

National Centre for Research Methods Working Paper

06/14

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1. Introduction

Trust is a word that we are increasingly using in our social lives: 'I trust you will find these shoes comfortable madam'; 'I trust the postman to deliver the mail on time'; 'I (mistakenly) trust the trains to run on time'; 'I trust my doctor to tell the truth'. Just from these examples, we can see that trust has an evaluative property – it predicts instances of 'good' people or outcomes. But what exactly is trust? When we say that word, what are we actually trying to convey? The trouble with trust is that we know why we need it, when it is possible, and we know when we benefit from it – but we often don't know what it means. Trust relationships are rarely formalised, often leading to ad-hoc definitions and haphazard usages of the word. Nonetheless, despite this conceptual murkiness, research on trust has exploded over the past few decades within the social sciences, and is seen as a central concept to understanding human and organisational relations within the fields of business and management, economics, psychology, social psychology, politics, and sociology (see Cook (ed.) 2001 and Gambetta (ed.) 1988).

Trust within healthcare systems has also been a focus for a considerable amount of research, and has recently in the UK become a topical issue in the light of recent structural changes to the National Health System. Within this context, trust is seen to have an indirect influence on patient wellbeing by promoting the sharing of information from patient to practitioner, increasing adherence to treatment, and increasing the chances of continuity of care with the same practitioner. An understanding of how trust dynamics between patient and practitioner work, therefore, is more than just an intellectual exercise. It is, instead, an intellectual endeavour with important direct implications for how healthcare systems can institute good practices aimed at increasing the trustworthiness of practitioners and, ultimately, successful patient treatment. This research programme, however, is complicated by the number of studies conducted across very different healthcare settings. Inferences about the primary explanations accounting for low or high trust in health practitioners will be, at least in part, dependent upon the country and type of healthcare system the study takes place within, as well as numerous contextual factors relating to the type of practitioner seen and for what reasons.

The purpose of this paper is to initially review the conceptual landscape of trust within the social sciences in order to highlight under what circumstances trust becomes a crucial concern for human interactions. From this basis, the concept of trust is unpacked alongside similar concepts, such as confidence, and goes on to explore trust within the context of a salient concern with the UK health profession, that is, trust between patients and general practitioners (GPs). As will be demonstrated, issues of trust are heightened under greater situations of vulnerability and uncertainty, which means that health researchers interested in trust between patients and GPs need to be sensitive to the types of medical conditions patients have when examining trust in patient/GP relationships. Building on recent focus group work in the UK specifically designed to explore issues of trust with patient/GP relations (Wiles 2014), and using data from the GP/Patient Survey, a set of multivariate analyses are employed to explain levels of perceived trustworthiness in GPs. The results outline the relative impact that patient characteristics, interactional histories, and GP characteristics have on levels of trust, with strong support given to the role of continuity of care as well as GP specific qualities.

2. Defining Trust

Within the social science, trust has been defined as an inductive expectation (Gambetta 1988), as risk-taking behaviour (Luhmann 1979) and as morality (Fukuyama 1995). It is often the case, however, that trust is left undefined meaning that our usage of the word often lacks precision. Part of the reason for this is that, conceptually speaking, trust has many cousins with it being closely related to other terms such as 'faith' and most notably 'confidence' (for example Gambetta 1988: 7). According to the Oxford English Dictionary, faith is defined as 'trust or confidence'; confidence is defined as a 'firm trust or belief'; and trust itself is defined as 'confidence in the truth of anything; resting on the integrity of another; faith; hope'. Not surprisingly, then, little consensus exists within academic circles as to what trust actually means. As Barber (1983: 7) identifies, "in both serious social thought and everyday

discourse, it is assumed that the meaning of trust and of its many apparent synonyms is so well known that it can be left undefined or to contextual implications”.

When definitions are offered, scholars tend to focus on the general positive or negative conditions which make trust necessary. Baier (1986: 10), for example, defines trust as “accepted vulnerability to another’s possible but not expected ill will (or lack of good will) towards one”. Warren similarly defines trust as “a judgment, however tacit or habitual, to accept vulnerability to the potential ill will of others by granting them discretionary power over some good” (Warren 1999: 311). Both scholars stress the vulnerability to ill will as an antecedent condition for trust, but others have also stressed the positive assumptions of shared values that under-gird trusting relationships. For example, Fukuyama defines trust as “the expectation that arises within a community of regular, honest, and cooperative behavior, based on commonly shared norms, on the part of other members of the community” (Fukuyama 1995: 26). Likewise, Elster (1989) posits trust as the “ability to make credible promises” when an individual is “part of a code of honour” (1989: 274–5). Giddens formalises this view more specifically by seeing trust as “confidence in the reliability of a person or system, regarding a given set of outcomes or events, where that confidence expresses a faith in the probity or love of another, or in the correctness of abstract principles...” (Giddens 1990: 34). In contrast to vulnerability, then, these scholars focus on the importance of shared norms as the basis for trust to develop. As such, they are institutional in nature, whereby trust emerges as a property of (i) the nature of formalised power relationships between actors, and/or (ii) an agreement on the rules and expectations of the relationship.

The conditions under which trust becomes a psychological or rational necessity, however, should not be confused with the factors that make others seem *worthy* of our trust. Indeed, the ‘conceptual slippage’ between trust and trustworthiness is something that pervades the social sciences (Hardin 2002). As a corrective, some rational choice approaches argue that we only find others worthy of our trust when we believe that our interactions with them will serve our own interests. For example, Hardin (1999) argues that “to say that I trust you means I have reason to expect you to act for your own reasons as my agent with respect to the relevant matter. Your interest encapsulates my interest” (Hardin 1999: 26). An important development within this ‘encapsulated interest’ account is that trust, as a rational belief, will only be formed when specified in relation to a particular outcome, that is, X trusts Y *to do Z*. On this reading, it makes little sense to talk of trust in GPs in general, for example, but perhaps makes more sense to talk of trust in GPs to respect patient confidentiality.

