Trust and Health Care

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Abstract

Trust is believed to be particularly salient to the provision of health care, and since the establishment of the National Health Service (NHS) in the UK, trust has played an important role in the relationships between its three key actors: the state, healthcare practitioners, and patients and the public. Service users trusted the judgement, knowledge and expertise of health professionals to provide a competent service that met their needs, and they trusted the state to ensure equity in the allocation of public goods and services. These implicit or taken-for-granted trust relationships have, it is claimed, been challenged as a result of the introduction of changes in the organisation and funding for the health service, in the regulation and performance assessment of health professionals, and in public attitudes to health care and scientific medicine. This paper considers the influences of social changes and recent policy and professional initiatives in health care on the structure of trust relations in health care in the UK. It presents a theoretical framework for examining trust relations using the NHS as a case study and concludes with an agenda for future research.

Introduction

Trust is believed to be particularly salient to the provision of health care because it is a setting characterised by uncertainty and an element of risk regarding the competence and intentions of the practitioner on whom the patient is reliant (Alaszweski 2003; Titmuss 1968). The need for interpersonal trust relates to the vulnerability associated with being ill as well as the information asymmetries and unequal relationships, which arise from the specialist nature of scientific, medical knowledge. Scientific medicine's expertise or claims to expertise appears to be the basic condition for generating trust in this context (Rose-Ackerman 2001), although the affective component may also have an influence (Hall et al. 2001). In the UK National Health Service (NHS), trust has traditionally played an important part in the relationship between its three key actors: the state, healthcare practitioners, and patients and the public. The postwar consensus was underpinned by trust in the 'altruistic' values associated with medical professionalism (Newman 1998) with the state and patients tending to

trust the norms of professional self-regulation and state licensing procedures to ensure that health professionals and healthcare institutions operated in the best interests of patients and citizens. Service users trusted the judgement, knowledge and expertise of health professionals to provide a competent service that met their needs, and they trusted the state to ensure equity in the allocation of public goods and services (Rowe and Calnan 2006).

These presumed or taken-for-granted trust relationships have, it is claimed, been challenged as a result of the introduction of changes in the organisation and funding of the health service, in the regulation and performance assessment of health professionals, and in public attitudes to health care and scientific medicine. This paper seeks to explore how and why trust relations may be changing using the NHS as a case study. It presents a theoretical framework for investigating trust relations in future empirical research and suggests an agenda for future research.

Definitions

Trust has been characterised as a multilayered concept primarily consisting of a cognitive element (grounded on rational and instrumental judge-ments) and an affective dimension (grounded on relationships and affective bonds generated through interaction, empathy and identification with others) (Gambetta 1998; Gilson 2003; Lewicki and Bunker 1996; Mayer et al. 1995). Trust appears to be necessary where there is uncertainty and a level of risk, be it high, moderate or low, and this element of risk appears to be derived from an individual's uncertainty regarding the motives, intentions and future actions of another on whom the individual is dependent (Mayer et al. 1995; Mishra 1996). Trust may vary in terms of its quality. For example, in elaborating on the nature of social capital, Putnam (2000) makes a distinction between 'thick' trust associated with close family relationships and 'thin' trust for more casual contacts (Beck 1992).

In the context of health care, the evidence suggests the concept seems to embrace confidence in competence (skill and knowledge), as well as whether the trustee is working in the best interests of the trustor. The latter tends to cover honesty, confidentiality and caring, and showing respect (Hall et al. 2001; Mechanic and Meyer 2000), whereas the former may include both technical and social/communication skills. The vulner-ability associated with being ill may specifically lead trust in medical settings to have a stronger emotional and instinctive component (Coulson 1998; Hall et al. 2001). Trust relationships are therefore characterised by one party, the trustor, having positive expectations regarding both the competence of the other party (competence trust), the trustee, and that they will work in their best interests (intentional trust).

Figure 1.   Framing trust relationships in health care.
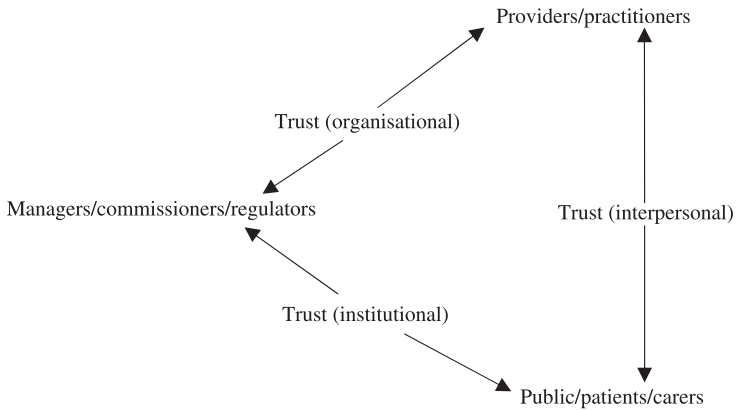
In the NHS, we can distinguish between trust relations (see Figure 1) at the micro level between an individual patient and clinician, between one clinician and another, or between a clinician and a manager, and those at the macro level, which include patient and public trust in clinicians and managers in general, in a particular healthcare organisation and in the NHS as a healthcare system. The former are broadly categorised as interpersonal and organisational trust relations while the latter constitute different types of institutional trust (Calnan and Rowe 2006).

A review of the literature of trust relations in health care (Calnan and Rowe 2004, 2006) highlighted that most empirical research (mainly carried out in the USA) has addressed threats to patient–provider relationships and trust in healthcare systems from the patient's perspective, but studies in the organisational literature suggests that trust relations in the workforce, between providers and between providers and managers, may also influence patient–provider relationships and levels of trust (Gilson et al. 2005). This approach suggests that trust is not primarily dispositional or an individual attribute or psychological state, but is constructed from a set of interpersonal behaviours or from a shared identity. These behaviours are underpinned by sets of institutional rules, laws and customs (Gilson 2006).

