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Doctors developing patient trust:

Perspectives from the United States and New Zealand

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ABSTRACT

Background

The purpose of the study was to identify strategies used by doctors that increase patient trust and to examine cross-national similarities and differences.

Methods

In-depth, face-to-face, semi-structured interviews were conducted in June–November 2001, with 35 primary care doctors in the Charleston, South Carolina, United States area (n=15), and the Auckland, New Zealand area (n=20).

Results

The interviews revealed several general strategies that characterised successful development of trust from the physician's perspective. Having a 'common language' with each patient was seen as crucial to developing the relationship and trust. US and New Zealand doctors differed in the belief in the utility of cultural competency in creating a 'common language' and trust, with US physicians focusing on equality rather than cultural sensitivity.

Conclusions

This study suggests the importance of the patient-doctor relationship in creating trust. Developing cultural competency among doctors may help to facilitate the development of trust.

Key Words

Trust, primary health care, cross-national

(NZFP; 30: 336–341)

Patients must be able to trust their doctors with their lives and well-being.[1] Trust is a central element in the doctor-patient relationship[2] and the trust that patients have in their doctor to act in their best interest contributes to the effectiveness of medical care.[3] For example, in an investigation of the impact of a publicised error in cervical cancer screening in the United Kingdom, the study showed that most women who reported that they were confident in the cancer screening programme kept their appointments while those who reported less confidence did not.[3] Despite the important role of trust in business practice, law, ethics and health production[4] and the acknowledged importance of patients' trust in their doctors, it has been investigated in little systematic research.[5]

Nearly all of the work focusing on patient-doctor trust has dealt with assessing patient trust in his or her physician.[6–9] No systematic study has focused on the strategies used by doctors to create trust, however one intervention designed to improve doctors' trust-building skills was un-

successful.[10] This one-day workshop with doctors was based on focus groups of patients regarding the characteristics of doctors whom the patients felt they would trust.

The purpose of this study is to examine from the doctor's perspective the development of a trust relationship between patients and doctors focusing on the development of trust and doctor strategies to achieve it.

Trust is a relationship between the patient and doctor where the patient expects the doctor to provide advice and treatment in the best interest of the patient

Methods

Thirty-five in-depth, face-to-face interviews were conducted by two trained medical student interviewers using a semi-structured interview tool.[11] The interview tool consisted of a variety of open-ended questions and probes that were used in all interviews. The interview lasted approximately 30 minutes. The questions were developed by a multidisciplinary team that was composed of two doctors who each have practised in the United States as well as other English speaking countries (South Africa, New Zealand, Australia), two students who were attending medical school in the US and the United Kingdom at the time of the study and a social psychologist from the US. The questions were designed to elicit the individual participant's perspective on building trust, strategies to build trust, longitudinal relationships and barriers to developing trust (Table 1). Planned probes were included in the interview tool to prompt the participants to reflect on more focused content. All interviews were audiotaped and transcribed.

Sampling

A group of community family physicians in the US and general practitioners in New Zealand was serially and contingently selected.[12] To ensure inclusion of individuals with adequate opportunities for building trust, participating doctors had to spend at least 50% of their time in direct patient care. Informants were selected to represent typical cases varying by practice setting, experience level, and country. Fifteen doctors were interviewed in the greater Charleston, South Carolina, area and 20 doctors were interviewed in the Auckland area of New Zealand.

The study was conducted in the United States and New Zealand to gain an idea of similarities and differences in the patient-doctor relationship in two geographically and culturally distinct yet linguistically similar countries. By using more than one country, a better understanding of the role of trust in the patient-doctor relationship could be obtained. Having countries with similar languages allowed for ease in exploring themes across countries.

Approval of the study was obtained from the Institutional Review Board of the Medical University of South Carolina and the University of Auckland Human Ethics Committee. Interviews were conducted between June and November 2001.

Data analysis

The transcribed interviews were analysed. Although a sequence of open-ended questions was asked of the informants in the semi-structured interview, the data were free text. We analysed the data via an 'editing style' which involves searching for meaningful segments of text and organising them into categories and themes.[11] Two of the investigators (AGM, CDB) independently studied the 35 transcripts to identify meaningful segments of text and categorised these segments into themes. The team met and compared segments of text and themes that had emerged. Following this meeting the investigators reread the transcripts to examine the data and come to a consensus.

