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# Changing Medical Organization and the Erosion of Trust

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MEDICINE HAS LONG BEEN ONE OF OUR MOST trusted social institutions. The profession recognized early in its history that public trust was one of its greatest assets, a resource that allowed it to define the scope of medical work and increase the political and clinical autonomy of its practitioners (Starr 1982). The profession achieved this by setting and enforcing high standards of medical and postgraduate education, by promulgating ethical standards that protected the interests of patients, and by controlling entry into the profession (Freidson 1970). The American hospital, developed under religious stewardship and viewed historically as an institution that worked for the public interest, also became a valued community resource (Rosenberg 1987; Stevens 1989).

In recent years, all social institutions, including medicine, have fallen from the public trust (Lipset and Schneider 1987). Confidence in medicine still ranks higher than in education, television, major companies, and Congress, for example (Kasperson, Golding, and Tuler 1992), but confidence in medicine's leaders has fallen from 73 percent in 1965 to 22 percent in 1993, which compares with the degree of trust felt for leaders of other social institutions (Blendon et al. 1993). This trend parallels a general decline in public trust, marked by the proportion of

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the public that says most people can be trusted falling from 58 percent in 1960 to 37 percent in 1993 (Lipset 1995).

Numerous explanations have been offered for this decline: the cynicism and challenge to expertise resulting from the Vietnam war; the broad and pervasive influence of television and other media on public opinion; the fragmentation of community; the widespread dissemination of information on political and other violations of public trust; and the restructuring of the economy. These general trends have affected trust in medical institutions, but changes in medicine itself also exacerbate the problem. The health sector is increasingly managed by for-profit corporations, which present medicine as a marketplace and view patients as consumers. Although there are many responsible companies, others seek quick profits and engage in dishonest practices like deceptive marketing, kickbacks, and corporate self-dealing (Rodwin 1993). New and unfamiliar arrangements for financing and managing care and new types of incentives that affect how physicians work increasingly place the interests of patients and doctors, and of doctors and insurance programs, in direct conflict (Rodwin 1993).

The situation is made more difficult by tightened restrictions on patient choice. Employers frequently choose insurance for their employees. Facing cost pressures, many employers have constrained employee options and embraced managed care approaches. Managed care in the form of HMOs and utilization management is pervasive, often restricting patients' choices. The need for management of care is undeniable, but limits on allowing patients to change doctors or plans easily when dissatisfied encourages lack of trust. Choice is wisely perceived not only as a personal preference but also as an organizational asset, in that it protects plans against disaffected and complaining patients. Some HMOs historically have welcomed multiple-choice options as a way of allowing patients to select plans that are consistent with their tastes, thus protecting themselves against dissatisfaction and distrust (Saward, Blank, and Greenlick 1968).

Other influences also challenge trust as we have known it. Patients are better educated, and the mass media provide abundant medical information both on new treatments and on physician and hospital errors. Patients are now more aware that some doctors make referrals to laboratories and diagnostic facilities in which they hold a financial interest and that others sign managed-care contracts containing "gag rules." They are urged to be thoughtful and skeptical consumers, ready not

only to question their medical treatment but also to scrutinize their medical and hospital bills for signs of fraud and to challenge abuse by their caretakers. Better educated and more sophisticated patients can contribute to meaningful doctor–patient relationships, but some of the information now readily available raises doubts and feelings of insecurity about the motives and behavior of medical providers and institutions.

### A Note on the Concept of Trust

To say we trust is to say we believe that individuals and institutions will act appropriately and perform competently, responsibly, and in a manner considerate of our interests (Barber 1983). Although we can test the likelihood of expected behavior in a variety of ways, we have no firm way of knowing the future; thus trust is always accompanied by risk (Luhmann 1989). Trusting is a function of personality traits, the characteristics of the person or entity to be trusted, and the context in which the interaction occurs (Earle and Cvetkovich 1995). Trust is dynamic and fragile, easily challenged by a disconfirming act or by a changing social situation. Slovic (1993) provides empirical support for the view that trust is particularly fragile because negative events are more visible, they carry greater psychological weight, they are perceived as more credible, and they inhibit the kinds of experience needed to overcome distrust.