Research into trust has been conducted from a variety of disciplinary perspectives. Studies in social psychology and economics has tended to focus on the attributes of the trustor (beliefs about or calculations of trustees motives; past experiences of health care and providers) and the characteristics of the trustee (their ability, competence, benevolence, integrity, reputation, communication skills). Taking the rational choice economics approach, trust may be reduced to instrumental risk assessment by individual actors, i.e. a rational gamble that the personal gains from trusting will outweigh the risks and costs involved. For example, an

economic analysis of why the public place trust in voluntary associations (Anheier and Kendall 2002) might suggest that voluntary associations are run by those who have a stake in services provided to meet their needs and because they are non-profit making and less likely to exploit user vulnerability. However, this ignores how trust may be constructed through the use of myths, images and other symbolic constructions. Newman (1998) points to the use of informal social mechanisms, such as gossip, to communicate information through organisations, in the process contributing to the creation of trust and distrust.

The sociological literature stresses that theoretical models must also consider contextual factors: the organisational context, the stakes involved, the balance of power within the relationship, the perception of the level of risk and the alternatives available to the trustor (Barber 1983; Luhmann 1979; Mayer et al. 1995; Tyler and Kramer 1996). In this paper, we take a sociological approach seeking to understand how the meaning and enactment of trust is influenced by wider social structures and in particular how changes in the organisation and delivery of health care as well as broader social changes may have affected trust relations in the UK NHS.

Does trust matter?

The case for examining trust in health care tends to hinge on theoretical arguments sometimes complemented by empirical evidence (Calnan and Rowe 2006). At the level of interpersonal trust between patient and practitioner, it has been argued that trust is important for its potential therapeutic effects (Mechanic 1998), although evidence to support such claims is still in short supply mainly because of the lack of intervention studies or quasi-experimental studies examining the effect of trust on outcomes (Calnan and Rowe 2004). However, there is a considerable body of evidence that shows trust appears to mediate therapeutic processes and has an indirect influence on health outcomes through its impact on patient satisfaction, adherence to treatment and continuity with a provider, and that it encourages patients to access health care and to make appropriate disclosure of information so that accurate and timely diagnosis can be made (Calnan and Rowe 2004).

Trust also appears to matter to patients as well as healthcare providers. In a number of studies investigating patients' experience of healthcare trust emerged spontaneously as a quality indicator, with patients suggesting that high-quality doctor–patient interactions are characterised by high levels of trust (e.g. see Safran et al. 1998). Trust, although highly correlated with patient satisfaction (Thom and Ribisi 1999), is believed to be a distinct concept. Trust is forward looking and reflects an attitude to a new or ongoing relationship whereas satisfaction tends to be based on past experience and refers to assessment of providers' performance. It has been suggested that trust is a more sensitive indicator of performance than

Figure 2.   Focus of studies identified in literature review (Calnan and Rowe 2004).
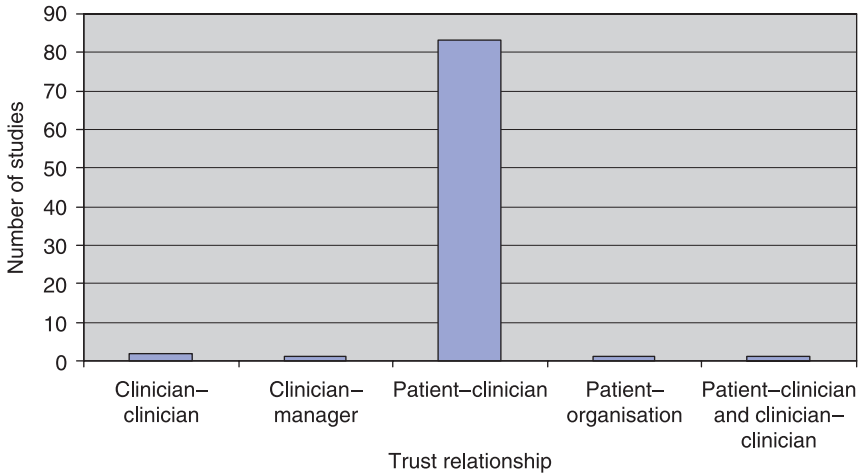
patient satisfaction (Thom et al. 2004) and might be used as a potential 'marker' for how patients evaluate the quality of health care.

In contrast to the sizeable literature assessing trust from the patient perspective studies examining either the value and impact of trust from the practitioner perspective and from a managerial or organisational perspective are very limited (see Figure 2) (Calnan and Rowe 2006). In research that has considered the impact of trust on workplace relations in healthcare settings, trust facilitated commitment to the organisation, enhanced collaborative practice between clinicians and was associated with employee satisfaction and motivation (Gilson et al. 2005). From an organisational perspective, trust is believed to be important in its own right, i.e. it is intrinsically important for the provision of effective health care and has even been described as a collective good, like social trust or social capital. Specific organisational benefits that might be derived from trust as a form of social capital include the reduction in transition costs due to lower surveillance and monitoring costs and the general enhancement of efficiency (Gilson 2003).

What are the costs or dangers of trust? The abuse of power on the basis of trust is a widespread danger (Gilson 2006; Warren 1999). As trust usually involves a relationship between trustor, trustee and a valued good, it sets up a potential power relation. Trust may provide legitimacy for the exercise of power, but 'blind trust' without caution may also enable the abuse of power in the form of exploitation or domination. This is a danger in health care given the vulnerability of patients and for groups living in poverty the consequences of misplaced trust can threaten livelihoods and lives (Coulson 1998); it may also be easier to trust if you are

powerful and wealthy (Gilson 2006). For some writers (Barbalet 2005), trust works as a tranquiliser in social relations in which trust shuts down the trust giver's uncertainty in the face of the trust taker's freedom to act how they wish. Thus, given the potential benefits and cost of trusting relationship, research may need to explore what levels and forms of trust contribute to positive health outcomes and healthcare performance.

Certainly, there may be tension between the development of trust and other policy goals, in particular the development of patient empowerment. The notion of more active service users empowered to both actively manage their condition and to participate in decision-making regarding their treatment has been vigorously promoted for the positive benefits that such participation may produce. This may be contrasted with the more traditional patient role that involved a passive approach and high, possibly blind trust in their clinician's decisions. If trust relations between patients and clinicians are becoming more conditional, can they still contribute positively to health outcomes?