2.2 Trustworthiness and Confidence

Scholars have also argued that a further conceptual slippage prevalent in the social sciences which needs tidying up is between confidence and trust (Baier 1986; Hollis 1998; Stoneman 2008). This issue is succinctly revealed when considering more closely the conditions under which scholars believe others to be trustworthy. Broadly speaking, two positions are offered. First, scholars like Hollis argue that being trustworthy is to recognise that “a promise should be kept simply because a promise has been made.” (1998: 20). Similarly, Dasgupta (1988: 53-4) states that trustworthiness is “a person’s overall disposition, his motivation, the extent to which he awards importance to his own honesty.” Both Hollis’ and Dasgupta’s definitions reduce trustworthiness to the presence of non-selfish motives or “internal values” (Ahn 2002: 1). Gambetta and Hardin, in contrast to Hollis and Dasgupta, offer instances of procedural rationality with primacy given to the role of “extrinsic incentives” (Kreps 1997: 18). Gambetta (1988: 16) argues that trustworthiness is a belief in “the probability that [another] will perform an action that is beneficial or at least not detrimental... is high enough to consider engaging in some form of cooperation with him”, while Hardin (2002: 28) defines trustworthiness as “the capacity to judge one’s interests as dependent on doing what one is trusted to do.”

By focusing on “probability” and “capacity” of a relevant other to act in an appropriate way, Gambetta and Hardin posit behavioural regularity, or at the very least behavioural *predictability*, as the crux of making others trustworthy, whereas Hollis and Dasgupta by focusing on “promise keeping” and “motivation” posit virtues of character. Of course, the two positions are not necessarily mutually exclusive: a person might adopt a behavioural regularity or tendency because their internal value

system motivates them towards promise keeping. However, any given behaviour is potentially compatible with a divergent range of motivational factors, some of which might be driven by externally generated strategic concerns (as opposed to an internalised value to keep promises). So while people can act in a way that satisfies our interests, the reasons behind the formation of the intention to do so is not always clear. As such, we rely on various cues which signal to us that the relevant other is trustworthy. When looking to trust another, we need these cues to indicate that not only will this person behave in line with our expectations, but they will also do so for the right reasons. Whether the decisions behind military interventions are done for humanitarian reasons or wider strategic reasons, for example, is a fundamental concern when evaluating the trustworthiness of political leaders. And here we can invoke the language of Baier (1986) to finesse the difference between having confidence in someone and finding them trustworthy: confidence is only disappointed, while trust can be betrayed (Baier 1986: 235). What this illuminates is the normative underpinnings to relationships of trust (Stoneman 2008). We are betrayed when someone fails to do something they *ought* to have done. As the old saying goes, trust is easy to break and hard to mend, and it is the potential for being betrayed that forces all of us to be careful in who we trust and when.

Motives, then, or more accurately our perception of the underlying motives of others, ought to be a central concern for trust research, and any explanations of why others are deemed trustworthy or not need to account for the mechanisms by which honesty and promise keeping are generated as well as how these virtues are communicated. This has led scholars, particularly in the field of psychology, to examine symbols, gestures, and observable characteristics, in addition to expressed intentions and demonstrable behaviour, as key features of deciding who is trustworthy (Cook 2001).

3. The Trustworthiness of GPs

As previously outlined, the mechanisms by which we find others trustworthy are located within institutional and interactional factors which determine the nature of the trust relationship (power, roles and rules) and the extent to which confidence can be built and signals of underlying motives can be evaluated. In terms of healthcare provision within democratic societies, there exist general institutional arrangements which create a need for trust between patients, practitioners, and policymakers. Underpinned by welfare systems, many liberal democratic governments across the world hold an implicit contract with their citizenries stipulating that, from cradle to the grave, the state will provide for the basic needs of its people, including basic healthcare. This democratic obligation requires governments to adequately fund and resource the healthcare system, for the system to be competently managed, and for the practitioners to diligently care for the needs of patients. It is in relation to this final responsibility where issues of trustworthiness become a pressing concern. For many citizens, the first point of contact of the healthcare system is a person's local general practitioner. The need for interpersonal trust with GPs is heightened by the fact that the relationship is established on the medical vulnerability of the patient which exposes the superior information and knowledge of the GP (Calnan et al. 2004). But as well as these general institutional arrangements, for many patients there will be an ongoing need to rely on a GP for medical advice and support, and it is the strong interactional nature of this relationship which brings forth issues of trustworthiness (Baker et al. 2003)

Currently, issues of risk have been heightened in the UK in relation to GP/Patient relationships that will have a direct impact upon the institutional arrangement, the ability to establish ongoing interactions with the same GP, and also the ability for GPs to signal trustworthy qualities. Specifically, the changing organisational structure and role of GPs has raised the question of whether the 'new deal' will increase the potential for conflicts of interest on the part of the GP as surgeries take control, and thus are held accountable for, budgetary issues. Concerns have also been raised regarding the pressures of time and stress and their knock-on effect for patient care as GPs take on the burden of extra administrative duties (RCGP 2013). In both cases, it is easy to see how the motivational factors behind medical decisions from GPs could alter, as well as their capacity to effectively carry out their work

