. Several individuals discussed being involved in patient participation groups at their GP surgery⁵ and as patient representatives in commissioning or quality assessment groups or committees. Some also identified being involved in sessions for teaching health professionals. This was reported most frequently, although not exclusively, among the participants of the chronic pain and mental health focus groups who were on average younger than participants to the Parkinson's Disease and visual impairment focus groups. Certainly there was evidence of some of these individuals being assertive with their choice of GP and in their interactions with them; this will be explored further in the findings.

At the focus groups participants were asked to discuss their views about the trustworthiness of their own GP as well as their views about the traits which characterise trust in GPs more generally. Specifically they were asked: what they thought of their own GP; whether they trusted their GP; what sorts of things help them to decide whether or not they trust a GP; whether their doctors manage their particular health concerns or condition well; what characteristics a 'good' doctor has; how they decide a doctor is trustworthy and how that may change over time. In order to stimulate discussion about the characteristics which engender trust in GPs, participants were given cards with personal traits on and asked to identify the three which they viewed as most important. The traits identified on these cards were: confident; respectful; empathetic; personal; friendly; and formal. Each of the definitions had a sentence outlining the features of each trait. Participants' decisions on the traits they identified as important were explored in depth and used to stimulate discussion in the group. Participants were also asked about their views of the Health and Social Care Act 2012, which came into operation in April 2013. They were asked what, if anything, they knew about the Act and whether they felt it had, or would have, any impact on trust in their GP.

The discussions lasted an average of one hour. Participants were given refreshments and a £20 Love2Shop voucher as a thank you for their participation.

⁵ See <http://www.patient.co.uk/doctor/patient-groups>

Discussion was digitally recorded and subsequently fully transcribed and subject to thematic analysis. Analysis comprised reading and coding transcripts and using a process of constant comparison to develop themes. Emergent themes were discussed among the research team in order to refine the coding scheme. The central themes emerging from the data concerned: technical competence; communication skills; interpersonal skills; embodied trust; Doctor-patient partnerships; status and reputation; environment; and, the Health and Social Care Act.

Findings

The context of trust in GPs

I have already noted that the context in which GP services are provided is central to people's conceptions of trust in GPs. Participants to the focus groups noted that the context of general practice is one in which there are many challenges to trust in an individual GP. Contemporary general practice was commonly characterised as comprising large practices with high numbers of part-time doctors, where locums and trainees are commonplace and where doctors lack the time to provide the type of care that patients want; that is, individualised care from a GP who knows them. Obtaining an appointment with an individual's 'own' GP (if they had one) was identified as challenging for some patients. While receptionists bore the brunt of some criticisms in relation to access to GPs it was largely noted that it was the way general practice was organised that was the problem. The problem stemmed from the fact that the ability to see a particular GP on the day people were experiencing health problems was severely limited. The result was that, in many cases, patients saw whatever GP was available on the day rather than their 'own' GP resulting in a lack of continuity in their care. Participants from the visual impairment focus group (who were generally older than other groups) reported regularly seeing practice nurses for the ongoing monitoring of their condition rather than doctors. There was an acknowledgement that doctors are too busy and lack the time to focus on individual patients. These issues were viewed as inevitably affecting trust. The following focus group excerpts illustrate these points⁶:

Arthur: And as to the not being able to see a doctor, so many of these doctors now, presumably because they're so well paid, they're just part-timers.

Sheila: Well Doctor T is like that.

Arthur: Particularly the ladies tend to be part-time, because when I've spoken to them, many of them say I only work two days a week.

Rose: Yes. Yes.

Arthur: So being able to get appointments with the doctor you want is not going to be possible, the only saving grace is, I think, is the nurse-practitioners.

⁶ All names given are pseudonyms.

Sheila: Yes, definitely.

*Arthur: Who, obviously I suppose being less well paid, but still well paid or whatever, but they do have time. And then they can report back to the doctor, but the doctors don't have time. I'm not saying that's their fault, but they don't seem to have time.
[visual impairment focus group]*

Pam: My problem at the moment is that I don't have a GP any more. I go to a large practice, and I did see a very good GP until about a year ago, when most of the main GPs left and there now seems to be a system, and a lot of them, there's obviously some problem with the practice, and most of the time it's locums. You can't get to see a set person, and they'll sort of say to you, you know, well we'll give, you know you have two weeks for an appointment unless you go for an emergency, and they can't guarantee who you're going to see. So at the moment I feel in a sea of, I don't actually have a GP anymore.

Dorothy: So what impact does that have not having a proper GP?

*Pam: Oh, people don't know me. People just know nothing about me and they obviously haven't got time to look back through the notes. And also the variation of, some of them know quite a lot about mental health and some of them know absolutely nothing really ... And one of the good things when I had a long term GP that had known me for quite a few years, was that he got to trust that I actually knew what I was talking about with mental health stuff ... Whereas I find the locums are a bit like, they're the experts or they have to consult with my psychiatrist before doing absolutely anything ... because the trust isn't there.
[Mental health 1 focus group]*

Anita: the system just distances you from your GP, and trust is not something, and not a, I think you were saying, it's not an overnight thing, it's, it's something that builds and you don't have much opportunity with your GPs because to go back to that gentleman's point, he said many of them are part-time. I think the majority of our doctors are part-time, and trying to get an appointment with the same one is almost impossible.

Ron: Do you think they are part-time?

Anita: They work part-time, yes.

Ron: Yes, but I thought they worked five days a week.

Betty: Unfortunately they don't.

Anita: No, ours don't, and to get an appointment with a continued, to get an appointment with a regular doctor is virtually impossible, and particularly if you want it urgently.

Betty: The secret is to go in very early in the morning.

Anita: *So you don't build up that trust. Do you know what I mean? You don't have that opportunity to build up trust.*
[Parkinson's Disease Focus Group]

A further feature of general practice was observed to be the increasing reliance on computers and the fact that all patient records and supporting documentation, such as letters from secondary care or other services, were held on computer. It was noted this meant that GPs were not always familiar with developments in an individual's condition as letters were scanned in by clerical staff and were often not seen by GPs until a patient mentioned it to them. Some participants felt that having their medical notes on computer meant that GPs interacted with the computer rather than with them and some felt that their diagnosis and treatment was largely driven by information provided by the computer rather than a doctor's training, knowledge or skills. This computerisation of general practice raised similar concerns about a loss of a relationship with a knowledgeable GP who knows and cares about their patients on an individual basis.

Anita: *But I do know that the letters don't always get read, because they go to, they're addressed to an individual doctor who probably never sees them, and probably the practice manager or the receptionist see them and they get put onto the computer so that whenever, whoever doctor you see.*

Richard: *That's right.*

Anita: *Looks at them, and.*

Betty: *I think that's what's happened to mine.*

Anita: *And at one stage I happened to mention the letter, because I hadn't heard from her, and she said oh well here you are, it's on the screen, you can see it; shall I print it off for you? But there wasn't that interest in it, that there wasn't, there's not that liaison*
[Parkinson's Disease Focus Group]

Richard: *It should be easier for them these days though because the diagnosis, they feed it into the computer and the computer suggests what treatment very often, I mean that's what they're doing when you're there.*

Betty: *Is it?*

Richard: *They feed the information in and out comes, these sort of symptoms, therefore the treatment, try this and then come back. It's like a car mechanic.*

Anita: *I am glad that I don't believe that.*

Richard: *If this doesn't work, try something else.*

Ron: *Is that, is that being used by GPs?*

Richard: *Yeah, they use it.*

Anita: *I'm glad I don't believe that, because I think that would undermine trust as well.*

Richard: You, next time you go in, you ask to have a look at the computer. I mean mine will say that the computer, the suggested dose of so and so is this; try it.