Little empirical research has been conducted to investigate the nature of trust relations within the UK health system, instead most studies have focused on assessing levels of trust. These suggest that while patients retain high levels of trust in individual clinicians ('your own doctor') (Calnan and Sanford 2004; Calnan and Williams 1992; Mainous et al. 2001; Tarrant et al. 2003) and that appears to have been maintained over recent years (Allsop 2006) lower levels of trust are found for healthcare institutions ('doctors in general'), although trust in the wider health system is higher than in other European health systems (van der Schee et al. 2007). For example, evidence from a recent national survey (Calnan and Sanford 2004; Calnan and Rowe 2006) shows that trust (Figure 3) in doctors is

Figure 3.   Levels of trust in health services staffing in England and Wales: Putting interests of patients above convenience of organisations.
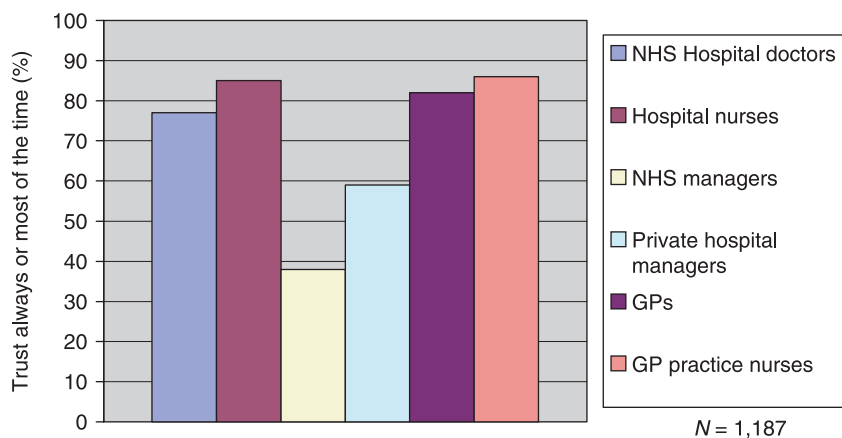
still relatively high and much higher than that for national health service managers, although how salient health service managers are to the public or users is difficult to judge. Certainly, stress levels in health service managers have been shown to be higher than other members of the health service workforce (Calnan and Wainwright 2002). Lower levels of trust in managers might reflect attitudes to the health system as a whole. There is evidence of a decrease in satisfaction with the NHS over the last decade or so (Appleby and Rosete 2003). However, there is no evidence available about whether there has been a parallel decline in public trust in the NHS. There is evidence, however, that complaints to the NHS and to the General Medical Council show an increasing trend as do claims for medical negligence (Allsop 2006). In the Netherlands, results from a national panel study showed that public trust in the healthcare system remained stable between 1997 and 2003 with a small increase in 2004 (van der Schee et al. 2006) despite intense media coverage about problems with health care.

A case study of trust relations – the 'new NHS'

Public and patient trust in health care in the UK appears to be shaped by a variety of influences (Rowe and Calnan 2006). From a macro perspective, any changes in levels of public trust in healthcare institutions appear to derive partly from top-down policy initiatives that have altered the way in which health services are organised and partly from changes in public attitudes to health care. The latter may be linked with how the NHS is run and financed and the pressure on NHS budgets due to increased demand by an ageing population, the rising costs of technology and increases in public sector pay (Taylor-Gooby and Hastie 2003). Or it may be linked with broader social and cultural processes, which are claimed to have produced a decline in deference to authority and trust in experts and institutions, increasing reliance on personal judgements of risk (Beck 1992; Giddens 1991; O'Neil 2002), and which may be linked to an overall decline in social trust due to the breakdown of communities, social networks and cohesion (Putnam 2000). Consumerist forces, it is proposed, have produced a shift in the balance of power within which trust relations are formed, changing public and professional vulnerabilities and the requirement for trust in their relationship (Newman 1998). Institutional trust may have also been affected by negative media coverage of scandals over medical competence in the 1990s, such as the enquiry into paediatric cardiac surgery in Bristol, the conviction of the general practitioner (GP) Harold Shipman and the removal of organs from children at Alderhey Hospital (Davies 1999).

The change in public attitudes towards professionals and the emergence of more informed and potentially demanding patients that may have occurred as a result of these broader cultural processes provide a context
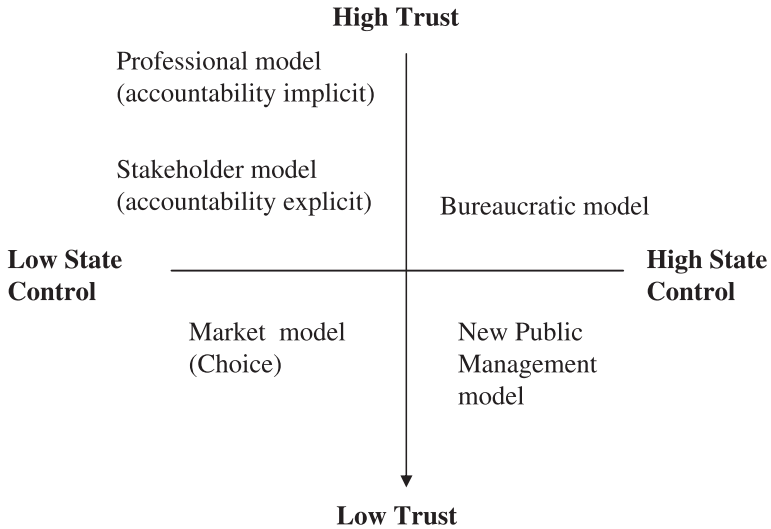
for government policy, which has positioned itself as seeking to make the NHS both more responsive to patients' needs and more efficient. Any change in interpersonal and institutional trust relations can be understood as the natural outcome of these wider changes in both government policy and social attitudes. In this section, we will examine how a variety of policy initiatives, including the introduction of clinical governance and the resulting use of performance management with heightened scrutiny of clinical activity and increasing patient choice and involvement in decision-making regarding their care, may influence trust relations (Rowe and Calnan 2006).

Policy discourses and trust: managerialism, choice and the expert patient

Trust and performance management

The postwar consensus in the UK NHS in which trust in professionalism underpinned the relationships between the public, health professions and the state (Newman 1998) is believed to have been undermined by the growth of consumerism, an erosion of the public service ethos due to the promotion of entrepreneurial values in the public sector (Brereton and Temple 1999), and by political and media portrayals of professional activity as paternalistic. This high trust system of governance has been replaced by the gradual introduction of new public management with its emphasis on regulation, audit and monitoring, which is believed to have brought with it a 'culture' of 'low trust' (Calnan and Rowe 2007; Gilson 2003; Rowe and Calnan 2006) (see Figure 4).