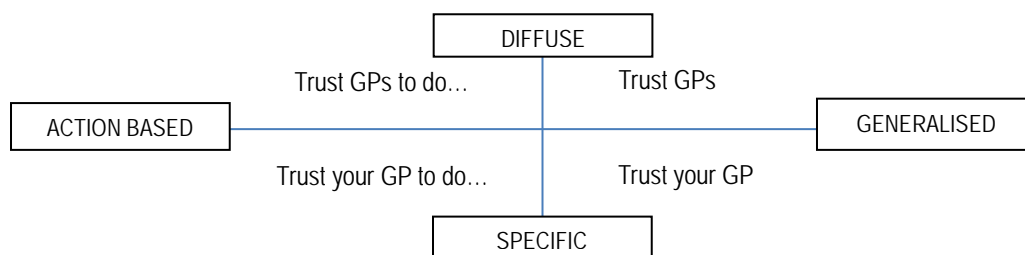
3.1 Empirical Studies of Trust in GPs

A great deal of literature on trust places emphasis on retrospective evaluations of behaviour/performance as key explanations for the trustworthiness of others, be that trust in public institutions such as government (Nye et al. 1997), the media (Ladd 2010), the banking/finance sector (YouGov 2013), or more targeted groups such as politicians (Pattie and Johnston 1997), journalists (Fielden 2011) or health professionals (Calnan and Rowe 2008). A consistent finding across studies into the trustworthiness of GPs is that patient satisfaction of previous treatment highly correlates with trust indicators (Thom and Ribisi 1999), a not so surprising finding given the close conceptual relationship that confidence has with trust. However, studies analysing trust between patients and healthcare practitioners are conducted in a number of different healthcare settings. Divergence in the literature occurs in relation to:

- a) the health care system the interaction takes place within, with most studies coming from the USA and other prominent studies from Canada, the UK, Australia and across the European continent (Calnan and Rowe 2008);
- b) the type of practitioner seen (local doctor, specialist, or hospital doctor for example);
- c) the type of patient being seen, with many studies focusing on patients suffering from one underlying medical condition (for example cancer or back problems);
- d) the type of sample the results are generated from, with many studies using purposive sampling techniques from targeted clinics and sometimes with a specific sub-population in mind (for example women or the over 65s).
- e) the survey instrument used to measure trust in doctors.

On this last point, aside from the different empirical referents of the survey question (such as trust in local doctor; trust in specialist etc.) survey questions are also 'diffused' in nature, that is, they ask respondents about GPs in general; sometimes they are 'specific' in that they ask respondents about 'their GP'; sometimes they are 'generalised' in that they ask about trusting GPs generally; and sometimes they are 'action-based' in that they ask respondents to think about how trustworthy GPs are or their GP is in relation to a particular action (for example, 'tell the truth'). These different ways of measuring trust in GPs are summarised below in figure 1.

Figure 1



To confuse matters even more, survey questions also have different response categories for different survey questions. For example, the Ipsos-Mori questions, which asks a diffused-action based question (trust doctors to 'tell the truth'), offers an agree-disagree option (in addition to don't know). The British Social Attitudes Survey (BSAS) question, on the other hand, asks a diffused-generalised question ('satisfied with GPs generally'), but is scaled with 5 response categories ranging from completely satisfied to completely dissatisfied. The GP-Patient Survey asks a specific-generalised questions ('confidence and trust in current GP') with a three point scale ('yes, definitely', 'yes, to some extent', and 'no, not at all'). Not surprisingly, these different ways of measuring patient evaluations of GPs offer slightly different marginals, although it is consistently the case that whatever measure is used, evaluations are always highly skewed towards positive responses. For example, the Ipsos-Mori

measure indicates that 89% of the population trust doctors (to tell the truth); the BSAS measure indicates 74% are satisfied with GPs; while the GP-Patient Survey indicates that 65% say that they definitely trust their GP.

We have, then, a variety of ways of thinking about and measuring trust in GPs. The headline figures, so prominent in the media, often make use of generalised/diffused measures where individuals are asked to think about all GPs in the abstract and not in relation to any particular behaviour. A caveat with such types of measures, most forcefully made within the literature relating to generalised social trust (Milner 2001), is whether they are actually measuring anything meaningful at all. Specifically, it must be asked what exactly the empirical referents are that people rely upon when provoked to respond to such abstract questions. The attitude gauged in such instances may or may not be tempered by actual interactions with GPs. As such, where possible, it would seem it is best to use measures that are at the very least specific in nature, that is, evaluations indexed to interactions with current GPs.

3.2 Explaining the Trustworthiness of GPs

Broadly, empirical studies attempt to identify the extent to which perceptions of trustworthiness depend on the nature of the relationship between patient and GP, or whether patient specific factors such as age or type of medical condition are the main drivers (Tarrant et al. 2003; Calnan and Sanford 2004). Specifically, higher trust levels are reported for older patients and women (Balkrishnan et al. 2003; Tarrant et al. 2003). Based on the antecedent conditions of trust outlined previously, we can envisage higher levels of trust here being a function of *need*. Trust in this sense is paternalistic in nature (Stoneman 2008), whereby the trustor has an overt reliance on the actions of a relevant other. A useful way to think about this is how trust in government indices react to external threats. In the aftermath of 9/11, trust in government indices in the USA rocketed to all-time highs (Chanely 2002). Nothing in the institutions of government had changed, be that in terms of structure, process or personnel. However, government's role as protector of the security of its citizens suddenly became the nation's number one concern. For a while, US citizens had a heightened need for government to perform its role effectively.¹ The implication for trust in GPs is that patients who feel confident in managing their own health problems have less of a need for the expertise of GPs, and as such, should demonstrate lower levels of trust than those with a heightened need.

The relative importance of GPs being trustworthy also seems to alter across different types of patients, with breast cancer patients in the UK, for example, particularly sensitive (Burkitt Wright et al. 2004) as well as mental health patients (Brown and Calnan 2012) and AIDS patients (Carr 2001). The mechanism at work here is not so much a need for the expertise of GPs, but rather a need for GPs to be sensitive to the personal and perhaps complicated nature of particular health conditions. There is also evidence to suggest that members of ethnic minority or gay, lesbian, bisexual and transsexual (GLBT) groups seem to report lower than average levels of trust in GPs, with both groups often feeling a sense of 'social distance' from their GP who is most likely to be white and middle-class (Mead and Roland 2009).