In this discussion I will address two levels of trust: interpersonal and social. Trust in persons is an intimate form, deriving from earlier experiences with family and other caretakers. Trust forms early in life based on emotional bonds and amplified cognitively over time, and it is one that has important psychological connotations. The most enduring trust relationships are found in families, love relationships, intimate friendships, and other primary-group associations. The doctor–patient relationship often reflects aspects of these bonds and contains strong elements of transference, particularly during times of critical illness when patients are vulnerable and frightened. Social trust, in contrast, is more cognitive and abstract, and typically is based on inferences about shared interests and common norms and values (Kasperson, Golding, and Tuler 1992).

This distinction between interpersonal and social trust is a simple way of characterizing a more complex reality, but empirical research

rarely allows us to generalize about more subtle variations. Interpersonal trust refers to several different dimensions that may be more or less consistent. Patients, for example, may trust the competence of their physicians but be less convinced of their personal commitment or caring. Or they may feel secure in their doctor's commitment to their welfare while doubting his or her competence or control over decision-making (as may happen in some managed care situations). Similarly, institutional trust can be divided into a generalized abstract sense about institutions, like the "health care system" or the "medical profession," and concrete perceptions about institutions with which patients have had experience, like their HMO or community hospital. In the latter case, trust may be cognitively differentiated according to types of personnel or performance. For example, patients may understand that their hospital is excellent for cardiovascular services but poor for urology or psychiatry. Thus, we may trust individuals and institutions in some ways but not in others. Trust is shaped both by media images and by personal experiences. This explains how we can distrust medicine or Congress but trust our doctor or congressman (Blendon and Taylor 1989; Parker and Parker 1993).

Although social and interpersonal trust are separate concepts, they are correlated and mutually supportive (Parker and Parker 1993). High trust in an institution transfers to unknown personnel, and we assume that a highly respected and well-run institution selects its professionals carefully and appropriately supervises and monitors them. Similarly, our trust in doctors and nurses often generalizes to their organizations and affects our willingness to bring our custom to them. Organizations tend to understand these relations and often try to assure the public of the quality of their selection processes and personnel while monitoring their personnel to assure appropriate standards of performance (Schlackman 1989).

Life is impossible without trust, and even the most cynical must depend on it. Trust reduces complexity and the need to plan for innumerable contingencies. Contracts, laws, and other regulatory devices substitute for trust, but even highly formalized systems cannot plan for every contingency and must depend to an important degree on trust. To the extent that high trust can be sustained, it is efficient and reduces the need for costly arrangements. Distrust, therefore, as Luhmann has observed, is not the opposite of trust but is more accurately a functional

alternative (Luhmann 1989). Distrust is costly in terms of personnel, monitoring time, and emotional energy.

The downside of trust is risk. Given real variabilities in performance among institutions and professionals, to trust excessively is to endanger oneself. As Hardin (1992) notes, trust can “be stupid and even culpable,” leading to dismal results and even quick destruction. Finding the proper balance between trust and distrust, and the appropriate and constructive vehicles to hold institutions and professionals accountable under uncertainty, are particularly challenging tasks. Patients arrive at this balance iteratively, as they experience the doctor–patient relationship over time. By building strong relationships with patients, doctors capitalize on their potential to achieve cooperation under uncertainty (Cassell 1995). Institutions whose relationships with their patients are more impersonal seek to enlist trust by building their reputations and by establishing programs for patient participation in decision-making, quality assurance review, and responsiveness to issues of patient satisfaction.

### Factors Contributing to Trust

Social trust of medical institutions reflects the general attitudinal trend in a society and the public’s optimism or pessimism (Lipset and Schneider 1987). While social trust is an attitude substantially shaped by media exposure and current events, interpersonal trust is based primarily on social interactions over time. Interpersonal trust builds on the patient’s experience of the doctor’s competent, responsible, and caring responses. High levels of interpersonal trust can contribute to social trust as well. Medical institutions increasingly advertise to build their public visibility and reputation, but medical leaders understand that the quality of care, and how it is perceived, is critical to their survival.