Performance management has been a central mechanism for reforming the way that services are delivered in the NHS in recent government policy. This target-driven approach has been applied to both managerial and clinical domains with the introduction of assessment of clinical activity through the clinical governance initiative aimed at ensuring clinical accountability for the quality of care provided. Increasing managerial monitoring of clinical activity has obvious consequences for trust relationships between providers and managers (Davies 1999). Harrison and Smith (2004) argue that the new policy framework of clinical governance has sought to achieve a shift in focus from trust relationships between people to confidence in abstract systems, such as rules and regulations. The more behaviour is constrained by such systems, so uncertainty is reduced and visibility is increased (Giddens 1990) and the less is the need to rely on trust (Smith 2001). More recent Labour government policy in the UK has returned to the use of market mechanisms of governance to try to secure increased accountability and responsiveness of healthcare providers. Figure 4 illustrates how the type of governance approach can produce different levels of trust and suggests that neither new public management

Figure 4.   The distribution of trust and state control in various models of governance.

High Trust

Professional model
(accountability implicit)

Stakeholder model
(accountability explicit)

Bureaucratic model

**Low State
Control**

**High State
Control**

Market model
(Choice)

New Public
Management
model

Low Trust

techniques nor market mechanisms will necessarily be effective in increasing public trust in the health service (Rowe and Calnan 2006).

Empirical evidence to show whether credible external performance measurements build up confidence in organisations, requiring less trust in them, is not yet available. Those studies that have explored this problem have reported quite negative findings. Goddard and Mannion's (2003) evaluation of the impact of the Clinical Resource and Audit Group (CRAG) clinical outcome indicators in Scotland reported limited use of such data by patients and GPs and also within hospital Trusts. Similarly studies of the use of US report cards have found on the whole that published performance rarely stimulates quality improvement and the public distrusts and fails to make use of it. As Power (1997) argues, the growth of performance measurement and audit may merely result in 'certificates of comfort' offering reassurance that performance is being measured without resulting in change. Where trust is low the reliability of information published may be questioned and any uncertainty in the data and what it means may do little to increase public confidence in healthcare institutions. The perverse incentives that may be generated by performance management systems, in that a system that 'does not trust people begets people that cannot be trusted' (Davies and Lampel 1998, 160), highlights the risk of gaming behaviour in such an approach. Obtaining a performance measure that is credible to providers, commissioners and service users and that enhances confidence in healthcare organisations is particularly pertinent in the context of patient choice (Department of Health 2004a).

Trust and patient choice

Patient choice has moved to the centre of the UK government's pro-
gramme of health system reform, which is well illustrated in the recent
papers on public health (Department of Health 2004b) and adult social
care (Department of Health 2005). However, choice has long been a
problematic concept at least in the arena of health care. Debates have
focused on whether an effective market for health care as a commodity
can be established given the existence of externalities, uncertainty and
information deficits regarding the cost, quantity and quality of care, and
difficulties in entering and exiting the healthcare market (Calnan et al.
1993). A core part of the UK government's initiative is 'choose and book',
which aims to give patients more choice on how, when and where they
receive treatment for elective care (Department of Health 2004b). The
rationale for greater patient choice appeared to be aimed at increasing
the responsiveness of the NHS to service users (Appleby et al. 2003).
Rather than passively trusting GPs' recommendations regarding referral
for specialist treatment, patients would be able to participate in decisions
about where to go for treatment and when.

Instead of negating the need for trust, the individualisation of commis-
sioning through 'choose and book' makes both institutional trust and trust
in specific healthcare practitioners even more salient. Where choice is a
meaningful option, secondary care hospitals may find that their financial
viability may depend on levels of patients' and GPs' trust in them as
institutions. Patient choice will influence financial flows in the NHS as
choice is being linked to 'payment by results' (Department of Health
2003) whereby payment of providers is linked to activity, with money
flowing with the patient. As providers in the USA have experienced,
sustaining trust may be something hospitals need to actively facilitate in
order to encourage patient loyalty and ensure financial survival (Mechanic
and Rosenthal 1999). A patient's trust in their individual GP will be all
the more important, not just for the potential therapeutic benefits, but
because they may rely on them to interpret performance data in making
referral decisions. Data regarding the waiting times and clinical outcomes
of different providers may need to be explained before patients are able
to use such information to make a decision as to choice of referral.

Choice also requires GPs to have increased trust in patients, that they
are able to make an informed decision about where to go for a referral
and in some cases that they will make the referral themselves (if they
decide to book an appointment electronically after their GP consultation).
In a feasibility study of GPs offering choice for routine adult surgical
referrals, Taylor and colleagues (2004) found that there were significant
delays in making the referral while patients considered their options. The
same study showed that only 22% of doctors in the study offered choice
all or most of the time and that most patients still opted for their local

hospital. Research is needed to identify the extent to which patient trust in their local healthcare organisations and in the recommendations of their GP influences choice; such decisions could be an expression of trust as much as an expression of choice. Empirical research is also required to understand how institutional trust can be generated and sustained as the financial viability of secondary care providers may depend on their ability to develop trust building activities with primary care providers and the communities they serve.

Trust and patient participation in disease management

Trust relationships are particularly important in chronic disease management as trust is known to be important for adherence with medical advice in the chronically ill (Lukoschek 2003; Mosley-Williams et al. 2002) and it is considered a core component of effective therapeutic relationships (Dibben and Lena 2003). Successful management of many chronic diseases depends at least as much on changes that the patient can make as it does on specific medical interventions, and as a result requires a partnership between patient and health professional.