4. This Study

Using data from the GP-Patient Survey (2012), it can be tested the extent to which certain patient characteristics are associated with relatively lower or higher levels of trust in their GP. The 2012 GP Patient data was generated from two separate waves of fieldwork between July 2011 and March 2012, and asks patients to comment on aspects such as ease of making an appointment, satisfaction with opening hours, as well as the quality of care received from GPs and surgery nurses. The response rate for the 2011/2012 waves is 38%, based on 1,037,946 surveys returned between 4 July and 6 October 2011 and between 3 January 2012 and 10 April 2012. The data is weighted to account for differences

¹ It is worth noting that within two years of the 9/11 attacks, the trust in government indices in the USA fell below its pre-9/11 levels (Gallup 2003).

between the demographic profile of all eligible patients in a practice and the patients who actually complete a questionnaire.² The analytical sample is restricted to only those patients who have visited a GP in the last 6 months to ensure that responses to any trust in GP questions are indexed to actual interactions with a GP.

4.1 Measures and Analytical Strategy

Trust in GPs is measured using the following survey item: "Last time you saw or spoke to a GP from your GP surgery, how good was that GP at each of the following?...Did you have confidence and trust in the GP you saw or spoke to?" Respondents can indicate "Yes, definitely", "Yes, to some extent", "No, not at all, or "Don't know / can't say". To minimise recall error, and to ensure that responses to this question will be answered in relation to specific interactions with GPs as opposed to being primarily determined by a general attitudinal response, the sample is restricted to respondents who have seen a GP in the last 6 months (72% of the original sample). This leaves a dependent variable that is distributed thus: 68% answered "yes, definitely"; 26% answered "yes, to some extent"; 4% answered "no, not at all"; and less than 2% answered "don't know/can't say".

A series of questions asks respondents to indicate from a list whether they are suffering from a long term health condition (such as Alzheimers or Cancer). Specifically, respondents are asked: "Which, if any, of the following medical conditions do you have?" (17 options, respondent indicates all that apply). Of the seventeen conditions listed, a small proportion of respondents (n = 126; < 0.02% of total sample) indicated that they were suffering from at least 13 of these conditions, including alzheimers, cancer, visual and audio impairment, diabetes, and epilepsy. Given the highly improbable cluster of medical conditions outlined within this group, we would have to assume that this is unreliable data and is therefore removed from the working sample.

As the dependent variable has more than 2 nominal categories, multinomial regression will be used to predict the probability of respondents answering "yes, to some extent" and "no, not at all" in relation to "yes, definitely" (the reference category). Building on previous research, the following control variables will be included: age (as a series of dummy variables), gender (0 = male; 1 = female), ethnicity (0 = white; 1 = member of ethnic minority group), and sexual orientation (0 = heterosexual; 1 = gay/lesbian). These are included in addition to the 17 separate measures of medical conditions.

4.2 Results

Table 1 presents the results of the multinomial regression. The important section of the results is found in the top half of the table which outlines the odds ratio (OR) of saying "no, not at all" in relation to "yes, definitely". As the demographics variables outline, older age groups are progressively less likely to express no trust at all in their GP, whereas women are slightly more likely to say so than men (OR = 1.08), ethnic minorities 1.5 times more likely, and the gay and lesbian community 1.25 times more likely to express not trust at all. Of the specific medical conditions, the following are significantly linked to having no trust at all in GPs, in order of magnitude: back problems (OR = 1.53); neurological issues (OR = 1.35); kidney/liver disease (OR = 1.32); Alzheimer's/dementia (or = 1.30); blind/sight impairment (OR = 1.17); arthritis/joint problems (OR = 1.17); and finally, mental health problems (OR = 1.10). In contrast, those with diabetes, epilepsy, or high blood pressure were more likely to at least express some trust in their GP.

These results were used to inform recent focus group work conducted in the UK designed to explore why people find their GP untrustworthy (see Wiles 2014). By highlighting the types of patients who are more likely to express no trust at all, six focus groups were convened to explore these trust issues in more detail. Specifically, and in line with the results in table 1, these were comprised of two groups for people with chronic pain (to cover back and arthritis/joint problems) , two for people with mental health conditions, one for people with visual impairment and one for people with Parkinson's Disease (a neurological condition).

² See <http://www.gp-patient.co.uk/faq/weighting/> for further details.