Physicians commonly link trust to continuity of care, and properly so. New doctor–patient interactions are like other new relationships, in which people use available cues to anticipate the other person’s values and likely responses (Thibaut and Kelley 1986). Initially, the doctor’s attentiveness, responsiveness, patience, and general demeanor give the patient a sense of what to expect (Roter and Hall 1992). Other cues may be inferred from the quality of the practice setting, the doctor’s insti-

tutional affiliations, and feedback from other patients. But initial cues are only rough guides to what lies ahead and are only perfected over time as doctor and patient become better acquainted and test the relationship.

Trust can be disconfirmed at any time, even after many years. Although patients discount small lapses because they appreciate that doctors, like others, can have good and bad days, a serious failure to be responsive when needed can shatter even the strongest of relationships. Verghese (1994), in his account of practice in a small town in Tennessee, describes a family that was shocked and appalled when their family doctor, after a close relationship of many years, refused to care for their son who had AIDS. Unless they are seriously ill, people have little opportunity to test the validity of their trust in doctors because of the routine of most medical practice. Typically, the test comes during crises when doctor and patient are already launched on a trajectory of care. People with critical illnesses depend most strongly on their doctors (Cassell 1995), and strong relationships help them to deal with frightening uncertainties.

Trust is multidimensional, and some aspects are more easily tested than others. Patients have little difficulty judging whether they are comfortable with the doctor's manner, whether the encounter is one in which they can disclose private feelings, whether meaningful feedback and useful instructions are elicited, and whether doctors convey a sense of caring (Roter and Hall 1992). They learn less quickly about the doctor's level of dedication and whether the doctor will behave faithfully and responsibly during a time of need. Competence is most difficult for patients to judge, although they often make attributions about this quality based on how doctors proceed in their assessment and physical examination and whether their treatment develops as expected. Trust tends to operate globally, but it can be undermined by evidence of failure on any of its important dimensions.

When they trust, people seek credible cues that such confidence is merited. Physicians who seek to behave competently, responsibly, and in a caring fashion often simply do not know how to convey these attributes in short, episodic encounters. Trusting responses are part of a caring technology that can be taught and even built into the organization of practice in both outpatient and hospital settings (Scott et al. 1995). In a recent communication to his medical staff, the chief medical

officer of a major university teaching hospital suggested that physicians give their undivided attention to patients during the first 60 seconds of a visit in order to convey the impression of willingness to spend time with them. He also advised doctors to communicate at the same physical level as the patient (sitting on the bed, for example) and to respond quickly to patient requests. He suggested that they be specific about what is likely to happen and what is expected of the patient, that they write instructions even for simple advice, and that they consider pre-surgical and follow-up phone calls. These, of course, are no substitute for competence and responsibility, but they help caring doctors convey their concern to the patient.

Trust is typically associated with a high quality of communication and interaction. Good communication increases the likelihood that patients will reveal intimate information and stigmatized conditions, that they will cooperate in treatment and adhere to medical advice, and that they will be open to suggestions about adopting health-promoting behavior, all goals that are important to the emerging health care agenda. Moreover, good communication is linked to shorter hospital stays, improved medical outcomes, and positive physiological changes (Roter and Hall 1992). Trust provides a context in which doctors and patients can work cooperatively to establish care objectives and to seek reasonable ways of achieving them. Eroding social trust in medical institutions forms a threatening backdrop to doctor–patient relationships, but the strength of patients' personal trust in their doctors has until now provided considerable insulation against serious conflict.

## Challenges to Trust

Emerging structures of care carry the implicit message that the patient must be on guard in the medical marketplace. Managed competition is structured so that patients choose among competing health care plans for their price, coverage, and amenities on the assumption that consumers seeking a best buy among competitors induce greater efficiencies among care providers. Although there are many benefits in this type of competition, its implicit message nevertheless is that medical care resembles other commodities and services and that one must be a prudent purchaser. While the change from “patient” to “consumer” may seem



little more than a figure of speech, it is one that suggests a significant change in how we think of health professionals and medical transactions.