Studies have explored the evolving nature of trust relations between clinicians and patients with chronic disease, seeking to identify how trust is built and sustained in the therapeutic alliance (Thorne and Robinson 1988, 1989). Their findings suggest that trust in clinicians depends not just on a provider's demonstration of care and concern for the patient as an individual, it also requires providers to show confidence in a patient's ability to manage their disease (Henman et al. 2002; Kai and Crosland 2001; Thorne and Robinson 1988). Being viewed as competent by a healthcare professional encouraged patients to feel more confident in their ability to control and manage their illness and at the same time increased patient trust in the provider. These findings are highly pertinent to current UK policy, which is encouraging patient self-management as part of its programme to reduce the burden of chronic disease (Department of Health 2004a). In order to stimulate activity in this area, chronic disease management has been identified as key to improving the quality and performance of general practice. This is reflected in the new GMS contract, which includes specific payments for practices to proactively manage patients with chronic disease through its new quality framework (Department of Health 2003). The government's chronic disease management programme has important implications for trust relations: requiring providers to increase their trust in patients' ability for self-care, encouraging more integrated approaches to service delivery between providers involved in disease and case management; and involving managers from primary care organisations who are responsible for assessing and rewarding practices' standards of activity in this area (Department of Health 2002). The success of this policy is of course dependent on patient's willingness and

ability to participate in decision-making, which in turn reflects wider changes in public attitudes and expectations of health professionals and in the social organisation of the provider–patient relationship. These policy initiatives may have implication for trust relations but what of the changes suggested by the medical profession or more specifically its elite representatives?

Professional discourses and the re-emergence of trust

This debate about the decline or not in trust in health care and the medical profession should not be divorced from the wider discussion about the extent to which medical power and authority is on the wane, or that medicine, in the face of recent challenges, has managed to retain its overall dominance (Coburn et al. 1997). Some sociological accounts (Freidson 1994, 2001) of the professionalising strategies of medicine have shown how, at least at the elite or macro level, it is able to respond to or anticipate possible challenges or changes and sometimes use the opportunities to maintain or even enhance its autonomy and control. For example, it has been argued that in the face of threats to autonomy from the new managerialism doctors have been increasingly recruited to management roles (Friedson 1994) and that the restratification of the medical profession into medical elites and the rank and file allows them to control both external forces and tighten internal controls over practitioners (Coburn et al. 1997).

One of the themes that runs through the current policy and to some extent, the professional 'discourses' on trust is that the so-called decline in public trust brought about by scandals, such as Shipman, has proved to be a 'problem' or threat for medicine, which has led to the introduction of tighter mechanisms for regulation and accountability (Calnan and Rowe 2007). However, it is difficult to know how far these changes were forced on the profession (Baker 2004) or whether it, or certain sections of it, may have colluded with the state as it enhanced their project of modernising medicine (Allsop 2006). The 'modern medical professions' representatives appear to have associated themselves with the philosophy of the 'new professionalism' and central to this is a call to the public for a partnership based on mutual trust. The old agreement between the profession, the state and the public founded on self-regulation and paternalism would be replaced with a new one based on patient autonomy and patients' rights, greater accountability on the part of doctors and partnership (Department of Health 2006, 2007; Irvine 2003).

This approach might be seen as another example of a professionalising strategy in that it is a way of heading off any further challenges to autonomy by the state or through the introduction of market principles by emphasising the need for patients to trust doctors to self-regulate and to work together with them. In the past, professionalism and trust were

presumed to be intrinsic to doctors values and the doctor–patient rela-
tionship, whereas now professional bodies or their representatives feel the
need to make them explicit. Similarly, it has been argued (Evetts 2006)
that there is an emergence or re-emergence of both an appeal to
professionalism and trust in sociological theories of occupational control.
Previous critical analysis of professionalism depicted occupations as driven
primarily by self-interest rather than altruism and the need for power,
status and material wealth. Trust was used as a means for duping or
coercing the public into believing in the superior product of scientific
medicine and, thus, enhancing the professionalising project. More recent
theories, according to Evetts (2006), have reconnected trust and profes-
sionalism although the renewed interest in risk and the challenges posed
by a possible decline in public trust.

Other sociological accounts of the link between trust and professionalism
(Kuhlman 2006) have shown how the medical profession have used the
development of external regulation, such as guidelines to reinforce their
professional position. They suggest that the development of the new tools
of bureaucratic regulation, which are signifiers of quality, are actively used
by doctors to build trustful relations with colleagues. They are used as
'public proofs' of quality of their services under conditions of tighter
control and regulation. They are also taken up by patients and perceived
as prerequisites for self-determined decisions and trustworthy relations.
The traditional 'embodied' professionalism is transformed into a 'disem-
bodied' professionalism founded on information. Thus, Kuhlman (2006)
argues that new patterns of building trust are emerging rather than in
decline. On this premise, exhortations by senior leaders within the medical
profession for their colleagues to engage with and lead implementation
of 'clinical governance' may be interpreted as a further way of clinicians
seeking to protect their power base. Clinicians may be more explicitly
accountable for the quality of care they provide but they continue to
define what quality is, how it is to be measured and how the results can
be interpreted.

Theoretical framework for explaining trust relations in the 'new NHS'

The framework (see Table 1) is based on the proposition that changes in
the organisational structure of medical care and the culture of healthcare
delivery have changed the experiences of health care for individual
patients and affected trust relations between patients, providers and man-
agers. These changes have in part been initiated by healthcare professionals
or their representatives, in part by the government, with clinical govern-
ance requirements that benchmark clinical performance, and in part by
patients or patient groups (Baggott et al. 2005), some of whom wish to
be equal partners in treatment decisions. It is not proposed that these

changes have cumulatively achieved a shift from trust in people to confidence in abstract systems. The provision of health care is still characterised by uncertainty and risk and there is evidence that not only are patients sceptical of institutional confidence building mechanisms, such as performance ratings, but that interactions between managers and clinicians continue to rely on informal relations and unwritten rules rather than performance management (Goddard and Mannion 1998). Rather, it is proposed that new forms of trust relations are emerging in this new context of healthcare delivery, reflecting a change in motivations for trust from affect based to cognition based trust as patients, clinicians and managers are encouraged to become more active partners in trust relations.

It is proposed that provision of information and greater patient involvement in their care, through the attempted shift towards shared decision-making in doctor–patient relationships, has produced greater interdependence between patients and clinicians. Certainly, in the context of primary care embodied trust (Green 2004), arising out of an enduring relationship with the 'family doctor' may be less relevant not least because of the structural changes that may have increased the range of points of access to primary health care and reduced the opportunities for continuity of care. For some patients, as their case may be provided by an increasing range of healthcare professionals, professional and educational credentials and status may no longer be sufficient guarantees that an individual clinician will provide the standard and type of care they want. It is possible that they may trust nurses or therapists to be competent in certain aspects of their care but for other aspects to insist on seeing a doctor.