[Parkinson's Disease Focus Group]

The organisation of general practices was also viewed as a particular problem for visually or hearing impaired patients; this may go some way to explaining why people with these sensory impairments may have been found to have lower levels of trust in GPs. GP practices often employ a range of computerised or electronic systems for checking in patients attending for appointments and informing patients when their GP is ready to see them. These systems are obviously unsuitable for people with visual impairment. Similarly, systems which rely on aural ability are not appropriate for people with hearing impairment. People with sensory disabilities such as these wanted their doctors to be aware of and make accommodation for their condition by coming into the waiting room and collecting them but there were many instances given in the visual impairment focus group of this not occurring:

Arthur: They often have receptions where they expect people to press touch buttons on a screen in order to log in. Well that is hopeless. Now whilst they've still got receptionists, it means receptionists take the attitude that they can go off and do something and come back every twenty minutes, which is very bad for visually impaired people.

Rose: Yes.

Elizabeth: So whenever, what's the other thing, like what you say, in my surgery there's this thing, a screen.

Rose: Right, yes [laughter]

Elizabeth: So it just pings, so if you are visually impaired, it's not speaking, so you don't know whose turn it is and what room to go to, so at least I've got my daughter with me, she'll say "oh it's this one here", and we go to that room.

[visual impairment focus group]

Arthur: I think that the biggest problem visually impaired people have with doctors, is they've got a complete, not complete, but they've got a lack of training in the actual conditions themselves and the social consequences of them.

Rose: Yes.

Arthur: And that's not necessarily their fault. Unless they take the trouble to have further education, because if there's like, presumably the doctor I spoke to was an older doctor, he'd trained in Edinburgh, but in his whole life, he'd only had half a day out of four years, well and he hasn't bothered, or had any opportunity to update himself in any way, then it's

certainly something he doesn't understand very well, both the social consequences and the actual diseases involved.

Rose: Yes.

Arthur: So no doubt there are other people, but I mean certainly for sensory impairment in general, and I think this is because they know very little that it curtails their understanding. I mean sometimes you go to a doctor and he looks at the drugs and he's read your notes so he knows perfectly well and then he turns the screen around for you to see what he's doing. He's being very open, but he's forgot straight away that you're not going to be able to read it.

*Elizabeth: You're not going to see the screen.
[visual impairment focus group]*

Dave: And that's why we rely on a particular doctor isn't it. My GP is the only one who will come out and talk to me face-to-face, say 'Dave come on in now'. All the others give it out on a speaker and I would still be sat there today, if I didn't go with Judy. So but he's the only one that'll come out from his surgery and come and get me.

Rose: Right. And is that because he knows you?

Dave: Well they all know me, but the others can't be bothered to come out.

Judy: Yeah, but he's the one, because you see him the most regular.

Dave: Yeah, I see him the most regularly.

Judy: But the others probably wouldn't.

*Keith: But he understands you are deaf, so therefore he will come out.
[Chronic pain 2 focus group]*

A further feature of contemporary general practice noted by participants was the move towards general practices becoming businesses in which GPs are providers and patients consumers. Participants discussed experiences of being offered a choice of where to go for treatment. They were critical of this practice as they felt they were not in a position to make informed choices on these matters and wanted their GP to tell them what the best option would be. Participants were critical of what they saw as the development of a business model in general practice. Interestingly, while participants were broadly in favour of working in partnership with their GP (and this will be discussed further below) they were all critical of being given a choice about place of treatment⁷; this appeared not to be viewed as giving patients a say in their treatment but as doctors absolving their responsibility.

Anita: Well it's nothing; the advantages of it don't seem to have come down to the patient at all. I mean at the moment you have patient choice, but

⁷ Calnan and Rowe (2008) argue that people want choice over treatment but not choice over the hospital they should attend to receive treatment.

*sometimes you need advice. You know you have a choice between hospitals sometimes, would you like to go to [one or another]. Well what do you know? I mean is it going to be like a hotel where you have to read a blog or go and get them on Facebook or Twitter, you know you need, you need more concrete help. Those seem to be things which are not based towards consumers. To me that doesn't seem relevant to my everyday life and the support I want from my GP.
[Parkinson's Disease focus group]*

Jane: I think there's another interesting thing, not financial, but financial driven perhaps, is patients choice and when I go to the doctor and the doctor says 'right we need to refer you on to a specialist service, you can have a choice here, whether you go here, here or here', and I'll think well actually I don't know about here, here and here, so I then say to him 'which one do you think is best', you know, and they'll go 'well maybe this one, but they've got a long waiting list, this one might be quicker because you know shorter time', so then you think but is that because they're not as good, is a long waiting list actually better, because they're top, you know and the shorter waiting list is because they're maybe not as good. And that, I find that really quite disconcerting.

Chris: Well it puts you on the spot.

Jane: Because I want, I just want to the doctor to refer to wherever they think is the next best person. The best one for you to see.

Andrew: Completely.

Jane: I don't want; I actually don't want the choice.

Mel: I agree with you, because as you, I'm not an expert.

Jane: No.

Mel: I'm not a consultant, I'm just a patient. The doctor's the mediator between me and the consultant, so I would expect him to say, 'well that's the best one, go for that, I know he's got a long waiting list, but that's the one I would go for'. Not go, you can have A, B, C, D. Well how do I make my choice? I don't have the information.

Andrew: I think they're having to be service providers rather than carers now, and people are much more aware of what good customer service is. But and when you go to a doctor do you want to be a customer or do you want to be a patient?

[Chronic pain 1 focus group]

Despite the limitations of contemporary general practice that focus group participants identified, many participants in the chronic pain and mental health focus groups had been able to forge positive relationships with a GP who knew a lot about their condition and with whom they were in regular contact. This was much less the case

for participants from the visual impairment and Parkinson's disease focus groups who were far more critical of their GP practices and who had fairly unsatisfactory relationships with their GPs. Participants in the Parkinson's Disease focus group felt their GPs were not knowledgeable about their condition and lacked the skills and interest to provide the care they felt they needed. They received support for their condition from secondary care consultants or from specialist nurses in the community. Similarly participants in the visual impairment focus group received support for the varied chronic conditions they had from practice nurses in primary care.

Whether or not they had managed to develop positive relationships, all participants discussed the elements that they viewed as important in comprising a trustworthy GP. In doing so they drew on their own experiences with GPs, both positive and negative. Issues relating to embodied trust (or 'blind trust'), that is, unquestioning trust in GPs, were rarely identified. While some participants did note that you 'have' to trust GPs this was unusual. Rather, participants discussed issues relating to GPs technical competence (GPs knowledge, skills and expertise), their communication skills and their interpersonal skills or characteristics in describing what defined a trustworthy GP. Each of these attributes was linked to each other so a trustworthy GP was viewed as needing skills in each of these domains.

Technical competence

Research indicates that patients are able to assess doctor's technical competence and that they do so with reference to their experience of how their condition is progressing under treatment or the outcomes of treatment (Calnan & Rowe, 2008; Coulter & Fitzpatrick, 2000; Mechanic & Meyer, 2000). We found that participants viewed technical competence as fundamental to trust; participants trusted GPs who demonstrated their technical competence in terms of knowledge and treatment of their condition. GPs who were able to diagnose a problem and prescribe appropriate and successful treatment were viewed as trustworthy. Participants found it difficult to trust a GP who did not demonstrate knowledge about their condition and participants who had a negative experience in relation to a GPs technical competence quickly lost trust in a GP. The following quotes provide some illustrations of this:

Gemma: You know mine job shares, and one of them I do trust and the other one I don't.

Rose: Oh okay, that sounds interesting.

Gemma: So I always try and see the one that I do because the other one who works with her, you kind of get fobbed off.

Rose: Right.

Gemma: And like a particular medication, I didn't get on with it and she said "well you either take that and put up with the side effects or you put up with the pain". So I went away thinking about it and then I thought well actually not, that's not good enough.

Lorraine: No [murmurs of assent from other people in the group].

Gemma: And then I made an appointment with the one I do trust, and he was like you know 'you can try this and if that doesn't work there's this, this and this to try'. So I do try to avoid the other one now.