Results

The characteristics of the informants is shown in Table 2. The doctors vary in their time in practice, gender, race/ethnicity and size of practice. The New Zealand informants were more likely to have been in practice longer and have larger practices than the US informants. Five main themes emerged from review of the data. These are outlined below.

Table 1. Explored issues in patient-physician trust

What does trust mean to you?
How does trust make a difference in patient outcomes?
How does trust affect your doctor-patient relationships?
What do you do early in the relationship to build trust?
How are you aware of trust developing?
Do you ever try to match your presentation to what you think the patient wants (expert, friendly, etc.) to create trust and if so, how?
How do time and continuity of care affect the development of trust between you and the patient?
How does your patient population's ethnic, cultural and racial mix play into development of trust with you?
How do you communicate to the patient that he/she is getting a good standard of care and how does that relate to trust?

What is trust to doctors?

Rapport, although essential, was not equal to trust. Trust is a relationship between the patient and doctor where the patient expects the doctor to provide advice and treatment in the best interest of the patient. Moreover, a trusting relationship allows patients to share sensitive information and bring forth their 'true agenda' and 'share their story with me, honestly' to the doctor. Doctors in both the US and New Zealand talked of patients bringing up sensitive health care problems other than the initially stated reason for the visit.

Many doctors reported using different language styles and acting differently depending on whom they are trying to develop a relationship with

Does trust matter in the minds of doctors?

Overwhelmingly, the doctors indicated that trust was important to the practice of medicine. Trust in the doctor allows the doctor to find out the 'patient's agenda'. A common belief about the importance of trust and its relationship to health outcomes was expressed by one doctor in the United States:

'I don't have any good evidence to prove it, but I would imagine so. I've certainly seen lots of patients who for one reason or another didn't fully trust their doctor or their medication and therefore did not do what they were advised to do and got into trouble as a result.' (US #2)

Similar views were expressed by doctors in New Zealand:

'I would imagine that the answer to that [does trust make a difference in patient outcomes] *would be* 'Of course it does.' *I'm not aware of any research on that but I would say that if trust is not there then you're certainly not going to have any information and you might as well be dealing with sheep and cows really.'* (NZ #13)

Relationship building as the key to developing patient trust

Trust was achieved by building a relationship between the patient and doctor. Trust begins with friendliness and building rapport between the patient and the doctor. In terms of trust in the patient-doctor relationship, a doctor in New Zealand provided an example:

'The obvious illustration would be when people come in, present a problem, you deal with the problem and they get to the door and they've got hold of the handle and they say 'It just occurred to me that...' *and this is the real reason they came.'* (NZ #4)

Adherence to regimens was an obvious sign that the patient trusted the doctor. However, many of the doctors indicated that their awareness that a trusting relationship was achieved was many times based on nonverbal cues, body language and a feeling on the part of the doctor:

'You can't know completely [that patients trust you]*, but I think it's the way you interact with these people and they interact with you. You'd feel that perhaps they are trusting you.'* (NZ #19)

'I think you develop a sixth sense with a patient whereby you can reach a level of communication that the patients are developing trust. They begin sharing more and more with you. Things which maybe you may be aware they may not normally share.' (US #7)

Achieving common ground or communication

The informants indicated that strategies like being professional, being unhurried and being willing to listen seemed to build trust. The patient expects to be listened to and understood. In the process of building a relationship, the informants noted that patients and doctors try to reach an accom-

Table 2. Characteristics of informants

	United States (n=15)	New Zealand (n=20)
Gender		
Male	13 (87%)	11 (55%)
Female	2 (13%)	9 (45%)
Race/ethnicity		
White	13 (87%)	19 (95%)
Black	1 (7%)	0 (0%)
Asian	1 (6%)	1 (5%)
Size of practice		
<2,500	4 (27%)	0 (0%)
2,500–4,999	3 (20%)	0 (0%)
5,000–9,999	5 (33%)	5 (25%)
≥10,000	3 (20%)	15 (75%)
Time in practice		
<5 years	5 (33%)	1 (5%)
5–14 years	5 (33%)	13 (65%)
≥15 years	5 (33%)	6 (30%)

modation and understand each other. The doctors focused more on the process of achieving 'common ground' and 'talking in their language' but also talked of partnerships and contracts with agreed upon expectations. Many doctors reported using different language styles and acting differently depending on whom they are trying to develop a relationship with:

'My language may deteriorate in some situations. Like, 'Oh, my. That's a real Bugger!' *But with my older lady I would say* 'That's a real nuisance, isn't it.' *With a young 20-year-old, I change my body language and my language changes.'* (NZ #10)