How can informed trust (see Table 1) be characterised from a patients perspective and in what ways would it differ from patients' perspectives on embodied trust? There are a number of possible dimensions. One is clearly in the area of decision-making where there would be an increasingly active patient involved in decision-making, who might expect doctors to trust his or her ability/competence to self-manage compared with the more passive and deferent role associated with paternalistic medicine. The second dimension involves the use of information. Informed trust might be associated with the use of information to calculate whether trust is warranted whereas with 'embodied' trust information may have been valued for the respect it shows rather than its content. In this way, patients may display a more rational response rather than emotive response to information. Thirdly, perspectives may differ on the willingness to take risks in that informed trust may involve the patient carefully weighing up the situation whereas embodied trust may involve the patient basing their judgement on the reputation of the organisation or individual. Finally, embodied trust implies that a clinician's altruism is unquestioned and the other party is well intentioned. This may be contrasted with informed trust where the patient may express greater suspicion and scepticism about 'others' intentions.

Table 1. Conceptual framework for explaining trust relations in the new NHS

Relationship	Trustor		Trustee		Context	Type of trust
	Affect based	Cognition based	Reputation based on status	Reputation based on performance		
Traditional clinician–patient	X		X		Paternalistic medicine	Embodied trust
Traditional clinician–clinician		X	X		Autonomous self-regulation/ hierarchical	Peer trust
Traditional clinician–manager	X		X		Prof autonomy/expertise	Status trust
New NHS clinician–patient	X	X	X	X	Expert patient	Informed trust
New NHS clinician–clinician		X		X	Shared care	Earned trust
New NHS clinician–manager		X		X	Clinical governance	Performance trust

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This shift towards informed, conditional trust may also depend on the patients circumstances, needs and preferences and the context in which care is provided. For example, in Mechanic and Meyer's study (2000), patients with illnesses such as breast cancer were more likely to describe their trust relations as being unconditional than those with Lyme disease who had experienced difficulties in obtaining a diagnosis. Trust relations are also dynamic and may change during the pathway of care. For example, Thorne and Robinson (1988) reported that patients went from a naive, unconditional trust in diagnosis through to a more conditional, negotiated relationship as their treatment became more established. Similarly, the nature of trust relationships and the balance between affect and cognitive-based trust may vary according to the social position of the patient. The ability to adapt this more 'active' stance may depend on the extent to which patients have access to appropriate resources (finance, time, energy) to do it (Gilson 2003). It might also be argued that all trust relationships have a conditional element to them and that traditionally there has been widespread ambivalence about scientific medicine and medical practitioners (Calnan et al. 2005). The suggestion here is that conditionality has now become more explicit.

For GPs and hospital doctors, trust relations (see Table 1) may have changed between themselves and in their relations with other practitioners as the health service has emphasised the need to be primary care led and other healthcare professionals have become responsible for delivery of services, creating new relations in which trust has to be earned through collaboration rather than relying on peer trust. Thus, 'earned' trust might be characterised by: an individual clinician's authority and reputation being based on their proven skills and competence, and being up to date with medical technology; there may be some limits to clinical freedom with trust gained by following agreed team-based protocols; successful relations between clinicians would be based on mutual respect for their different competencies and knowledge; and communication skills and providing information would be important in building trust. This stands in marked contrast to more traditional relations of 'peer trust' where an individual clinician's authority and reputation are based on their position in the medical hierarchy, personal networks and word-of-mouth recommendation. Hierarchical relations dominate as clinical freedom is unquestioned as are senior clinician's views and decisions, performance is self-regulated and successful relations between clinicians are based on conforming to traditional roles. Trust may be generally higher between clinicians of the same profession and specialism.

Finally, what of the changes in trust relations between managers and practitioners created primarily by the government's clinical governance policy. We argue that this has led to a change from a relationship characterised by status to one characterised by 'performance' (see Table 1). The former might be depicted as a one-way relationship with clinicians having

little need to trust managers where as managers have to trust clinicians. A clinician's authority relates to their position and role within the organisation and managers act as administrators, trusting strategic decisions as to how services are to be delivered and how resources are to be used to clinicians. There would be minimal monitoring of activity and managers would not be involved in such assessments. In contrast, performance trust might involve a two-way relationship as clinicians need to work with managers to secure resources and to develop services and managers have to work with clinicians to achieve their performance goals and to meet government targets. A clinician's authority would be related to their involvement in managerial activity, their ability to meet targets as well as their position within the organisation and clinical skills. Trust would be important in successful clinician–manager relations as it reduces the need for monitoring and may produce greater job satisfaction, higher staff retention and more efficient organisational performance.

This general typology of trust relations outlined in the framework (see Table 1) suggests that trust relations in all three types of relationship in the 'new' modernised NHS might, in general, be particularly characterised by an emphasis on communication, providing information and the use of 'evidence' to support decisions in a reciprocal, negotiated alliance (Rowe and Calnan 2006).

An agenda for future research

Trust in different healthcare relationships

Most of the research relating to trust in healthcare contexts has focused on patients' trust in health professionals. However, the trust that patients (and more broadly members of the public) express and place in healthcare teams, healthcare provider organisations, healthcare practitioners and possibly broader systems of healthcare financing, provision and regulation, may also warrant more attention than they have been paid to date. A better understanding of the relationships between the trust that people place in individual healthcare professionals and in healthcare organisations, professions or systems might be important to facilitate understanding of the various claims and counter claims that are made about the so-called erosion of public trust in medicine and other healthcare institutions (Calnan et al. 2006).

Questions also need to be asked about how expressed trust in healthcare organisations and professions are shaped by personal experiences, media reports about health services and other factors. For example, are people who have direct experiences of health service use more trusting, and does this depend on their satisfaction with their healthcare experiences? Are the levels of trust expressed by those who do not have significant experience of health service use shaped by what they see or hear in the media?