Table 1: Multinomial Regression: Predicting Perceived Trustworthiness of GPs

		OR	95% Confidence Interval	
			Lower	Upper
No, not at all	<i>Demographic variables</i>			
	Age 25-44	0.54***	0.52	0.56
	Age 45-64	0.26***	0.25	0.28
	Age 65+	0.13***	0.12	0.15
	Sex	1.08***	1.05	1.11
	Ethnic minority	1.49***	1.43	1.55
	Gay/Lesbian	1.25***	1.15	1.35
	<i>Long-term health conditions</i>			
	Alzheimer's/dementia	1.30*	1.03	1.63
	Angina/heart problem	1.01	0.93	1.10
	Arthritis/joint problems	1.17***	1.11	1.22
	Asthma	1.00	0.96	1.05
	Blind/sight impairment	1.17*	1.01	1.37
	Cancer last 5 years	1.05	0.95	1.15
	Deaf/hearing impairment	1.06	0.97	1.16
	Diabetes	0.90***	0.85	0.96
	Epilepsy	0.84**	0.74	0.95
	High blood pressure	0.83***	0.79	0.87
	Kidney/liver disease	1.32***	1.19	1.46
	Learning difficulties	0.90	0.80	1.02
	Back problem	1.53***	1.47	1.60
	Mental health	1.10***	1.03	1.16
	Neurological	1.35***	1.23	1.47
	Another	1.47***	1.42	1.53
	Prefer not to say	1.68***	1.55	1.82
	Yes, to some extent	<i>Demographic variables</i>		
Age 25-44		0.75***	0.74	0.77
Age 45-64		0.58***	0.57	0.59
Age 65+		0.46***	0.44	0.47
Sex		1.07***	1.06	1.08
Ethnic minority		1.46***	1.43	1.49
Gay/Lesbian		1.06**	1.01	1.10
<i>Long term health conditions</i>				
Alzheimer's/dementia		0.97	0.89	1.06
Angina/heart problem		0.92***	0.90	0.95
Arthritis/joint problems		1.03***	1.01	1.05
Asthma		0.99	0.97	1.01
Blind/sight impairment		1.10***	1.04	1.17
Cancer last 5 years		0.85***	0.82	0.89
Deaf/hearing impairment		1.09***	1.06	1.13
Diabetes		0.89***	0.87	0.91
Epilepsy		0.93**	0.88	0.98
High blood pressure		0.94***	0.93	0.96
Kidney/liver disease		1.02	0.98	1.07
Learning difficulties		0.84***	0.79	0.89
Back problem		1.14***	1.12	1.16
Mental health		0.88***	0.86	0.91
Neurological		1.01	0.96	1.05
Another		1.05***	1.03	1.07
Prefer not to say		1.22***	1.17	1.27
Nagelkerke r			.04	
N			558,557	

Delving deeper into trust issues, then, Wiles (2014: 8) found that English patients were sometimes thwarted in their attempts to secure continuous care:

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.

It is interesting to note, however, that there is evidence to suggest that English patients' perceptions of how trustworthy doctors are in primary care settings has no relationship with continuity of care (Tarrant et al. 2003), although studies conducted in other healthcare settings have demonstrated that continuity in the provider of healthcare is important in building up trust over time (for example, Mainous et al. 2001). As such, whether ongoing interactions with the same GP in England increases perceptions of trustworthiness is a claim that needs to be tested with larger number of observation, representative data.

An implication of the conceptual landscape of trust as previously outlined is that it is not ongoing interaction per se that fosters perceptions of trustworthiness but rather ongoing interactions provides the opportunity to demonstrate trustworthy qualities. Above all else, *competence* will be a key characteristic that patients look for and this would explain why iterated interaction is not guarantor of increasing perceptions of trustworthiness. As Wiles (2014: 14) uncovered:

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.

Indeed, a raft of studies testify to the importance of demonstrable competence for facilitating trust between patient and doctor (for example Henman et al. 2002; Thom et al. 2004; Burkitt Wright et al. 2004). However, it is too easy to overstate the importance of competence. Most patients are reasonable enough to realise that medicine is not an exact science and that GPs will often lack certainty in their medical judgements and may not always know the best course of treatment.

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 (Wiles 2014: 15-16).

A GP's openness and willingness to involve others in the decision-making process is potentially another way of demonstrating trustworthy qualities. This *involvement* of others extends to the patient themselves, with research suggesting that patient views need to be taken into consideration when deliberating on medical decisions if trust is to be fostered (Joffe et al. 2003; Burkitt Wright et al. 2004).

[It is] 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 (Wiles 2014: 23).

GPs on this reading become more trustworthy when the medical decision-making process is presented as a 'team effort', something demonstrated by Kai and Crossland's (2001) study of patients with mental health problems in the UK. Formalising interactions that provide patients with the opportunity to express concerns and discuss the relative merits and risks of treatment options is a way of breaking down the knowledge/information asymmetry between patient and GP, and thereby placing the relationship on a more even footing. An essential ingredient in instituting such a joint decision making process, however, is for the GP to genuinely empathise with the patients' situation.

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 (Wiles 2014: 25).

A knock on effect of these more personal demands placed upon GPs is that the amount of time spent with patients becomes a crucial concern:

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 (Wiles 2014: 28).

We can begin to see here how the institutional setting of healthcare providers can have a direct effect on their ability to display trustworthy characteristics. In short, we can see a trade-off between an ability to see patients relatively quickly and an ability to take each patient's case with the duty of care it warrants. This is further complicated by modern developments in how technology mediates the interaction between GP and patient:

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 (Wiles 2014: 10).

4.3 GP Characteristics and Iterated Interactions

As outlined in section 2, building up confidence with someone through iterated interactions is an important step along the way to building up trustworthiness. However, we have also seen that GPs also need to demonstrate certain qualities/characteristics to foster a perception of trustworthiness. Finally, as outlined in section 3.2, perceptions of trustworthiness could also be a function of need, with patients less confident in managing their own health more likely to trust (by default) the judgements of their GP.

The initial model tested, then, needs to incorporate these additional dynamics. As such, the multinomial regression model will also include variables generated from the following survey items:

- Iterated interactions: “How often do you see or speak to the GP you prefer?” (5 point response scale - “Not tried at this GP surgery”; “Never or almost never”; “Some of the time”; “A lot of the time”; “Always or almost always”).
- GP characteristics: “Last time you saw or spoke to a GP from your GP surgery, how good was that GP at each of the following? (1) giving you enough time; (2) listening to you; (3) explaining tests and treatments; (4) involving you in the decisions of your care; and (5) treating you with care and concern (5 point scale for each item ranging from very poor to very good).
- Need: “How confident are you that you can manage your own health?” (4 point response scale ranging from “not at all confident” to “very confident”).