'So yes, absolutely. When I recognise on the chart that someone is... I take care of a few dentists and a couple of attorneys and when you see a professional person there, you know their educational level is probably higher. I'll present myself, not arrogantly, but with a little more..., well just mind my p's and q's a little bit more and use appropriate grammar because, again, you are trying to sell yourself and selling yourself to that lawyer is going to be different than the other [low income, education patient]. You are still the same person, but you can vary your presentation and how you present yourself.' (US #5)

Time and trust

Within the context of relationship building for patient trust, the informants discussed the role of time and continuity of care. Time was seen as important to the relationship, but trust could develop in a short period of time or not at all. The relationship was the key rather than the time to develop it. Similarly, continuity of care was seen as important to trust with reported beliefs that frequent contact would help in developing the trusting relationship but it wasn't continuity in and of itself but rather the relationship that engendered trust.

'I think, generally speaking, probably the longer they have been with you, presumably, that they have built their trust in you. I'm always amazed that people who can, I guess...who seem to trust you right from the start. I get people after they've been with you for a long period of time that don't trust you.' (NZ #3)

'The more shots you have in seeing the same person the more likely you are to develop trust.' (US #10)

'Continuity of care with the same caregiver enables a person not only to see a medical person but to see the medical person they have been seeing. And it would have built up that relationship going beyond just the disease, treatment, result type scenario where on a personal level, as mentioned before, the interpersonal relationship, the sense of humour, the just general functioning and working of the relationship.' (NZ #14)

Perceived poor care and deteriorating trust may be based not on quality but on interpersonal interactions

Cultural diversity and trust

Following from the general theme of relationship building, a barrier to trust that was identified from the New Zealand doctors was language and cultural differences between patients and doctors. Using the concept that trust is facilitated when patient and doctor are on similar wavelengths both literally and metaphorically, cross-cultural issues, when the patient and doctor were not from the same culture, did make this more difficult. Knowledge of the patient's culture was important to trust as well as the doctors actions in engendering trust.

A barrier to trust that was identified from the New Zealand doctors was language and cultural differences between patients and doctors

'I'm not a racist person myself, but I do wonder sometimes when some of these doctors in other countries, particularly from China and the States...and it's like, how on earth do they really get to the nitty gritty on our patients' problems?' (NZ #11)

'I think if you don't speak the same language [literally and metaphorically speaking] *then you have a problem.'* (NZ #1)

'I think I have to work harder with the Maori patients because I think there is a lot of past grievances...historical grievances and there are cultural differences as well.' (NZ #19)

Doctors reported working at understanding patients from culturally diverse backgrounds, by taking more time and 'standing in their shoes'.

Several of the informants from the United States framed cross-cultural issues in delivering care not in terms of cultural sensitivity but rather more in terms of discrimination. Many of the US doctors reported behaviour with racially and ethnically diverse patient populations in terms of providing equal and nonbiased care rather than in terms of trying to be on the patient's wavelength.

'Clearly different cultural and religious backgrounds could be a barrier. I don't think I let it, or allow it to be. And again I try to approach everybody, you know, basically the same.' (US #4)

'I think if you show that you care for the patient, period, on the whole, and not as white or African-American or Chinese or whatever, that you just care about them as a person they're going to sense that. In my practice, I don't think that plays any part at all, and I treat all my patients the same regardless of their race.' (US #12)

Competence and trust

No informants talked directly about building trust via competence. The

majority of informants believed that patients could not recognise quality health care. Thus, a primary concern in relating trust to quality of care was that the relationship between the patient and doctor may be good but the doctor may not be delivering good care. Similarly, perceived poor care and deteriorating trust may be based not on quality but on interpersonal interactions.

'People are much more prone to think that they got bad care if they got bad treatment in the office. People's perception of inadequate medical care are usually perceptions of inadequate human care. I think it is very difficult for general lay people to know if they got good medical care or not.' (US #3)

'They might decide that good quality of care is given because they liked you. I think that the bulk of people do that. The reasons they say the care is good or bad quality is pretty grey.' (NZ #12)

Many doctors felt that patients perceived positive health outcomes to be as a result of good quality of care thereby increasing trust. A more proactive strategy building trust was to communicate to the patients that their advice and treatment recommendations were consistent with clinical practice guidelines, or the best available evidence. This was used by doctors in both the USA and New Zealand.