A serious challenge to trust comes from the growth of for-profit medicine and the commercial aggressiveness of the medical-industrial complex (Relman 1994). Increasingly, individuals making major social decisions about health and medical care are managers whose background in medicine is limited. When corporations that deliver medical care are primarily motivated to bring generous returns to their stockholders, and when a significant proportion of the medical care dollar goes to investors rather than patient care, then people are inclined to question the motives and decisions of these organizers and providers of care. As provider organizations seek to become more efficient and to reduce expenditures, they introduce incentives that make professional rewards dependent on withholding care, thereby placing the interests of patients and doctors in direct conflict (Hillman 1987). "Gag rules" that limit physicians' ability to discuss these arrangements and treatment options with patients help kindle public distrust (Woolhandler and Himmelstein 1995; Pear 1995).

Some economists and sociologists dismiss the significance of such trends in the belief that dependence on trust in the profession is naive and not in the patient's interest (for example, see Zola 1990). They see trust as a barrier because it allows medicine to define the health paradigm, to dominate the medical division of labor and other health occupations, and to reinforce the medical authority and economic position of doctors and hospitals. They believe that patients should be active and aggressive seekers of information rather than depend on physicians and hospitals to provide it. Their ideal is an active patient who shops among possible providers, who defines her treatment needs and participates actively in treatment, and who is willing to challenge the doctor and take responsibility for her own treatment decisions. Activism is not a bad idea, but it is an illusion to believe that it can reasonably substitute for trust. As Arrow (1963) noted in his classic discussion of the medical marketplace, trust is needed because in much of medical care the activity of production and the product are identical.

The context of medicine has changed dramatically. There are now extraordinary amounts of information about new treatments and medical possibilities. Television, newspapers, and magazines provide enormous coverage to the latest medical advances, quickly reporting the

most recent research findings from the *New England Journal of Medicine*, the *Journal of the American Medical Association*, and other major journals. Texts and reference books initially meant for physicians can be found in any large bookstore, and massive amounts of medical information are easily available by surfing the Internet. We know little about how all this potentially conflicting information is digested, but it seems inevitable that the public will be better informed, more aware of uncertainties, and more skeptical of expert opinion. Applied thoughtfully, such knowledge can lead to a strong and meaningful therapeutic alliance. Unwisely applied, it is an additional disruptive force in medical relationships.

### Managed Care and Trust

Several emerging trends suggest that interpersonal trust will be under assault in coming years. The largest threat comes from increasingly prevalent physician incentives that create opposition between doctors' and patients' interests. When significant proportions of the individual doctor's income depend on meeting goals of reduced utilization, the fiduciary relationship between doctor and patient and the credibility of the doctor's role as the patient's agent are threatened. Although the general public is generally aware of some of the alleged difficulties of managed care, relatively few know the extent of these remunerative arrangements and the degree to which their own doctors are governed by such incentives. Information diffuses slowly, but inevitably patients will become better informed about this situation. Patients are already uncomfortable with the idea that the physician may weigh their needs and interests against the insurance program's budget (Mechanic, Ettel, and Davis 1990). But new arrangements are even more discomfoting. Proposals have been made to require physicians to inform their patients about such arrangements and about their ties with other medical profit-making entities to which they refer. This may make patients better informed, but it is unlikely to enhance interpersonal trust.

Perhaps a more damaging aspect of managed care is the push toward greater efficiency and more tightly scheduled doctor-patient interactions. The quality of medical encounters and trust depends on a relationship evolving between doctor and patient. More time also allows for patient instruction, greater participation in treatment choices, and op-

portunities to give and receive feedback. While the instrumental aspects of care can probably be achieved in short encounters, pressured interactions inhibit patients from revealing concerns and doctors from responding appropriately. Although good data are not available on how time is allocated in varying types of managed care, data from earlier studies show that fee-for-service doctors allot more time to patients, allocate time differently, and typically work longer hours than those on capitation or salary (Mechanic 1975; Freeborn and Pope 1994). To the extent that managed care truncates the encounter, it will have an impact on trust.