Mel: Well I can understand why you would.

Rose: Yes. So, do you think you didn't trust that one before or is it because of that particular thing that happened?

Gemma: There's been a couple of things. She gave me something else, which I was allergic to but I didn't know the ingredient was in there until my eyes puffed up.

Rose: Oh dear.

*Gemma: It was in my notes so she probably should have seen that.
[Chronic Pain 1 Focus group]*

Richard: Yeah. I think, as I say he has retired now, but I had mostly to do with him, and I think he had all those years of experience, but he also kept abreast of things. And he diagnosed me initially by watching me walk from the waiting room to his, I went for something else, but he noticed when I was walking from the waiting room to his office that possibly it was Parkinson's.

Anita: That's very good.

Richard: I thought it was quite observant of him. And you felt after that he was watching you all the time when you arrived.

Jaimie: Yes, to see your progress.

Richard: Well I mean he recognised potentially the symptoms and referred me to the, or suggested that I saw a consultant, whereas I think with some of them they wouldn't bother. They probably wouldn't even notice.

Anita: No.

*Richard: Well I think, that's why I think it's important that when you go to see the doctor they sort of come to the waiting room and mention your name, and please follow me.
[Parkinson's Disease focus group]*

Having a GP who was not only knowledgeable about a condition but interested in it was also viewed as important. While some participants recognised that GPs are generalists and can't have in-depth knowledge about all conditions, a trustworthy GP was viewed as one who was interested in a patient's condition and who sought further information if they didn't know enough to diagnose or treat a condition. Some participants identified it as important for GPs to be aware of what they didn't know and to be honest about this. A GP acknowledging that they didn't know what was wrong or how to treat a condition did not appear to lose patient's trust in their technical competence. Indeed, GPs who referred patients in order to get more information on a condition and who liaised closely with secondary care about a

patient was viewed as trustworthy. Trust was threatened only when GPs made mistakes and when they seemed uninterested in a patient's condition:

Arthur: Of course it's quite possible that he may not, and the better the doctor the more likely he is to refer you.

Rose: Yes.

Arthur: And if he refers you I'd normally take that as a good sign.

Rose: Yes.

Arthur: Saying well I'm a GP, let's, you know I'm not an expert. I'm an expert in a general sense but I'm not an expert, expert on whatever you've got, so if I'm in any doubt or I think it should go further, it's a good idea to refer you to somebody else.

Rose: Yes, yes.

*Arthur: I see nothing wrong in that from your point of view, and it wouldn't diminish my view of the doctor in the slightest sense, just the reverse.
[Visual impairment focus group]*

*Pam: Yeah, I said communication, and I mean sort of with other mental health professionals and again with the sort of medical stuff, communicating, because it was found out last year that I had hormone problems that really would have affected depression, and it really should have been found out years ago. And also that it almost definitely was a result of prolonged, sorry to say this, use of lithium had probably caused this. And so sort of communications between different branches, and basically my GP being a good communicator and being able to sort of at times when I've been under the crisis team and stuff, actually being the one who holds it all together
[Mental health 1 focus group]*

Participants viewed a GP as lacking technical competence when GPs assumed any symptom that a patient with a chronic condition consulted their GP about must relate to their primary condition. This limited the level of confidence and trust that patients had in their GP. This was an issue raised by participants in the mental health and chronic pain focus groups:

Helen: And I think the main prejudice can be against certain diagnoses. Against, well against the whole mental health thing. I was amazed, as soon as you've got a mental health diagnosis of any kind, you kind of lose credibility almost. But, and it's so easy for them to put everything down to that sort of thing, and you get, very often get that kind of retort which we just dread, 'well it's only because of your mental health issues that you're

thinking like that and feeling like that'. And you know darn well it's not. And it's so hard then to, you can't get through the negative and you kind of get locked into this cycle, and once, once you've kind of gone that route with the GP, and once they've kind of got locked into that way of seeing you, it's very hard for you to actually convince the GP that your version is the one they should be listening to.

*Pam: Yes, exactly. The other thing is that you were sort of touching on I think was, was this, I mean there's evidence, there's actual research, and I've certainly had experiences of it as well, is this when you've got physical ailments they're often not believed and you're sort of told "oh it's all in the mind, it's psychological", especially around things like pain.
[Mental health 1 focus group]*

Keith: Mine would think it's, you know if you've got a problem, oh it's part of your condition. Well it's not always part of your condition. You know something isn't always part of your condition. You know it's something else.

Rose: Yes, yes.

Keith: So that's always a worry. And I think that goes for everybody with chronic pain really.

Rose: Yes, so that whatever you're going with they think it must be something to do with

*Keith: yes part of the condition
[Chronic pain 2 focus group]*

Some participants evaluated the technical competence of GPs in relation to the age of the GP. Some participants felt that 'young' GPs could not have the necessary experience to be technically competent and they therefore found it hard to feel confident in them and to trust their ability to treat them competently. Conversely, however, some patients noted that younger GPs were more open to new ideas and willing to try different things and to 'work with' patients which was seen as potentially advantageous:

Rose: So thinking about the last doctor you saw for example, would you say you trust them?

Beryl: No.

Rose: Okay. Why?

*Beryl: I don't think she had enough experience. I may be wrong, and maybe she looked younger than she was, but no, I had no confidence whatsoever.
[visual impairment focus group]*

Dave: Can I ask Keith, because you've told me about this when we came to visit you, is she a younger GP, is she a fairly newly qualified?

Keith: No.

Dave: Because she seems to be trying different ideas doesn't she?

Keith: Yes.

Dave: And I wonder if it's because GPs are younger now is my understanding.
[Chronic pain focus group 2]

Behaving professionally was also viewed as being part of technical competence. Professionalism was seen to encompass reliability; that a GP could be trusted to do the things that they have said they would do, such as writing letters, making referrals or returning phone calls. It also encompassed issues relating to confidentiality, such as ensuring information about patients was kept confidential and that patient's wishes were taken into account in relation to putting sensitive information in patient's notes or passing on information to others. This was a particular issue for patients from the mental health focus groups who recounted experiences of personal information which they thought was confidential being transferred across services and being seen by non-medical staff. While participants noted that professionalism among GPs should be 'a given', participants observed this was not always the case.

Helen: Reliable is a word I'd like to see in there somewhere. Being reliable, and it comes under professional.

Jill: Yes.

Helen: That's first and foremost. In a way you should be able to take it as read that the GP is going to be professional and reliable, but

Pam: You can't.

Helen: You just can't.
[Mental health 1 focus group]

Melanie: I think people following up letters, making sure they're sent, referrals are made when they say they're going to make them. Making sure everyone's in the loop.

Amy: Vital.

Melanie: Because so often people aren't informed properly. And when you're not well you're not able to do it yourself are you.

Helen: But maybe there's something that could be added to the confidence one, that is just about professionalism, because it isn't just about them being confident in their opinions.

Amy: Yeah, it is.

Helen: It is about them being truly professional and actually ticking all the boxes and doing all the things that they need to do as a GP, because some don't even cover those basic things.

[Mental health focus group 1]

Stella: It's less important now, but and I think my awareness of what confidentiality means to the service, which let's face it, it's not particularly confidential, you know once you've told your GP, then it's available in your notes to a lot of other people, secondary services, it goes even further. And it's understanding I think for me that it will be flagged up to me if my GP is going to speak to somebody else, then I expect to be told beforehand. And that if she writes, I expect to be copied in. And that's holding on to a degree of confidentiality. Or if I'm saying 'please don't contact my children', they won't.