Is and if so how is trust in healthcare organisations and systems related to the ways in which health care is financed and organised? Does this and how does this vary according to individuals' status, political opinions and loyalties?

Differences between the levels of trust that people express in individual and institutional healthcare providers raise further questions about these issues. Hall (2006) offers a number of possible explanations for the higher levels of trust that American patients and/or members of the public express in individuals. First, people typically have stronger trust in individuals than in professional systems or organisations. Second, people are generally inclined to have an optimistic view of themselves and their personal relationships. This is particularly important in the context of health care because of the patients' position of vulnerability. Third, it could be a methodological artefact, reflecting a form of cognitive adjustment or social desirability bias in responses to questions about trust (there are several reasons why it may not be in patients' interests for them to express displeasure with their own doctors). It might even reflect a selection bias (because patients might switch doctors until they settle with one that they trust). Another possible explanation is that trust in individual health professionals may have a stronger affective component that trust in healthcare organisations, which may reflect a more critical evaluation and a greater emphasis on the cognitive element of trust.

Trust relationships between healthcare providers, for example, in the NHS between general practitioners and hospital doctors, and between clinicians and managers, also appear to have been under-researched. It is not clear why they have been neglected, although one possible explanation is that the relationships are not seen to be problematic or important in terms of consequences for care. Such an assertion is contradicted by (Gilson 2006) who suggests that managers' treatment of providers can affect providers' treatment of patients, and that managerial behaviour and practices set the rules and norms that shape provider behaviour. Gilson argues that manager–provider relationships will be particularly important for low- and middle-income countries, where issues of human resource management in health services has virtually been ignored to date.

In the UK, changes in manager–provider relations arising from recent clinical governance initiatives and the developing roles of clinical managers will make research into trust between managers and providers and its potential impact on quality of care highly pertinent. The strains and tensions between GPs and hospital doctors, and doctors and managers, have been well documented, but questions about the implications of trust, or the lack of it, is in these relationships have yet to be answered.

The implications of trust

The second theme for future research (Calnan et al. 2006) focuses on the implications of trust for important healthcare processes and outcomes.

Although trust may have an intrinsic value, interest is more often focused on its possible instrumental value. The implications of trust may be extremely far-reaching. For example, as Gilson (2006) suggests, trust relations between citizens and health systems may, in some contexts, provide an opportunity to build civic trust with a much wider social value. More usually, considerations of the implications of trust focus on questions about whether and how trust relations impinge on healthcare outcomes. These questions can be asked about trust relations between patients and their healthcare providers (at both micro and macro levels) and about trust relations between healthcare professionals within healthcare organisations.

It is still not clear whether particular forms and levels of trust between patients and their healthcare providers have benefits for patients in terms of improved clinical and health status outcomes, and if so, how these effects might be mediated. Entwistle and Quick (2006) highlight the uncertainty about whether and how patients' trust in their healthcare providers might in practice make them more or less likely to be vigilant about the possibility of errors in their health care, and thus more or less susceptible to iatrogenic harm. Also as has been suggested, the trust that patients place in healthcare providers may be more or less active and informed, with potentially different consequences for the kinds of choices and contributions that patients are able and willing to make in relation to their health care, and thus to their healthcare outcomes. These and other possible pathways between trust and health, including the possibility that trust has direct therapeutic benefits and is key to the placebo effect, need to be examined. Some of the potential dangers of blind trust have been identified and in some contexts lower levels of trust may be both understandable and appropriate. However, the key questions are what levels and types of trust contribute to positive health outcomes and effective healthcare delivery and whether positive outcomes for the organisation are compatible with positive outcomes for the patient and the clinician. This is linked to the question raised about what kind of trust relations are compatible with empowerment or whether these two concepts are at odds with one another.

In terms of trust relations among and between healthcare professionals and managers within healthcare provider organisations, there are important questions to be investigated about the relationships between trust and performance, and particularly trust and the implementation of changes to organisational structures and approaches to healthcare delivery. Organisational research in other settings has shown that trust is important for group cohesion, team working, job satisfaction and organisational efficiency, but questions about the ways in which trust might contribute to the effectiveness of health service provision, and how it might be built and sustained, have been relatively neglected even though they are highly salient for health service managers.

The role of trust in the context of efforts to implement changes in service delivery and/or the introduction of innovative technologies also warrants assessment. Questions arise, for example, about the formation and implications of trust in local 'product champions' and other 'brokers of change and knowledge', and in other sources of information and advice, including the kinds of summaries of research findings and clinical practice guidelines that are disseminated as part of the drive towards evidence-based practice. There are also still questions to be asked about whether and how things other than persons might be trusted, and how trust in these is mediated by interpersonal contact.

Complaints from patients have sometimes been used as an indicator of the performance of healthcare organisations and this raises questions about the relationship between trust, medical errors and complaints. Is there a linear and simple inverse relationship between trust and complaints, i.e. a high level of complaints reflects a low level of trust, or as with patient satisfaction, is the relationship more complicated? There is a need to examine in what contexts mistakes lead to a loss of trust or even intense blame and when errors are forgiven. There is also the more broader question about how the nature of complaints and their presentation affect public levels of trust in the medical profession as an institution and the wider health system (Allsop 2006).

Contexts and circumstances

The third theme (Calnan et al. 2006) examines the importance of contexts and circumstances in influencing the salience, domains, levels and appropriateness of trust. Questions need to be asked about whether and why different relationships of trust are found in different clinical and organisational settings. For example, how important are trust relations in primary care compared with hospital and secondary care? Have innovations in service delivery in the UK, such as walk-in clinics and specialist open access clinics in primary care undermined patient–clinician trust relations, traditionally claimed to be based on continuity of care and associated with general practice. Another key question is whether trust relations are more important and/or different for different clinical conditions and in different clinical settings. Successful management of many chronic diseases (e.g. diabetes) appears to depend at least as much on changes that the patient can make as it does on specific intervention, as a result it is believed to require mutual cooperation and participation and a 'partnership' between patient and healthcare practitioner. In other contexts, where there is considerable uncertainty about outcomes such as the treatment of cancer, patients may take or have to take a more 'passive' role and higher levels of trust or different trust relations may emerge. Trust may be particularly pertinent for patients with mental health problems with concerns about confidentiality because of the stigma and because

the trusting relationships may be the actual modes of treatment (e.g. psychotherapy) and therefore may be critical to therapeutic outcomes.