The effect of managed care on continuity of care is unclear. In theory, patients in HMOs choose or are assigned to a primary care doctor, who is their link to the system and a gatekeeper to other services. In reality, HMOs often limit available physicians, so that patients have to wait for an unacceptable amount of time to see their designated primary care physician when they feel they need care. Patients often have the option of seeing a doctor on call more immediately, and many do so. To the extent that this is a prevalent practice, it interferes with continuity and the maintenance of a strong trust relationship (Mechanic, Weiss, and Cleary 1983; Freeborn and Pope 1994). Some HMOs have recognized this problem and have taken measures to minimize it.

## Building Social and Institutional Trust

Social trust is influenced by performance in a variety of ways, but even one, or a few, visible failures to conform to community expectations in some important way can undo years of dedicated service (Kasperson, Golding, and Tuler 1992). Trust is built slowly by the aggregation of positive experience. Effective, visible crisis management in the public interest can reinforce trust, as Johnson and Johnson's handling of the Tylenol tampering incident demonstrated. Although in the short run the steps taken by the company were costly, the fact that executives responded quickly to protect the public contributed to social trust and the company's reputation. A respondent at the Oklahoma Medical Center to my inquiry, discussed later, similarly suggested that public trust in the medical center increased as a result of its effective response to the 1995 bombing incident.

Building trust is an uphill battle in an environment of fierce competition for resources and a general climate of social distrust. With the failure of health reform, cutbacks in health entitlements, and growing neglect of a significant proportion of the population that is uninsured or significantly underinsured, resentments feeding distrust are likely to increase. Distrust increasingly also is evident in previously protected areas like medical research and clinical trials following highly publicized incidents of dishonesty and fraud.

Recognizing the limits to what any institution could do to build trust, I thought it important to learn what I could about initiatives taken by medical institutions in their own communities to maintain and enhance trust. I was aware of some significant efforts, but in a country as varied as the United States many innovative and worthwhile initiatives are not visible. As a consultant to the Commonwealth Foundation, I was aware of the Picker–Commonwealth effort to build patient-centered programs in hospitals (Gerteis et al. 1993) and to assist young physicians and patient care researchers in developing their research capacity to address such themes.

As a beginning, I sent a short inquiry regarding initiatives and current innovations at their institutions to a group of clinicians and administrators who had been elected to the Institute of Medicine. This inquiry was informal and was not intended as a systematic or representative survey. I was simply trying to obtain a better picture of the range of trust-related initiatives. To help respondents focus, I suggested six types of programs, inquired whether their primary institutions had any of them, and asked whether they believed programs of this type contribute to trust. They included programs to involve patients formally in treatment decision-making; primary hospital nursing, where nurses accept continuing responsibility for specific patients; mediation for dispute resolution; patient representative/ombudsmen programs; use of interactive, patient-oriented informational technologies; and formal supportive and educational programs for patients and families. Although these approaches are thought to be trust enhancing, we have no independent evidence to confirm this belief.

About three-quarters of the approximately 100 respondents believed that trust in health professionals had declined in the past five years, but most did not indicate any special initiatives at their institutions to deal with trust beyond the six types I have listed. Most indicated that their institutions had such programs, which they believed were trust enhanc-

ing, but disagreed when it came to assigning their relative value. Almost everyone endorsed formal supportive and educational programs for patients and families as well as programs to involve patients formally in treatment decision making. But one-quarter to one-third were skeptical about the value of mediation to resolve disputes and about the use of interactive informational technologies to supply patient information.