[Mental health 2 focus group]

Communication skills

Research indicates that patients view communication skills as very important in health care, and often as lacking in both primary and secondary care (Coulter & Fitzpatrick, 2000). Alongside technical skills, a competent and trustworthy GP obviously needs to have good communication skills. Good communication skills appeared to be a further factor in participants' assessment of a trustworthy GP. Communication skills involve GPs exploring patient's symptoms with them in order to reach a diagnosis and treatment plan and communicating this to patients in ways that are understandable to them. Focus group participants noted the importance of GPs listening to them, giving them time to explain their symptoms and being respectful, engaged and 'believing' them. Several participants referred to the GP needing to 'really listen' and the problems that occurred if they didn't which could leave patients feeling they were wasting a GPs time or 'making a fuss'. For example:

Mel: I think it's listening skills, I think are probably the most important, because obviously they've got to listen to what you say about whatever the problem is, because obviously without listening they're not going to be able to say 'right this is what's going on', because otherwise he just hasn't read it. They've got to ask you the right questions, and how can they diagnose you without half the information, because if one part of the puzzle isn't quite right and they could misdiagnose you because they haven't asked, and then questions come back in a different way than they thought, so there is that kind of, they've got to be very careful haven't they?

Lorraine: Well they need to know how to coax you to get the questions out, because I know people that go to the GP and don't say a word other than, 'I'm fine', you know and they need to be able to get that out.

Mel: Drawing out the information.

Lorraine: Yeah. That's a skill isn't it?

- Chris: *I think it's important that they take you seriously so that you don't get the impression that you're wasting time. You're forward or that sort of thing is important, [so you know] that they're taking you seriously.
[Chronic pain 1 focus group]*
- Norma: *And I think that's the most important thing of all, really, is a doctor that will listen to you, and talk to you. That is really important; that's the start.*
- Beryl: *And they mustn't talk down to you. They've got to be on the same level. I mean I don't want the doctor that's going to sit in the chair and say "I'm a doctor and I know everything and you're nothing".*
- Elizabeth: *They talk to you.*
- Beryl: *I think they've got to be on the same level all the time.*
- Margaret: *Some doctors are rather abrupt, and that puts you off right away.*
- Rose: *Yeah, so you want them to listen to you, to allow you to talk.*
- Beryl: *And not use long words that I do not understand.*
- Arthur: *Well you've got to interject then, if they use a long word you've got to say, "explain what you mean".*
- Beryl: *Well I've always done that, and asked for simpler words.*
- Elizabeth: *Well that will depend on the attitude of the doctor. If he's abrupt, you cannot interrupt him. You are already, when he's abrupt when you go in, you're already intimidated
[Visual impairment group]*

Explaining a diagnosis or condition and the treatment options in ways that patients can understand is obviously important. Participants noted that this is a skilful activity because people's understandings are variable as is the amount of information that they want. It was noted that a good GP needs to assess how much information people want and the best way to explain their condition and its treatment in ways that take into account their social, cultural and ethnic differences. So, while a number of participants viewed honesty and extensive information as important others noted that they preferred minimal information and did not like to be given too much detail.

- Andrew: *I suppose in some ways they have to use their judgement on that as well to decide whether explaining something to somebody is going to be harmful for that person.*
- Rose: *Yes.*
- Andrew: *And then do they stop at that point? I think most of them, and the ones that I've seen certainly have been very good at adapting the language for the person. So if my daughter goes in, she understands what's being said. And if I went in it would be at a different level and I could understand what's being said*

Susan: You know I think I'll agree with that, because with us she'll talk to you [Mary] in a different way than she'll talk to me. So I prefer somebody to talk to me in black and white.

Rose: Right.

Susan: I don't do grey, whatever, just tell me as it is.

Rose: Yes.

Susan: With Mary, she'll fluff it up a little bit, and then if need be, explain it to me in black and white.

[Chronic pain 1 focus group]

The importance of having relationships of trust with their GPs was noted by several participants and issues of trust were evident in relation to discussions around treatment. This was especially the case for participants with chronic pain and mental health conditions. Patient-centred care and shared decision-making, in which patients and doctors work together in reaching decisions about treatment, have gained currency in primary care (Murray et al, 2006). Shared decision-making is appropriate when there are multiple treatment options and where the 'right' decision is one that is concordant with an individual's preferences, needs and desired outcomes (Elwyn et al, 2000; King and Moulton, 2006; O'Connor, 2007). Some participants in the chronic pain and mental health focus groups reported working in partnership with their GPs to reach decisions about their treatment. Patients with long-term conditions such as these gain considerable knowledge about their condition and its management and they value being treated as partners in managing their care. Having relationships with their GP in which they were involved in decision-making in relation to their treatment appeared important in their views of the trustworthiness of their GP.

Fareeda: Yeah, and I think because I was saying he did a lot of good things like, yeah build a relationship with me, I get trust of him, he talked to me about holistic things in my personal life, asked me questions and I can question him, maybe this doesn't, like if obviously he says do I want to go off the medication, I'll say 'I don't feel ready yet' or 'I don't think so', you know he works half-way, so meeting him in the middle, respecting me as a person and yeah, asking me what I thought. If he's recommended counselling, what I thought or if this group worked or this didn't, so it's kind of a two-way communication.

[Mental Health 2 focus group]

Judy: But I do think patients today, well there's so, there's loads of books isn't there.

Rose: Absolutely.

Judy: And people like to know more about their medical conditions today.

Rose: Yes.

Linda: They're much more assertive aren't they? And like to be consulted as well usually, so they might, well there's an issue basically with my GP about a consultant, a pain consultant I've seen and there was these three recommendations, and so I went back to the GP and she went, her eyebrows went up and I thought oh right, okay, it's a bit, oh right, okay, but we've chatted about it and you know we were in a partnership together, you know so that's quite important to me. That I'm not treated, well I don't want to be treated as the patient as such.

Keith: No.

Linda: No, I want to be treated as a fellow human being with intellectual thought, and feelings and all the rest.

*Keith: That's it. Because we've all got a brain and you know we're not, well, stupid and we know if our bodies aren't right.
[Chronic pain 2 focus group]*

*Stella: going back to the honesty thing, medication, at the moment we are having a sort of chronic debate between the pair of us about the validity of antidepressants, because even the Royal College of Psychiatrists is saying that it's only a fifty percent chance that they're going to help nowadays. And we are having this debate, because she is worried that if I stop, my condition might deteriorate. I'm saying it deteriorates anyway, you know it's because it's chronic. And we have an agreement at the moment that yes we will consider stopping, but the honesty is around the fact that if she feels, as a GP, I need to be taking them, then we need to agree that I will restart.
[Mental health 2 focus group]*

The absence of partnership and collaboration in decision-making was also noted by some participants in the mental health and chronic pain focus groups and this appeared to impact negatively on the levels of trust they had with their GPs:

Melanie: I guess for me personally, I have had quite a lot of experience from GPs and other specialists, where they haven't really been listening to what I really feel I need and what's going on with me, and you just feel brushed aside and very disrespected. So it's hugely important to me, that.

Dorothy: Okay.

*Helen: I think it's especially important with mental health, because especially when you're unwell you kind of lose faith in your own mind, you lose faith in your own ability to reason things through and think things through, and so if the professional is doing the same to you, you can totally lose any confidence in yourself, so for them to maintain that respect, even when you're unwell, is absolutely imperative.
[Mental health 2 focus group]*

*Angela: I've had to sort of fight to get diagnosed with the illness that I've got. I kind of have always known I've got the illness I've got. I've always known it. But they've always said, no, it's **just** depression. It's not just depression. You know we have the internet nowadays and, and I guess for my GP, it was easier for them to sort of say 'yeah it's just depression', so they didn't have to deal with the problem. They could just give me tablets and that's it, you know as opposed to actually well actually I've got borderline personality disorder. It's not **just** depression.*

Dorothy: Sure.

Angela: So I am fighting, not even just with that, I've got sleep apnoea as well. It took them twenty years to say, you know, 'this is, you've got sleep apnoea' you know and I'm constantly fighting with them, saying 'well this is what I've got'. 'Well no, you can't have that; we're the experts'.