4.3 Results

Table 2 below presents the results of the multinomial regression. Again, the most revealing results appear in the top half of the table which outlines the odds ratios (OR) for the independent variables in terms of being a member of the “no trust in GP at all” group (reference category = yes, definitely trust GP). The first finding to highlight is that older patients are less likely to have no trust at all in their GP and more likely to have complete trust (Age 65+ OR = 0.57***), perhaps reflecting a greater deference to authority, while women are more likely to say that they have no trust all in their GP (OR = 1.23***). Patients with high levels of confidence in managing their own health demonstrate a lower probability of having no trust at all in their GP (OR = 0.71***). The source of this confidence, however, is not clear, as it could be the case that patients with a higher overall confidence in medicine are, by extension, more likely to find GPs trustworthy. An alternative explanation is that through interactions with a competent and trustworthy GP, confidence in ability to manage a health problem is increased (an instance of reverse causation). Either way, it is interesting to note that the hypothesised relationship has turned out to be false, with the more confident in managing their own health also more likely to find their GP trustworthy, thereby undermining the ‘need’ hypothesis. We also find that patients suffering from particular health conditions are more likely to find their GP untrustworthy, that is, those suffering from arthritis/joint problems (OR = 1.12***), cancer (OR = 1.50***), kidney/liver disease (OR = 1.39**), and neurological problems (OR = 1.26*). We also find that continuity of care *does* seem to increase perceptions of trustworthiness, with patients who see their preferred GP more often less likely to report having no trust at all in their GP (OR = 0.52***). Finally, we can also see the strong effects that GP characteristics have on such trust in GP measures, with all of the items reducing the probability of having no trust at all and increasing the probability of complete trust.

Comparing the results from tables 1 and 2, we can see how including confidence in managing own health, iterated interactions, and GP characteristics as explanatory variables have altered the types of medical conditions that are now associated with expressing no trust at all in a GP. While arthritis, kidney/liver disease, and neurological patients are still more likely to express no trust at all in their GP, those with back problems, visual impairment, or mental health conditions are no longer significantly associated with such a view. The notable difference is that cancer patients now also reveal themselves to be 1.5 times more likely to express no trust at all in their GP. As such, these new set of results reveal how these additional variables, once included, suppress the significance of certain medical conditions when relating them to their effect on trust in GPs.

Table 2: Multinomial Regression: Predicting Perceived Trustworthiness of GPs

		OR	95% Confidence Interval	
			Lower	Upper
No, not at all	<i>Demographic variables</i>			
	Age 25-44	0.87***	0.80	0.94
	Age 45-64	0.91	0.82	1.00
	Age 65+	0.57***	0.48	0.68
	Sex	1.23***	1.15	1.31
	Ethnic minority	0.85***	0.77	0.93
	Gay/Lesbian	1.20	0.99	1.45
	<i>Patient characteristics</i>			
	Confidence managing own health	0.71***	0.68	0.75
	Alzheimer's/dementia	0.74	0.43	1.28
	Angina/heart problem	1.16	0.99	1.34
	Arthritis/joint problems	1.12***	1.01	1.23
	Asthma	0.93	0.84	1.02
	Blind/sight impairment	0.82	0.59	1.15
	Cancer last 5 years	1.50***	1.25	1.80
	Deaf/hearing impairment	0.92	0.76	1.11
	Diabetes	0.94	0.83	1.07
	Epilepsy	0.93	0.71	1.23
	High blood pressure	0.95	0.87	1.05
	Kidney/liver disease	1.39**	1.11	1.74
	Learning difficulties	0.99	0.74	1.34
	Back problem	1.07	0.97	1.17
	Mental health	1.06	0.93	1.21
	Neurological	1.26*	1.05	1.52
	Another	1.23***	1.14	1.34
	Prefer not to say	1.30**	1.07	1.58
	<i>Interaction and GP characteristics</i>			
	How often see GP	0.52***	0.51	0.54
	Enough time	0.66***	0.63	0.69
	Listening	0.29***	0.27	0.30
	Explaining	0.32***	0.30	0.33
	Involving	0.36***	0.34	0.38
	Care/concern	0.13***	0.13	0.14
Yes, to some extent	<i>Demographic variables</i>			
	Age 25-44	0.94**	0.91	0.98
	Age 45-64	1.01	0.97	1.04
	Age 65+	0.87***	0.82	0.91
	Sex	1.17***	1.14	1.20
	Ethnic minority	1.15***	1.10	1.19
	Gay/Lesbian	1.03	0.95	1.12
	<i>Patient characteristics</i>			
	Confidence managing own health	0.74***	0.72	0.75
	Alzheimer's/dementia	0.70***	0.59	0.82
	Angina/heart problem	1.02	0.97	1.07
	Arthritis/joint problems	1.01	0.98	1.05
	Asthma	1.03	0.99	1.06
	Blind/sight impairment	0.88*	0.79	0.98
	Cancer last 5 years	1.06	1.00	1.13
Deaf/hearing impairment	1.02	0.97	1.09	
Diabetes	0.90***	0.86	0.94	
Epilepsy	0.97	0.88	1.08	
High blood pressure	1.03*	1.00	1.07	

Kidney/liver disease	1.16***	1.07	1.26
Learning difficulties	0.89*	0.79	0.99
Back problem	1.09***	1.05	1.13
Mental health	1.04	0.99	1.09
Neurological	1.11**	1.03	1.20
Another	1.10***	1.07	1.14
Prefer not to say	1.27***	1.17	1.38
<i>Interaction and GP characteristics</i>			
How often see GP	0.71***	0.70	0.72
Enough time	0.76***	0.74	0.78
Listening	0.53***	0.52	0.55
Explaining	0.54***	0.52	0.55
Involving	0.54***	0.52	0.55
Care/concern	0.32***	0.31	0.33
Nagelkerke r		.634	
N		300,326	

Notes: * = p.<0.05; ** = p.<0.01; *** = p.<0.001

The bottom half of table 2 outlines the likelihood of patients saying that they only have some trust in their GP, as opposed to complete trust. Here we repeat some of the findings, with older people less likely to say they have some trust in their GP and more likely to say they have complete trust (Age 65+ OR = 0.87***), women more likely to have they have some trust relative to complete trust (OR = 1.17***), and those with greater confidence in managing their own health less likely to report having only some trust in their GP and more likely to report complete trust (OR = 0.74***). We also find that patients with some medical conditions are more likely to have complete trust rather than some trust (those with Alzheimer's/dementia, blind/sight impairment, diabetes, and learning difficulties), while other patients with specific medical condition are more likely to have only some trust rather than complete trust (high blood pressure, kidney/liver disease, back problems, and neurological issues). Finally, interactional history and GP characteristics again demonstrate that they are key drivers in increasing trust, with all variables associated strongly with a greater likelihood of patients having complete trust in their GP as opposed to only some.