The context of chronic illness appears to raise a further set of issues which relate to trust. The enhanced knowledge, experience and expertise of some people with chronic illness may increase their awareness of both the benefits and the risks and limitations of modern, scientific medicine and technology. Consequently, they may have an increased awareness of the possible risks and harm of certain orthodox medications and, possibly inclined to be attracted to and trust in complementary treatments that are perceived as less harmful and safer because they are more 'natural'. This is particularly salient where discreet pathology is more elusive such as with some chronic illnesses.

The discussion in the above about the attractions of complementary medicine shows how it is sometimes difficult to disentangle beliefs about trust in scientific medicine from beliefs about trust in medical professionals. However, a more 'straightforward' example is the debate about MMR that has been amplified in the media (Hobson-West 2007). The focus here was on confidence in the 'scientific' evidence as well as trust in the purveyors of this evidence. Are government sources of evidence more trustworthy than professional sources? Other technologies also have implications for issues of trust such as the developments in molecular genetics and the increased use of genetic testing and therapy and the use of DNA, which have implications for trust relationships not only between the patient and clinician but also between family members. These technologies capacity to intervene at a fundamental level of human biology has given rise to increased awareness of risk and uncertainty about the consequences of such interventions and specific concerns about ethical issues and the social implications of the new genetics.

What of the diverse social and economic circumstances in which people live and their possible impact and consequences for trust relations? Does gender, socioeconomic status or age of the patient influence the nature of interpersonal relations with clinicians? For example, evidence from research into patient satisfaction shows the most consistent pattern of relationships between satisfaction and indices of social position is for age, i.e. satisfaction levels with healthcare increase with age and the relationship is a linear one with the most marked increases occurring in their 50s. There are a range of explanations for this, but is this pattern also evident in the case of trust? (Allsop 2006).

There is also the broader question of how trust relations in health care compare with those in other sections of welfare and public sector services. Have the unique characteristics of the healthcare setting proved more resistant to organisational and social change that may have eroded or changed trust relations in other settings or is 'conditional trust' now common in service provision throughout the public sector? There is also the question of whether trust is still as politically salient now as it was in the late 1990s. The current direction of UK government policy with its

emphasis on individual choice and the marketisation of public services may have a cumulative negative impact on social capital through its influence on citizenship and participation and intra–agency and interagency cooperation. This returns us to the question of the nature of the relationship between interpersonal and institutional trust and whether in the context of patient choice of provider healthcare managers will perceive a value in fostering public trust in their organisation and the clinicians they employ. In this context, the potential financial implications of consumer choice may increase the salience of trust and may stimulate research to better understand the nature of institutional trust and how it links to the individual patient's experience of clinical care.

Conceptualising trust

Finally, research investigating trust will depend on the way it is conceptualised (Calnan et al. 2006). Hence, the fourth thematic area involves the conceptualisation of trust and how differences in the way it is conceptualised may have important implications for how to operationalise and measure it. A distinction can be made between beliefs and behaviour or felt and enacted trust and the nature of the relationship between the two needs to be explored empirically. The latter concept might have limited explanatory value, at least in this context, as it may be influenced by elements not directly related to trust. There are a number of methodological questions about the design and methods to be used when investigating trust in empirical studies, not least of which is whether trust should be measured in similar ways across settings.

A conceptual framework for examining changing trust relations in the NHS in the UK derived, in part, from a sociological analysis of the implications of recent policy and professional discourses has been proposed. This can be contrasted with Robb and Greenhalgh's (2006) analysis of narratives of interpreted consultations in primary care, which is also informed by sociological theory, in this case critical theory. They begin to tease out the relationship between institutional and interpersonal trust through the use of three concepts of trust: voluntary, coercive and hegemonic, which they argue apply to both the macro and micro levels. Central to their theoretical approach are different dimensions of power that they argue can be both identifiable and invisible. They draw on Weberian concepts of bureaucracy and Habermasian concepts of communicative and strategic action to develop their typology and suggest voluntary trust at both interpersonal and institutional levels is or would be associated with a more open communicative strategy in the interaction in the consultation. The three types of trust were found to exist in different components of the triadic relationships but coercive and hegemonic trust dominated which had an impact on the nature of communication that tended to be strategic and on the outcome of the consultation. Their

analysis raises the question about how 'informed' or 'conditional' trust will manifest itself in the clinician–patient relationship given the prevalence of coercive and hegemonic trust rather than voluntary trust. This question needs to be further explored in other clinical and organisational settings with patients from different backgrounds.

This paper illustrates and reflects the range and body of conceptual and empirical research that has addressed trust relations in health care and has suggested how and why trust relations may have changed. However, it clearly shows that there are still major gaps in empirical research and fundamental conceptual and methodological issues that still need to be addressed. This concluding section has summarised some of the questions that still need to be addressed.

Short Biographies

Michael Calnan is a medical sociologist and has worked in health policy and services research and training for over twenty years. His most recent post was Director of the Centre for Health Services Studies at the University of Kent and he was also Course Convenor for the MA in Health Studies, and is currently Professor of Medical Sociology at the University of Bristol. Michael has published extensively in journals, chapters and books about a range of health-related issues and his books include '*Health and illness*: *the lay perspective*', '*Going private*: *why people use private health care*', '*The prevention of coronary heart disease*: *prospects, politics and policies*' and '*Work stress: the making of a modern epidemic*'. His current research interests include: diffusion and innovation in health care and technology, comparative health care systems, trust in healthcare and ageing and health and social care.

Rosemary Rowe is a Research Associate in the Department of Social Medicine at the University of Bristol, currently undertaking research into trust, how it is built and maintained, and its impact in health care settings. In 1999 she received an MSc in health policy and health economics from the London School of Economics and in 2003 was awarded a PhD by the School for Policy Studies at the University of Bristol for her study into governance and accountability in Primary Care Groups and Trusts. In 2003 she was Visiting Lecturer at the Milano Graduate School for Health Policy, New School University, New York. In addition to her current work she has two other key research interests: the changing nature of medical professionalism and the impact of quality initiatives on standards of care, clinical autonomy and the delivery of health services.

Note

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