Discussion

Trust has been suggested as a critical component of the patient-doctor relationship.[13] This study of the views of doctors about development and maintenance of patients' trust in their doctors shows that the patient-doctor relationship is the key strategy in creating trust. A key finding of this study is that primary care doctors in two culturally and geographically distinct but linguistically similar countries use similar strategies and descriptions of the process of creating trust. This cross-national similarity points to the importance of the patient-doctor relationship in delivering primary health care.

Trust in one's doctor by the patient helps in revealing the reason for the visit and the acceptance of a management plan. Doctors build trust by displaying professionalism and empathy. Understanding the patient and 'speaking a common language' is a skill that is particularly salient to doctors. The doctors in New Zealand seem to be particularly aware of the impact cross-cultural differences may play in their ability to communicate with and understand patients. The US doctors included in this study seem more oriented to trying to assume similarity with the patient and affirm equality rather than emphasising cultural sensitivity. This finding from US doctors may be illustrative of patient-doctor interactions that may not engender trust on the patient's part. Data from a national US survey of patients that showed that racial and ethnic minorities, particularly African Americans, have lower trust in their doctors than do Caucasians.[14]

Because of the limited ability of patients to evaluate the doctor's technical competence doctors...use strategies to try to convince patients that they are providing high quality care

Cultural competence focuses on the capacity of the health worker to improve health status by integrating culture into the clinical context.[15] This concept is perhaps poorly understood by providers as reflected in the varying views of primary health care doctors expressed in this study. While cultural issues were appreciated, in being non-discriminatory, the attempt to 'treat everybody the same' could be seen to undervalue the contribution that the patient's ethnicity and cultural health belief makes to the clinical encounter.

Patient-doctor racial concordance leads to higher patient ratings of doctors and confidence in care received.[16] Where racial concordance is not possible, the potential impact of cultural diversity on the development of trust was clearly appreciated by some doctors in this study. This is an area requiring more outcome-related research.

Key Points

- Trust is a central element in the doctor-patient relationship and the trust that patients have in their doctor to act in their best interest contributes to the effectiveness of medical care.
- Strategies like being professional, being unhurried and being willing to listen seemed to build trust.
- Knowledge of the patient's culture was important to trust as well as the doctor's actions in engendering trust.
- A primary concern in relating trust to quality of care was that the relationship between the patient and doctor may be good but the doctor may not be delivering good care.
- Doctors who are skilled at developing the patient-doctor relationship may not be the same ones who are also technically competent in medicine.
- It is crucial that all doctors should be trained in a clinical method that includes both evidence-based technical skills and communication skills if they are to develop trusting patient-doctor relationships and provide quality care.

Technical competence may initially be conceptualised as the key to gaining the patient's trust. However, this study indicates that because of the limited ability of patients to evaluate the doctor's technical competence, doctors recognise that and use strategies to try to convince patients that they are providing high quality care. Doctors who are skilled at developing the patient-doctor relationship may not be the same ones who are also technically competent in medicine.

While it is clear that the doctor-patient relationship impacts outcomes for patients, health system interventions to improve the relationship are not entirely clear. The doctors in this study saw continuity of care as a vehicle to developing trust but not necessary for trust to occur. In fact trust was seen to sometimes occur instantly. This reinforces the centrality of the art and science of medicine in providing efficient and effective care by doctors.

This study has several limitations. First, only primary care doctors were interviewed. Although perhaps somewhat limiting in perspectives, these informants provide care across the age spectrum and conditions. In New Zealand, over 90% of the population see a general practitioner in any year and the general practitioner co-ordinates contact with secondary care and specialist referrals.[17] Second, although the chosen qualitative design was particularly appropriate for obtaining doctors' perspectives on a relatively under-investigated topic, we are limited by self-reports without direct observation of the doctors. The participants were not given a distinct definition of trust and it is possible that doctors' views of exactly what trust is varies. Thirdly, almost all of these doctors were white. Non-white doctors may hold different views particularly with respect to the impact of cultural group of the patient on trust. Further research in this area is needed.

Many doctors felt that patients perceived positive health outcomes to be as a result of good quality of care thereby increasing trust

In conclusion, patient trust in his or her doctor is a critical component of delivering quality health care. From the perspective of these doctors, developing the patient-doctor relationship is critical to creating trust. It is worth noting that having good relationship skills does not necessarily equal technical competence. Thus it is crucial that all doctors should be trained in a clinical method that includes both evidence-based technical skills and communication skills if they are to develop trusting patient-doctor relationships and provide quality care.

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