The purpose of this preliminary inquiry was to discover programs worth examining more closely, and this initial effort yielded useful impressions of strategies for gaining both social and interpersonal trust. First, many of the most interesting programs are specific to particular service areas or diseases, reflecting the commitment to improve patient care and family involvement in areas like childhood diabetes, Alzheimer's disease, maternity care, cancer, and AIDS. Second, it appears that well-established HMOs devote considerable thought and effort to programs they describe as enhancing public trust and go to some lengths to initiate them, particularly in the areas of consumer feedback and professional and patient education. Third, although there are many interesting programs, they are not widely recognized outside their own institution or even among professionals in other units. Relatively few of the program ideas have high visibility. One informant believed this to be a reflection of the fact that these programs were usually outside the reward systems of the major involved professions, and that their impetus came from entrepreneurs who were highly committed locally and who contributed their own time and effort beyond usual tasks.

The most common areas of innovation seem to fall within seven broadly defined designations. The three categories mentioned most often were efforts to elicit consumer feedback, informational programs for patients and the public, and staff and professional education and sensitivity training. Others commonly involved specific programs to improve professional-patient relationships, sponsorship of support groups, patient empowerment programs, and ethics consultation within institutions. These areas overlap, and many specific programs can be assigned to multiple designations. I will describe some of these initiatives without presuming that they successfully enhance trust.

Measurement of patient satisfaction and the use of focus groups to assess patient expectations and treatment responses are relatively common, varying from systematic efforts to informal approaches. Many assessments seek general information on the overall performance of hospitals, HMOs, or health insurance plans, but others are physician spe-

cific. A recent national survey of managed care plans found that more than 95 percent of HMOs and 55 percent of PPOs monitored care to some degree through consumer surveys (Gold and Wooldridge 1995). Some carry out continuing surveys that monitor trends and identify issues needing attention. A 1992 HMO industry survey reported that 60 of 326 plans studied adjusted primary-care physician payments using consumer satisfaction measures (Gold and Wooldridge 1995).

The public relations advertising campaigns by major medical institutions and programs increase visibility but do not provide much useful information. However, informational programs for patients and the community are also common, and they range from brochures on health, specific diseases, and treatments to formal, intensive instruction for patients and their families in preparation for major surgery or for self-management of chronic disease. These programs are often clinical and specific to particular illnesses, but a good deal of generic information is directed to patients and the public in the form of information centers, learning centers, health fairs, open houses, and computer bulletin boards. One medical center sponsors a health knowledge kiosk at the public library with electronic search capabilities, runs a medical-center conference hour that is open to the public, and offers a one-week minimedical school to enhance public appreciation of biomedical research.

The "minimedical school," according to one of its early sponsors, Dr. Bruce Fuchs, an immunologist and acting director of the Office of Science Education Policy at the National Institutes of Health, is being implemented in some 20 medical schools. Directed to members of the general public, who enroll for a program of lectures on the process of science and various biomedical areas, the program seeks to educate people about the impact of biomedical research on society (Hill 1994). One objective is to convey a sense of science as it is experienced by medical students through programs of varying intensity, sometimes including informal interaction with scientists, some laboratory exposure, and graduation ceremonies. Harold Varmus, Francis Collins, and Anthony Fauci, among others, have lectured at the NIH Minimedical School, which began in 1994. The Minimedical School has been received enthusiastically by the public at a number of centers, and Dr. Fuchs is now developing a handbook on organizing such programs.

Professional and staff education also involves many efforts to improve responsiveness and increase sensitivity to diversity through professional and staff workshops and seminars. HMOs in particular are working to

improve physician interpersonal skills. Staff education includes a range of efforts: ethnically oriented teaching rounds with caregivers and staff, management and staff rounds, doctor–patient relationship conferences, and ethics education for dealing with critically ill patients. One institution sponsors a staff program entitled “Confidentially Speaking,” which instructs staff about appropriate and inappropriate conversations in public places.

High-quality professional–patient interaction is an intrinsic part of trust and is commanding more attention as competition among institutions and programs increases. More programs and institutions are working to enhance the interactional skills of their physicians and nurses and to provide patient feedback. Some of these efforts are intensive and highly sophisticated. Such programs are now commonly integrated into medical education and residency programs, particularly in family medicine, general internal medicine, and pediatrics.