5. Conclusion

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 little more sceptical picture. Indeed, the increase in the availability of health information and support online (Hesse et al. 2005), the growth of complementary and alternative medicine (CAM) (Coulter and Willis 2004) and increasing media scrutiny of GPs (Tanner, Foy and Harrison 2010) plus various medical 'scandals' (for example, the Alder Hey and Bristol Hospitals organ scandals) have indicated that the trustworthiness of the medical profession can no longer be assumed (Allsop 2006). The nature of patient-doctor interactions will be further complicated by the Health and Social Care Act (HSCA). Various health care organisations have argued that the HSCA poses a further threat to trust between patients and GPs (Guardian 2012). Institutional arrangements provide the fundamental basis upon which the nature of trust relationships are determined, and the 'rules of the game' between patients and GPs in the UK are undergoing a period of transformation with potential for instituting practices that undermine the trustworthiness of GPs.

It is argued that the vulnerability associated with being ill means that when patients evaluate the trustworthiness of their GP, they will do so on more 'affective' grounds than rational (Hall et al.

2001). Indeed, the results presented here suggest that trust in GP indices are highly responsive to personal and contextual factors where GPs can signal trustworthy qualities (such as empathy and concern). Furthermore, solid evidence is also presented that continuity of care with the same GP is important in terms of allowing GPs to develop their trustworthiness. Some of the findings presented require further exploration. For example, what is the precise mechanism(s) behind the association of confidence in managing own health and finding GPs trustworthy? Also, why are there differential effects across medical condition on the perceived trustworthiness of GPs. For example, why are patients with arthritis/joint problems lacking trust in their GP? Why are cancer patients 1.5 times more likely to have no trust at all in their GP, despite having controlled for demographic variables, continuity of care, and GP characteristics? Women also consistently express lower levels of perceived trustworthiness in their GP, a finding not consistent with similar studies (Croker et al. 2013), while the gay/lesbian community are more likely to express no trust at all in their GP in the reduced model, but not in the more comprehensive second model.

A further feature of contemporary general practice not explored here was the move towards general practices becoming more market driven in their operations with GPs assuming the role of providers and patients consumers. As Wiles (2014: 12) found:

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 they were all critical of being given a choice about place of treatment; this appeared not to be viewed as giving patients a say in their treatment but as doctors absolving their responsibility.

So while involving the patient in the decision-making process as a general rule seems to foster trust, there might be particular areas of decision-making where patients want their GP to take a lead. While patients clearly appreciate the opportunity to discuss the relative risks and benefits of various treatment options and how they might impinge on their everyday lives, not everyone appreciates the added pressure of having to choose where to have treatment.

6. Bibliography

Ahn, T.. (2002) "Trust and Collective Action: Concepts and Causalities" Paper presented at the annual meeting of the American Political Science Association, Boston Marriott Copley Place, Sheraton Boston & Hynes Convention Center, Boston, Massachusetts, Aug 28, 2002

Allsop, J. 2006. 'Regaining trust in medicine. Professional and state strategies'. *Current Sociology* 54 (4): 621–636.

Baier, A. (1986). 'Trust and Antitrust' *Ethics*, 96: 231-60

Baker R, Mainous III AG, Pereira Gray D and Love MM (2003). 'Exploration of the relationship between continuity, trust in regular doctors and patient satisfaction with consultations with family doctors.' *Scandinavian Journal of Primary Health Care* 21: 27-32.

Balkrishnan R, Dugan E, Carnacho F.T. and Hall M.A. (2003). 'Trust and satisfaction with physicians, insurers and the medical profession.' *Medical Care* 41; 9: 1058-1064.

Barber, B. (1983). 'The Logic and Limits of Trust.' New Brunswick, NJ: Rutgers University Press

Brown, P., and Calnan, M., (2012). *Trusting on the Edge. Managing uncertainty and vulnerability in the midst of serious mental health problems*, Bristol, The Policy Press

Burkitt Wright E, Holcombe C, Salmon P. (2004). 'Doctors' communication of trust, care, and respect in breast cancer: qualitative study.' *British Medical Journal*, 328; 864-7.

Calnan M. & Rowe R. (2008) *Trust matters in Healthcare, Berkshire, Open University Press*

Calnan, M., Montaner, D. and Horne, R. (2004). 'How acceptable are innovative health care technologies? A survey of public beliefs and attitudes in England and Wales.' *Social Science and Medicine*, 60(9): 1937–948

Calnan, M. & Sanford, E. (2004), "Public trust in health care: the system or the doctor?", *Quality and Safety in Health Care*, vol. 13, pp. 92-97.

Carr GS (2001). 'Negotiating trust: a grounded theory study of interpersonal relationships between persons living with HIV/AIDS and their primary health care providers.' *Journal of the Association of Nurses in Aids Care*, 12; 2: 35-43.

Chanley, V. A. (2002). 'Trust in Government in the Aftermath of 9/11: Determinants and Consequences.' *Political Psychology* 23:469-483.