Dorothy: Yes.

*Angela: But I know me. It makes you feel you are not trusted.
[Mental health 1 focus group]*

An important element of the trust relationship with GPs raised by some participants, particularly those from the mental health focus groups, was that it was important not only that patients trust their GPs but that GPs demonstrate that they trust their patients. These demonstrations of trust arise in the context of discussions about treatment when, for example, GPs might demonstrate that they trust a patient's knowledge and experience about their condition and its treatment or trust them to take medication appropriately. Where trust in a patient was demonstrated this contributed to a trusting relationship and enhanced patients' views of a GPs trustworthiness. Conversely where a patient clearly wasn't trusted this had a negative effect on the patient's assessment of the trustworthiness of the GP.

Pete: Well I've got one example, I don't know if anyone else has sort of found this. I mean my GP is very good and I trust him and it's a surgery with probably a dozen other doctors, most of whom I've seen. You know sometimes when you know you can't see one, because he's got like a week or two's bookings so you see somebody else. But there's one in particular that I sort of have reservations about seeing, because she's very by the book, you know sort of strict

Rose: Right.

Pete: And when I see her, you know, she will say, 'oh I'll give you enough [medication] until sort of Monday' and that's it you know, it's like no trust there whatsoever. So that's a difficult sort of situation and I suppose when, you know when you've got two people sort of within one surgery, it's difficult to, you know, have the sort of trust and expectation of one and not get it with the other.

Rose: Yes.

Andrew: I suppose as well the GPs have to trust the patients, to give them the right information, at the right time.

Rose: Yeah, yeah.

Andrew: So they must understand trust, they must.

Rose: Yes. Well that's the other side of this isn't it?

Andrew: It's two-way

*Pete: Yeah, it's got to be two-way hasn't it, it's got to be two-way to an extent.
[Chronic pain 1 focus group]*

Helen: You know really it's a lot of that. Certainly the issue of being listened to, really properly listened to and not just kind of picking up key words and thinking they've got it. And also not relying on old notes and other people's past diagnoses or past opinions, which can be totally, I mean you know if you read my notes from twenty or thirty years ago, it's a totally, I'm a totally different person.

Dorothy: Sure, of course, sure.

Helen: I am a different person, but even back then I was a different person from the one that was depicted in those notes.

Dorothy: Yes.

Helen: And so if they just go by the front page of the notes, which still happens, you know, there's something called an 'event insert card' on the front of my notes. I've seen my notes, and they are absolutely atrocious, unbelievable. And I'm incredibly lucky to have a GP now who will listen to me and who is understanding. And I've had to go to the lengths of calling on a kind of loophole in the GMC regulations, to prevent my old notes actually being sent to that practice, well I haven't actually registered a hundred percent, because my old notes are so horrendous that every other GP has either deregistered me straightaway, so soon as my notes arrive, or the relationship's become so difficult I haven't been able to continue.

Dorothy: So an awful experience with your GPs.

*Helen: There's a letter that says this patient cannot be helped. This patient cannot be believed. This patient cannot be trusted.
[Mental health 1 focus group]*

One participant in one of the mental health focus groups discussed the importance of being pro-active and assertive in ensuring she had a relationship with her GP that met her needs. As she notes, her actions are probably unusual:

Stella: I would like to draw attention to the fact that when I said I interviewed my GP for the job, everybody without exception, that I have spoken to thinks, you know, that this is a very strange thing to do, but actually it's only strange because traditionally it has never been done. You would interview anybody else for a job, you know and this is a very key role in

my life, so it's important that I find the right person to do it. And the assumption that, you know, any GP will do doesn't work. So I think we need to move forward and partly taking the responsibility for ourselves and being allowed to do that, is to say 'this is what I need from you, are you prepared to work with me in this way?', and not to then face this issue of 'oh well I'm just going to take you off my, what do you call it, practice list', which they have the right to do without any reason. The doctors don't have to give any reason why they take somebody off the list. You do if you want to change doctors. So it's that moving forward. For goodness sake we're in the twenty-first century now. This is a very different world from the world that I was born into, when they, well it was forty-seven, which was when the National Health Service started, and we need to move forward. We are very much more informed. You know we have access to things like the internet. I don't want a GP saying to me 'oh you shouldn't be looking things up on the internet, that's my job' no, actually it's part of my job as well, it's me looking after myself

[Mental health 2 focus group]

Interpersonal skills

Alongside technical skills and the ability to communicate with patients, participants viewed a range of interpersonal skills or characteristics as important and as indicative of a trustworthy GP. These characteristics seemed to be highly valued by participants and discussion of these comprised a large amount of the discussion in the focus groups, particularly that generated by the sorting task of characteristics of a trustworthy GP. Several participants with long term chronic conditions, such as those in the chronic pain and mental health focus groups, appeared to have (or have had) relationships with their doctors which were characterised as supportive and where GPs were seen as having a number of positive interpersonal traits that helped patients to manage their condition. These patients felt they could trust their GP as their GP was identified as supporting them, caring about them and acting in their best interests.

Participants regarded empathy as an important skill or characteristic for GPs. Discussion of empathy occurred primarily in response to the sorting task within the focus groups when participants were asked to identify the three most important characteristics necessary for a trustworthy GP; empathy was identified as an important trait by all participants. Participants wanted GPs to demonstrate that they understood their symptoms and were sympathetic and supportive of the experiences they had of living with a condition. For some participants this meant that they wanted their GP to be optimistic about treatment and positive about the potential for improvement or recovery. The notion of 'holding hope' was mentioned by several

participants; they wanted their GP to demonstrate hope that recovery, or at least an alleviation of symptoms, was possible.

Chris: I think the most important for me is the empathetic one. So that your doctors says 'yes I know you're having a hard time', whether it's whether you're still having loads of investigations or you now know that you've had all the investigations that can be done and this is it, and if the doctor says 'I know you've had a hard time recently', that that's the one that makes me cry anyway, when they say 'I do know you've had a hard time'.

RW: Yes.

*Chris: so empathy's very important
[Chronic pain 1 focus group]*

Anita: I think for me it's empathy; if you've got a chronic illness it is extremely difficult to live with it. I mean none of us wants Parkinson's, and we all have different ways of coping, but if you're having a bad day it just is really difficult, and empathy is priceless.

Ron: Absolutely.

*Anita: Because you don't want them to live the Parkinson's for you, you know and you know they can't take it away, but just, just that sense that, as this lady said, you're not making a fuss; just that sense that it's difficult
[Parkinson's Disease focus group]*

Pam: it is important for them to understand how difficult it is, but it is also I think really important that they're holding hope for you, and that they're not doing this, 'you're a schizophrenic and you will be for the rest of your life'. And it's sort of like you know at times when things are really bleak it's a sort of holding a hope that you can get better and this sort of recovery framework.

Amy: Yes, but also they're not giving [you] unfair expectations as well.

Pam: Well yeah, absolutely.

Helen: And that belief, it has to be that kind of belief in you.

Pam: No, absolutely.

Helen: The belief that you can do it. That they're not going to let you down.

Angela: I think there's a big difference, empathy and sympathy and I think there's a big difference there, because somebody that obviously, I never want my GP to say to me 'oh don't worry, it's going to be alright', whereas if he sort of you know, that there's a huge difference. I mean empathy is such a key word, for me, because I actually believe in it so much, so for me yeah it's quite important that they understand what I'm talking about. They can relate, not so much relate, just hear me, listen to me and get what I'm saying, you know.

[Mental health 1 focus group]

The distinction between professional empathy and characteristics that might be indicative of a more informal and personal relationship with a GP was very blurred in discussions. Some participants wanted, or indeed appeared to have, a relationship with their GP which contained some characteristics of a friendship. These characteristics were identified as important in a trustworthy GP. Some of these participants talked about wanting to have (or having) a GP who demonstrated that they cared about them; they wanted (or had) a GP who was interested in how they were coping with their condition and who demonstrated care and concern if they were finding managing their condition difficult. Others identified the importance of a GP demonstrating personal characteristics such as warmth and friendliness. Having a GP who 'knows' their patients and is interested in them, that is, who knows things about them over and above their illness or condition, was identified as important. Participants observed that GPs should be interested in wider aspects of a person's life. This was so that GPs can approach their care holistically and understand the impact that a patient's health condition might have on them.