In response to my informal inquiries about innovative programs for building trust, no institution has been mentioned more frequently than Boston’s Beth Israel Hospital, perhaps in part because of the large number of respondents from Boston institutions. More than two decades ago, Beth Israel developed a program of primary hospital nursing, in which nurses assumed continuing responsibility for specific patients. Such programs have now been adopted in many institutions, and most of my informants believe that this approach is an important aspect of trust. Dr. Rabkin, president of the hospital, further reports that “the creation of the role of support assistant, combining house-keeping, transportation and dietary functions on the patient care units, has led to a greater identification of individual workers with specific patients and with their nurses, and therefore—by fostering stronger human interactions—has, we believe, contributed to trust.” Also, models for management of specific diseases with a patient–family component are becoming more common.

A fifth area, adopted to some extent by almost every institution, is sponsorship of supportive educational programs for patients and families. These range from providing facilities for a variety of self-help patient and family groups to creating highly developed programs of instruction and support. The idea of support groups seems well-established and institutionalized among health institutions, and a large descriptive and analytic literature is available (Cohen and Syme 1985;

Thoits 1995). The subject "Self-help groups" elicits over 3,000 items on Medline, and "Social support," almost 10,000.

The idea of personal and social empowerment has taken hold in our culture and politics, supported by suggestions from the research literature that individuals who feel in control of their lives experience less distress, report better health, and even have an advantage in longevity (Rodin 1986). Empowerment notions are also pervasive in the social sphere, and the sense of social efficacy and participation are seen as mainstays in building community solidarity and reducing alienation and hopelessness. The empowerment concept itself is ambiguous and is used in many ways. My purpose here is not to review the concept critically, but simply to note the growing numbers of programs that seek to increase patient empowerment for managing their own health status. These range across preventive health programs, family planning, pregnancy and childbirth, women's health, and chronic disease programs. At the social level, health institutions are more likely to put patient representatives on their boards and committees. In some long-term patient services, the patients themselves or family members may participate in certain recruiting and hiring decisions. Moreover, it is not uncommon for client groups themselves to organize and administer services, as exemplified in some programs for persons with disabilities (Albrecht 1992; Scotch 1989).

This brief review has barely scratched the surface in describing the adaptiveness of health institutions to a rapidly changing financial and social environment. There is an abundance of interesting ideas and programs, but only a small number has been seriously evaluated. Some of these programs are little more than a pet idea of an administrator or a couple of clinicians, and many are only of limited interest. Others are increasingly being institutionalized into routine patterns of care and are seen as part of the everyday tasks of clinical and managerial personnel. Some of these innovations are part of a larger organizational and cultural transformation that requires more responsiveness to patients. It is often unclear, however, why one innovation takes root and diffuses while another does not, nor is it always apparent what innovators expect to achieve. Some involve little investment: they cost little, are easy to replicate, are not controversial, and pretty much run themselves. Others require significant startup and continuing costs, threaten traditional practices, and require complex administrative arrangements. For ex-



ample, video presentations to enable patients to participate in treatment choices demand coordination and a considerable investment of energy in order to present the issue fairly and accurately and to produce updates as new knowledge emerges. Drug companies, provider groups, and medical industries compete in this arena with their own treatment choice materials. What “sheriff” will adjudicate among alternative presentations? These and many other issues make institutionalization of some of these programs uncertain.

## Conclusions

Trust building is an iterative process, requiring repeated evidence of competence, responsibility, and caring. Achieving public trust, particularly in an environment of rampant distrust, requires continuing efforts to demonstrate good faith. Medical institutions have fallen dramatically in public trust in recent years. Although this trend is common to all social institutions, many believe that the problem is exacerbated by commercial restructuring of medical care and visible evidence of self-interested and unscrupulous behavior by a segment of programs, institutions, and professionals. Even long-respected and dedicated institutions now function in a climate of suspicion. Maintaining trust requires organizational strategies as well as good intentions (Scott et al. 1995). Institutions can do much to develop and evaluate mechanisms across the wide range of relevant services that demonstrate their commitment to responsive and high-quality care.

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