Cook, K. S. (ed.) (2001). 'Trust in Society.' New York: Russell Sage Foundation,

Coulter, D. and Willis, E. M. (2004). 'The rise and rise of complementary and alternative medicine: a sociological perspective.' *Medical Journal of Australia*, 180 (11): 587-589.

Crocker JE, Swancutt DR, Roberts M, Abel G, Roland M, Campbell JL. Factors affecting patients' trust and confidence in GPs - analysis of survey data. Evidence from the English National GP Patient Survey. *BMJ Open* 2013;3(5)

Dasgupta, P. (1988). "Trust As A Commodity". In Gambetta, D. (Ed.), *Trust: Making And Breaking Cooperative Relations*: 47-72. (New York: Blackwell).

Elster, J. (1989). *The Cement of Society: A study in social order*. Cambridge: CUP

Fukuyama, F. (1995). *Trust: the social virtues and the creation of prosperity*, London: Hamish Hamilton

Gambetta, D. (1988). *Trust: Making and Breaking Cooperative Relationships*, New York: Blackwell

Giddens, A. (1990). *The Consequences of Modernity*, Cambridge: Polity

Guardian, The (2012). 'NHS reform bill 'complex, incoherent and not fit for purpose', say doctors'. Electronic version: <http://www.theguardian.com/politics/2012/mar/01/nhs-reform-bill-incoherent-doctors>
Last accessed 26/04/14

Hardin, R. (1999). "Do We Want Trust in Government?" in Warren, M. (ed.), *Democracy and Trust*, Cambridge University Press, pp. 22-41

Hardin, R. (2002). *Trust and Trustworthiness*, New York: Russell Sage Foundation

Henman M.J., Butow P.N., Brown R.F., Boyle F., Tattersall M.H. (2002). 'Lay constructions of decision-making in cancer.' *Psycho-Oncology* 11(4): 295-306

Hesse, B. W., Nelson, D. E., Kreps, G. L., Croyle, R. T., Arora, N. K., Rimer, B. K., & Viswanath, K. (2005). Trust and sources of health information. *Arch Intern Med*, 165(22), 2618-2624.

Hollis, M. (1998). *Trust Within Reason*, Cambridge: Cambridge University Press

Joffe, S., Manocchia, M., Weeks, J.C. and Cleary, P.D. (2003). 'What do patients value in their hospital care? An empirical perspective on autonomy centred bioethics.' *Journal of Medical Ethics*. 29(2), pp.103-108.

Ladd, J. M. (2010) *Why Americans Distrust the News Media and How it Matters*, Princeton: Princeton University Press

Kai, J. & Crossland, A. (2001). Perspectives of people with enduring mental ill health from a community-based qualitative study. *British Journal of General Practice*, September, 730-736.

Kreps, D.(1997), "Intrinsic Motivation and Extrinsic Incentives", in *American Economic Review* 87(2): pp. 359-364

Luhmann, N. (1979), *Trust and Power: Two Works*, Chichester: Wiley

Mainous AG, Baker R, Love MM, Gray DP, Gill JM. (2001). 'Continuity of care and trust in one's physician: evidence from primary care in the United States and the United Kingdom.' *Fam Med* 33:22-7.

McKinstry, B., Ashcroft R., Car J., Freeman, G. & Sheikh A. (2006) Interventions for improving patients' trust in doctors and groups of doctors. *Cochrane Database of Systematic Reviews* Issue 3. Art. No.: CD004134. DOI: 10.1002/14651858.CD004134.pub2.

Mead N, Roland M. (2009). Understanding why some ethnic minority patients evaluate medical care more negatively than white patients: a cross sectional analysis of a routine patient survey in English general practices. *British Medical Journal*, 339(163), b3450-. eScholarID:[5876](#)

Milner, H., (2002), *Civic Literacy: How Informed Citizens Make Democracy Work*, Hanover, University Press of New England

Nye, J., Zelikow, P., and King, D. (1997) *Why People Don't Trust Government*, Massachusetts: Harvard University Press

Pattie, C.J., and Johnston, R.J., (2001), "Losing the voters' trust: evaluations of the political system and voting at the 1997 British General Election", in *British Journal of Politics and International Relations*, 3: pp. 191-222.

Royal College of General Practitioners (RCGP) (2013), 'Patient care compromised as funding for general practice slumps across the UK'. Electronic version: <http://www.rcgp.org.uk/news/2013/november/patient-care-compromised-as-funding-for-general-practice-slumps-across-the-uk.aspx> Last accessed 26/04/14

Stoneman P. (2008) *This Thing Called Trust - Civic Society in Britain*. Sage: London

Tanner F; Foy R; Harrison W. 'Wads up, doc'—trends in British newspapers' reporting of general practitioners' pay. *Primary Health Care Research and Development*. 2010; 11 (04):405-409.

Tarrant, C., Stokes, T., & Baker, R. 2003, "Factors associated with patients' trust in their GP: a cross-sectional survey", *British Journal of General Practice*, vol. 53, pp. 798-800

Thom, D. & Ribisi, K. 1999, "Further validation and reliability testing of the trust in physician scale", *Medical Care*, vol. 37, no. 5, pp. 510-517

Thom, D., Hall, M., & Pawlson, L. 2004, "Measuring patients' trust in their physicians when assessing quality of care", *Health Affairs*, vol July/August, pp. 124-132.

Warren, M. (1999), *Democracy and Trust*. Cambridge: Cambridge University Press

Wiles, R. (2014), *Trust in GPs: Findings from focus groups*, NCRM working paper 01/14. Electronic version: http://eprints.ncrm.ac.uk/3270/1/trust_in_GPs.pdf Last accessed 26/04/14

YouGov (2013), *Public Trust in Banking: Final Report*. Electronic version:

http://cdn.yougov.com/cumulus_uploads/document/ylf7gpof19/Public_Trust_in_Banking_Final.pdf

Last accessed 26/04/14