Pam: I mean I've bumped into my really nice GP. I was going in to pick up a prescription and I was actually quite distressed at the time, and he was popping out for his lunch, and he actually said 'are you alright?', and I sort of said 'no, no, no I'm not'. And he actually stopped going for his lunch and took me back into the GP service and phoned the crisis team.

Melanie: That's brilliant.

Pam: Isn't that amazing?

Melanie: It's really lovely.

Jill: Yes, we need more like that don't we.

Helen: Whereas I had the opposite effect, really.

Jill: Yes.

Helen: You know when I was really upset and happened to pass him in the corridor, and I'd written a note to explain something that I needed him to know and I gave it to him, and the next time I had a routine appointment with him, he admonished me because I'd approached him outside the official boundary of the surgery. And taken up his time when he was off duty kind of thing.

[Mental health 1 focus group]

Rose: What about the doctors showing that they care about you; does that matter, or not?

Judy: I think it does, yeah.

Dave: Yes.

Judy: Quite often if I go up and he'll say to me 'how's hubby' you know or something, he'll, you know he'll ask, and 'how's the family' and things like that, and he might not really care, but he does make, it sounds like he does.

Rose: Yes.

Judy: And we always ask him, because we've known him so long, I was his very first patient, but he, he, we know his children. You know we haven't met them, but they've grown up and we always ask how his family is, at the end of the, you know so yeah I think it does.

Dave: I mean he says like 'we've got a dog now, we've got a dog', I mean he'll offer information about what he's doing in life, so I think it does.

Rose: Yeah, so it's a sort of personal relationship.

Dave: Yeah. Yeah, it is, because I mean he went to Australia and he was telling us about his trip to Australia, and I was thinking all those poor patients out there [waiting to see him], you know.

[Chronic pain 2 focus group]

Fareeda: Yeah so my one was quite good actually. I've had him for about ten years and so he, he does the whole holistic and it's strange, because I've had a doctor when I lived in Luton, ten years ago, and he didn't, but this one, although he might not know about mental health, he asks about relationships, work, family.

Rana: But that's good.

Fareeda: And, yeah, and you don't really get that with anybody. And I don't have to disclose lots of details, but he's.

Rana: He sounds good.

Fareeda: Yeah, he's aware that you don't have, if you have a partner or not, if you have a partner or like a family or how it affects if you're working or if you're volunteering.

[Mental health 2 focus group]

Another aspect of these positive interpersonal skills identified by participants that was similarly highly valued was the willingness of GPs with these 'personal' traits to give patients time. A corollary to having an empathetic, friendly and personable GP is that they have to give patients time. The standard ten minute appointment is probably not going to be sufficient for a GP to carry out these sorts of behaviours in cases with patients who have complex conditions. Those participants who identified their GP as having these positive personal characteristics also identified them as giving time and being accessible. These GPs were identified as being the most popular GPs in a practice but whose surgeries always ran late as they tended to give more than the allotted ten minute slot to patients. Some participants noted that their GPs in addition also found alternative ways of consulting with them, such as telephone or email consultations, so that they could give them additional time.

Judy: Because he really, he's a very popular doctor in the practice.

Rose: So why is he so popular do you think?

Judy: I think because he spends the time with you. Although he gives you, you get a ten minute slot, he sometimes, I mean I had to see him two weeks

ago and I was in there for about forty minutes. I know that makes everybody else [late], and you do have to wait a long time sometimes to see him, but you feel that he cares and he understands and he does everything he can to help you.

Rose: Yes, yes.

Judy: And that comes across you know.

Dave: And if he is running late we understand, because he would give the same treatment to us as well, so most people who go to see him, realise if he's running late there's a reason for it, so you don't get impatient, because he would do the same to us

[Chronic pain 2 focus group]

Stella: Because there are times when presenting in person is something I find very difficult to do, and both of these two have been very good about that. I'd email them and they will always be reliable and email back, and I think that reliability is important. And that they will respond if necessary to phone calls as well. We have phone call consultations. But also it's seeing the person. My GPs now co-manage my mental health with secondary services. So I don't see a psychiatrist, I just see a GP and I have a care coordinator who I see from secondary services and their ability to work together again, is important.

[Mental health 2 focus group]

Looking towards the future: the Health and Social Care Act

The 2012 Health and Social Care Act (HSCA) became operational on 1st April 2013. This act provided a new and powerful role for GPs in that it devolved responsibility for a large part of commissioning of services to Clinical Commissioning Groups (CCGs) which are GP-led and dominated. As well as GPs, each CCG also has patient representation as well as limited representation from other medical and health care professionals. All GP practices must be members of CCGs which commission services they view as appropriate to meet reasonable local needs. CCGs have been encouraged to use competition and to be open to care providers in the voluntary and private sectors.

A number of concerns have been raised about CCGs from doctors themselves, from policy analysts and from more general commentators and the media (e.g., Campbell, 2013; Ham, 2013; Toynbee 2013). In particular, concern has been raised that many GPs on CCGs have a conflict of interest because they have financial interests in companies from whom services could potentially be commissioned (Iacobucci, 2013). Concern has also been raised that the 'special relationship' between GPs and patients may be damaged and that patients may suspect GPs are trying to save money if they do not provide the services or medication that a patient wants and may

fear that these changes herald the privatisation of the NHS (Jaques, 2013). Finally, it has been noted that GPs themselves, in anticipating the changes that would be brought about by the HSCA, were concerned it would mean that they would have less time to spend with patients (Ipsos Mori). Several commentators have observed these changes to the NHS might impact negatively on patients' trust in GPs (Campbell, 2013; Toynbee, 2013).

Nick Triggle noted on the BBC News website in April 2013 that, while the changes to the NHS had received significant attention, most people were unlikely to experience any visible change in the short term. We commenced the focus groups in February 2013, when there was considerable media attention on the impending HSCA, and we completed them in August 2013, when the furore over the HSCA has largely abated but when the impact of it had probably been fairly minimal. We were interested to explore whether our participants knew about the HSCA and what their expectations, and perhaps their experiences, were in aspects relating to trust in GPs.

While we anticipated that the majority of our participants would probably have little knowledge of the HSCA, in fact several of our participants were knowledgeable about it and were members of committees or groups that had been consulted about it in their local area. These individuals raised some specific concerns about the conflict of interest for GPs, the composition of commissioning boards and the monitoring or regulation of GPs. Other participants, who were less personally involved in consultation about the HSCA, in discussion about it in the focus groups, raised concerns about the pressure on GPs time that their commissioning role might bring. There was also considerable discussion, and concerns raised, about the perceived privatisation of the NHS heralded by the Act and the impact that the Act might make on the availability of services and treatments for certain conditions.

While a small number of participants were very knowledgeable about the HSCA, it was clear that the majority of participants were confused about what the HSCA comprised and what impact it might have on them. Interestingly, some participants who had been involved in consultation or discussion about CCGs remained confused about it and some felt that they were not given enough information or opportunity to discuss their views.

Rose: So has anybody heard about the Health and Social Care Act or do you know anything about it at all?

Andrew: Did we have one of the guys from the Health Trust, because he came in and spoke to us?

Rose: Oh okay.

Andrew: If not exactly that, but and what they were doing with some of the money. How it was going to interact with GPs, so a bit, but not, so I can't remember too much about it.

Chris: I belong to the patients' group at my GPs surgery.

Rose: Okay, yes.

*Chris: And the practice manager goes to meetings and she's been talking about commissioning and things like that. I've heard it many times and I still really don't understand it.
[Chronic pain 1 focus group]*

Aadi: I've been to a group which every surgery should have. It's called Patient Participation Group. I've been to one of those meetings. GPs are good. People in the Health Watch⁸, they're too bossy. I find them too bossy.

Dorothy: So not a good experience on that level.

Aadi: Yes, yes, you know they talk you down and they don't let you have your say.

Dorothy: Yes. That sounds discouraging.

Aadi: Discouraging, and it's not working very well.

Dorothy: Because it's meant to be a key part of the new commissioning system isn't it?

Aadi: Well their point of view is that it's only an hour or so, so everybody should get involved but they don't want everyone to get involved in the discussion.

[Mental health 2 focus group]

One individual expressed concerns about the HSCA, particularly the potential conflict of interest that GPs on CCGs might have and the composition of CCGs. These concerns raise clear issues of a lack of trust in GPs to manage their new role with integrity.

Arthur: I'm afraid I've done a lot of consultation on it and I think it's a complete and utter dog's dinner.

Rose: Okay.

Arthur: And I don't think it's a very good idea to have doctors, to have incestuous organisations where doctors run services and doctors may also have fingers in the pie of whatever they do. Even if they're very conscientious, I don't think it's possible to split that in their mind. So if they, if they will financially benefit from what they're doing, and who they're giving contracts to, even if they're always straight down the middle, they're either going to veer away from somebody that they have an interest in who might be the best, or the complete reverse. I think their job is to diagnose and find the best service, and that best service should not be one that they also run, or I don't think it is. And also the boards involved, I asked a question at one of the seminars leading up

⁸ Healthwatch launched in April 2013. It operates at the national and local level; its aim is to gather and represent the views of services users and to provide a complaints advocacy service including those relating to care quality. <http://www.cqc.org.uk/public/about-us/partnerships-other-organisations/healthwatch>

to this, and it turns out that, who are the lay people who are advertised on the boards, and he said 'oh well they have been advertised'. I said 'well where have they been advertised?' 'Oh well they've been advertised mainly in the Health Service and in Health magazines'. Well the lay public don't read the Health Service and Health magazines. So not only have you got you know like an eight to two ratio on a board or whatever of doctors, as against lay people, but even the lay people are normally people involved in the industry anyway.
[Visual impairment focus group]

For the most part, however, participants' concerns related to the time pressures that having responsibility for commissioning and having significant roles in CCGs would inevitably have on GPs. Their concerns were that this would inevitably have a negative impact on patients because GPs would have less time to spend with them. Indeed, some already had experience of this happening. The view was also expressed that GPs should focus on looking after their patients rather than becoming responsible for finances. Underlying this concern was the notion that practices were moving further into becoming businesses and that this would impact negatively on the relationship between doctor and patient. The changes brought about by the HSCA were viewed as moving general practice further away from the type of GP relationship that participants favoured; the impact of the HSCA was viewed as very much at odds with the notion of a family doctor.

Melanie: I think they're going to be overwhelmed to be honest with you, and so that's going to be worrying.

Amy: Of course they are.

Melanie: And that's going, that would overwhelm me, and but looking at it from a humanistic point of view, I think I'm going to be quite nervous and almost feel bad about giving them more to do now and

Amy: Ahh. Yeah.

Melanie: And it shouldn't really be the case.

Angela: But they should be looking after your health shouldn't they, not the money-crunching, thinking, yeah I agree.

Amy: I suppose then it comes back to the fact that they're general practitioners; they're not specialists, why have they been given this responsibility?

Jill: It's too much and they're not accountants or, no they're not.

Pam: Are they going to start doing finances and statistics in medical school now, you know.

Amy: Probably, they're going to have to.

[Mental health 1 focus group]

*Helen: And then the time factor, I know my GP is now on the CCG and it was already difficult enough to get an appointment with him. Now it's even, you know she's going through the diary, 'oh he's not in that day, oh that day he's got to go to a meeting for the whole afternoon, and you know it's another CCG thing'. And he's such a valuable GP, yes, he'll be very good on the CCG, because he's got a very good brain, he'll be able to kind of understand the mechanics, but he's wasted. You know he is the most fantastic GP, and he needs, there are people who are just clambering to see him, who really need to have that time with him, and he should be there in his surgery seeing patients and not out there money-crunching with some bureaucrats, you know.
[Mental Health 1 focus group]*

Participants' greatest concerns regarding the HSCA, and the issues relating to the HSCA which they spent most time in the focus groups discussing, was the impact that the HSCA might have on the services and treatments available for specific conditions. People with mental health and chronic pain problems were particularly concerned that CCGs would not view these conditions as priorities and that there would consequently be inadequate services commissioned to meet their needs. It was felt that there was a danger that there would be fewer services available for their condition than is currently the case. The concern was also raised that 'expensive' medication, even though patients had found it successful in treating their symptoms, might cease to be available to them if it was found to be beyond the budgets of practices. Many participants viewed the decisions to be made by CCGs to be at the level of the practice rather than a broader geographical community; some concern was raised that GPs might exclude 'expensive' patients from their lists in order to 'balance the books'. Participants noted that the concern with budgets could impact negatively on the relationship between doctor and patient and on the levels of trust in a GP, as one participant noted 'it will be hard to trust GPs if you can't trust them to do what's right, only to do what they can afford' [Chronic pain 1 focus group]. While the majority of people commented negatively on the potential repercussions of the HSCA, the alternative view, that services could be more responsive to, and better able to meet, patients' needs was made by one participant in one of the mental health focus groups

Stella: I think people are perhaps seeing the clinical commissioning as more individual than it actually is. It's overarching, it's a group of GPs representing other GPs who are taking the largest say in it. And they are, the ones that I've come into contact with, are very much taking the service user views and listening to service user views and they're having, and setting up service user forums or patient forums, or however you want to describe them. I think my main concern with regard to mental health is that I have yet to have a meeting with clinical

commissioning teams where I haven't been banging on the table saying what about mental health, where does that fit in? Because not enough GPs have an interest in mental health, partly because they haven't necessarily had any training in it, and don't necessarily understand it. ... But I think eventually it could be better. It's just, it's I think politically it's how much of a risk they're prepared to take to a certain extent.

Barbara: I think it's a positive and negative thing really, a mixed thing, yeah. It, the budgets, the new budgets that the GPs have got puts them in a great deal of power and they need to work with other organisations to give their patients the best benefits of these new, of the new system

Stella: Yes it is going to give the GPs a lot of power, well wouldn't you prefer GPs to have a lot of power rather than hospitals where there is this huge, huge hierarchy? And if it makes the systems easier and more communicable, I think that is better.

[Mental health 2 focus group]

Mel: Because as I say I think with long-term conditions, because obviously there are people who have got you know quite complex long-term conditions and if the GP is then going to think well actually I've got this percentage who are you know quite expensive to manage.

Andrew: I think there needs to be, and I'm sure there will be, rules to stop GPs then saying like well this is a bit expensive, we'll just cross them off the bottom and send him somewhere else. I think there must be, it's still, it's still a National Health Service.

Mel: well exactly though a lot of it is being privatised though, I think that is what it is

[Chronic pain 1 focus group]

Pam: One of my concerns is kind of like that I'd imagine we're going to end up with very patchy services and in a way I think that GPs have special interests and specialisms, like some are very good on mental health, some are very good on women's issues and stuff, surely the GPs that are setting up these services are quite likely to put budgets in the things that they think are most important by their, by their interests and stuff, and I'm a bit worried that mental health might get left out a bit. And I think it's kind of forgotten that it's one of the most common, you know there's kind of like one in, I don't know how many other illnesses.

Angela: One in four. One in four it is, and that's the last recorded.

Pam: And sort of one in four people a year, I don't think, I can't think of anything else that would be one in a four a year, other than coughs and colds and things, so it's kind of like are they going to really realise what percentage

should be going to mental health, right? I'm just worried that it's going to end up really, really patchy and GPs setting the priorities it's going to be just like what their preferences are in what medical journals they read and what they learn about you know.

Helen: I think though it could swing back the other way. If they do discard mental health and don't give enough money for it, then they'll, then people won't be able to go to the specialist services and so the GPs will have a flood of people coming back to the GPs and so it will rebound on them.

Angela: I agree, because I don't think mental health is seen as a priority to be honest with you, and I totally agree and if there is money left in the pot I don't it's going to be for mental health. I totally agree, and because I don't think they see it as something like cancer, diabetes or something like. It's a hidden illness isn't it, nobody can actually tell somebody's got a mental health problem, so I kind of agree that it's there's not going to be enough money left in the pot.

[Mental health 1 focus group]

Discussion

This study sought to explore what factors might explain why people with certain health conditions have lower levels of trust in GPs. As part of this, we also explored how people with certain conditions conceptualise trust and their views on the services they receive from their GP, and the context in which this occurs. Of course this study cannot explain *why* people with certain health conditions have lower levels of trust but it can explore what some of the reasons that *might* account for that could be.

Participants with sensory impairment reported a lack of consideration of their needs in accessing GP services, particularly the use of visual or aural cues within GP surgeries which acted, in effect, as a barrier to them being able to access services independently. The use of electronic systems for 'booking in' at appointments and for patients being called in to see the GP are widely used; patients with sensory impairment require a GP (and receptionist) to be sensitive to their specific needs when coming for a GP appointment. Such forethought may be difficult in a context where patients no longer have their 'own' GP who knows them and their condition. These access issues may be factors that help to explain the lower levels of trust in various aspects of interaction with GPs of patients with sensory impairment (visual and hearing) found in the 2012 GP-patient survey (Stoneman, 2014)

Participants with visual impairment also noted, although they were not alone in this, that GPs lacked understanding and knowledge about, and perhaps interest in, sight problems. People with visual impairment are among those groups who, in analysis of the 2012 GP-patient survey, view GPs negatively in terms of giving them enough time, listening to them, explaining to them and involving them in decisions about their care (Stoneman, 2014). A lack of knowledge among GPs about visual impairments,

and a perceived lack of interest in them, may be one factor that might explain this. Participants with Parkinson's disease also reported a lack of knowledge and interest among GPs about their condition. Most patients with this condition have decisions about their care managed primarily through clinics in secondary care or by specialist community nurses. This may help to explain why the analysis of the 2012 GP-patient survey found that people with neurological conditions viewed GPs as poor at listening to patients and explaining their condition.

People with chronic conditions, such as chronic pain, neurological conditions and long-term mental health problems, are frequent users of health services and are likely to become knowledgeable about their condition. This appeared to be the case, particularly for participants with chronic pain and mental health conditions who were younger than participants to the Parkinson's disease and visual impairment focus groups. Age appears to be a factor in the levels and types of trust that patients have in their GPs, with older patients more likely to have 'blind' trust in GPs (Tarrant et al, 2003⁹). For the participants with chronic pain and mental health conditions, the ability to develop partnerships with their GP in which their care was negotiated and in which each party brought different but important knowledge to bear on the situation appeared to be an important factor in the development of relationships of trust. Trust was also identified as a two-way thing by these groups; part of having trust in a GP involved their GP demonstrating that they trusted the patient and their (the patient's) knowledge of their condition. Participants in these groups, in general, valued partnership working and shared decision making. GPs who were trusted were those who had 'earned' trust by listening to patients, taking their problems seriously, 'believing' them and working with them to manage their symptoms (see Calnan & Rowe, 2008). The sometimes nebulous nature of chronic pain and mental health conditions may make these sorts of relationships crucial, especially when a definitive diagnosis has not been made (see Mechanic & Meyer, 2000). Relationships with GPs without this level of interaction may be particularly unsatisfactory for patients with these types of conditions. This may help to explain why both chronic pain (arthritis and joint pain and long term back pain) and mental health conditions are associated with lower levels of trust in GPs in the analysis of the 2012 GP-patient survey (Stoneman, 2014).

Analysis of the 2012 GP-Patient Survey shows that people with mental health problems are one of the groups for whom there is an association with lower levels of trust in their GPs overall. However, analysis of survey responses to questions about how good their GP is in spending time with them, in listening and explaining, in involving them and in showing them care and concern shows an association between respondents with mental health problems and *positive* evaluations of these characteristics in relation to their own GP (Stoneman, 2014). It may be that, as found with some participants in the focus groups, people with mental health

⁹ In their 2003 survey of general practice patients in the UK, Tarrant et al report that ethnicity was also strongly associated with patient's trust in their usual GP.

problems go to some lengths to find a GP who is interested in mental health and sympathetic to their needs for support, information and involvement in decision making. Equally it may be that GPs are, on the whole, good at managing mental health problems; such problems constitute a considerable proportion of GPs workload and there have been various policy developments aimed at improving the quality of mental health care in primary care (Kendrick, 2007; Gyani et al, 2012; Shaw et al, 2013). However, the challenges of living with mental health conditions may mean that some patients with these conditions nevertheless find it difficult to trust their GPs; Mechanic and Meyer (2000) found in their study in the US that patients with mental health problems feel vulnerable because of the uncertainty associated with their condition and the risks of stigmatisation and rejection.

These findings also provide some interesting insights in relation to participants' conceptions of a trustworthy doctor. As well as viewing a trustworthy GP as one who demonstrates technical competence and communication skills, participants viewed a range of interpersonal characteristics as important in establishing trust in a GP. Participants discussed the importance of feeling a GP 'really knew' them and cared about them. Mechanic and Meyer (2000) also found that caring emerged as an important feature by which patients assess trustworthiness. While it might be argued that some of the interpersonal characteristics that people value, such as friendliness, might be viewed as inherent personality characteristics, Mechanic and Meyer argue that these are largely behaviours that medical students or practitioners can be taught (Mechanic & Meyer, 2000). In some respects, some of the characteristics that participants in this study valued, and which were viewed as indicators of trustworthiness, bear some relationship to those found in friendships. The particular interpersonal skills used by trusted health professionals may encourage people to, perhaps inappropriately, view health professionals as friends; a finding that has emerged in relation to other health professional-patient relationships (Demain, 2009).

Underlying patients' conceptions of the behaviour and characteristics of a trustworthy GP appears to be an ideal of the family doctor of the past. In discussing the trustworthiness of GPs, participants drew on two distinct types of GP; that of the family doctor on the one hand and the doctor who is a manager of a business on the other. The former was seen as trustworthy and as someone who acted in the best interests of their patients and the latter as someone who acted in the best interests of the 'business'. Participants viewed a trustworthy GP as one who 'knows' them and has knowledge about their life, who treats them as an individual and who they can have ready access to at a time when they need it. The many demands on GPs, exacerbated by the HSCA, mean that a return to this ideal of a GP as a 'family doctor' is unlikely and probably impossible. Many of the participants to this study were aware of this and regretted the move to bureaucratic and rationalised general practice.

This study indicated that there are many barriers in contemporary general practice that make it difficult to develop the sorts of relationships of trust that patients seek.

However, despite this, some participants in this study appeared to have been able to forge a relationship of trust with their GP with which they were satisfied. This is perhaps best explained by the fact that focus group participants were members of health support or user groups. As such, these individuals are likely to be more assertive and knowledgeable users of health care services and to use various strategies to forge the relationships with GPs that meet their needs; there were certainly examples of this among participants to the chronic pain and mental health focus groups. Mechanic and Meyer (2000) found in their study in the US that participants recruited from self-help groups had higher expectations of doctors and that they focused more on issues of advocacy and of the importance of doctors fighting for patients' rights. It is likely that the experience of these groups of people is atypical of all people with these conditions. Nevertheless, it demonstrates that such relationships are possible despite the constraints patients and GPs experience.

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