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## **Trust Matters for Doctors? Towards an Agenda for Research**

**Douglass T and Calnan M *Social Theory and Health* , accepted 25/05/2016**

### **Abstract**

*Sociological research offers crucial understanding of the salience of trust for patients in mediating a plurality of healthcare activities and settings. Whilst insights generated surrounding the salience of trust for patients are important, other trusting relations within healthcare have largely been neglected. This paper focuses on the significance of trust for doctors, arguing that trust is salient for doctors in facilitating their professional role, in the management of complexity and uncertainty in contemporary medical practice, and is a key mechanism underpinning professional identity. As such, the paper develops a preliminary conceptual framework for researching trust by doctors built upon the idea of a 'lattice' of doctor trust relations in various entities and at various levels that may be interconnected. The lattice of doctor trust is comprised of four primary conceptualisations – trust in patients, self trust, workplace trust, and system trust. The paper explores notions of doctors' need to trust patients to provide accurate information and to commit to certain treatment pathways; the relationship between the self trust of the doctor, clinical activity and trust in others; the need for doctors to trust their professional colleagues and the broader organisational setting to ensure the smooth running of services and integration of care; and notions surrounding the complexity of the broader systems of modern (bio)medicine and the role of trust by doctors to facilitate system functioning.*

Key words: trust by doctors, healthcare, uncertainty, patients

(Word Count: 6990)

### **Introduction**

The importance of trust in a variety of contemporary healthcare settings has been well documented (see: Calnan and Rowe, 2008; Brown and Calnan, 2012b). Despite claims of declining trust levels in professionals' in general in western societies (Evetts, 2003), and government directives at the macro level to foster trust in the NHS as a system following several scandals towards the end of the twentieth century (Pilgrim et al 2011), trust continues to be a prevalent and mediating factor in the effectiveness of healthcare delivery (Calnan and Rowe,

2008). However, research has focused largely on the patient perspective (Brennan *et al* 2013), and mostly neglects other relations of trust within healthcare – relations of trust that may hold salience in their own way within contemporary healthcare delivery. A focus on doctors' perspectives on trust is important not least because of its potential implications for the quality of patient care (Gilson *et al* 2005), and facilitating patient autonomy (Rogers, 2002). Beyond these initial patient impacts, however, the primary aim of this paper is to extend medical sociological understandings of the salience and scope of trust in contemporary healthcare settings, particularly in terms of the role it may play for doctors in facilitating their role in healthcare delivery. The paper also necessarily addresses the role of trust in relation to professionalism, moving beyond existing understandings of the importance of trust in professionals by lay populaces – instead debating the importance of trust by doctors in terms of the acceptance of certain developing professional identities.

Although investigations of doctors' and professionals' perceptions of and actions towards individuals with certain socially marginalised characteristics (for example non-white ethnicities) that may be related to trust have been undertaken (Burgess *et al*, 2008; Moskowitz *et al* 2011; van Ryn and Burke, 2000; Warner and Gabe, 2004) little work has offered coherent and sustained analysis of trust by doctors. The need for mutual trust for quality of and experience of care has been acknowledged by doctors (see Calnan and Rowe, 2008: 59) although explicit sociological analysis of trust by doctors fails to explore this further. In this paper a conceptual framework is proposed for researching doctor trust across a variety of scenarios, with four primary conceptualisations – trust in patients, self trust, workplace trust, and system trust.

### **Sociological Narratives of Trust: An Overview**

Trust has been widely theorised by prominent social theorists (see Giddens, 1990; Luhmann, 1979) and has grown into an important research endeavour in medical sociology, particularly in

terms of how trust by patients in professionals shapes healthcare processes (Brown and Calnan, 2012b; Brownlie, 2008; Calnan and Rowe, 2008; Pilgrim *et al* 2011; Fotaki, 2014).

Fundamentally, trust relates to some responsibility for a social action being placed in a trustee by a trustor (Luhmann, 1979). This social relationship can take the form of a placing or delegating responsibility for completing an individual task or it can comprise a longer term relationship – both of which may be relevant in the context of contemporary doctor-patient relationships and the broader organisation of healthcare systems. Trust helps a trustor to overcome uncertainties in evidence and proof in order to maintain social relations (Barbalet, 2009). As such, trust is salient in managing scenarios where complexity and uncertainty abound (Brown and Calnan, 2013; Brown *et al*, 2015). Trust is a multi-layered concept which consists of a “cognitive element (grounded in rational and instrumental judgements) and an affective dimension (grounded in relationships and affective bonds) generated through interaction, empathy and identification with others” (Calnan and Rowe, 2008: 6). It has been characterised in terms of intentional and competence trust with the latter being shown in empirical research to be embedded in the former. However, research such as Calnan and Rowe (2008) also shows that trust is conceptualised in different ways, particularly comparatively to the past. Earned/conditional trust as opposed to traditional notions of blind trust seems to be favoured due to the dangers of blind trust embedded in high trust cultures leading to a lack of vigilance and a risk of exploitation particularly for those with a lack of resources (Calnan and Rowe, 2008).

Trust has been recognised as particularly significant for effective healthcare provision across many national systems and provider contexts (Mechanic, 2001; Dibben and Lena, 2003; van der Schee *et al*, 2007) and moreover as incorporating a number of different dimensions – such as macro-level policies, inter-professional cooperation and professional/patient communication (Calnan and Sanford, 2004). Trust relations are significant in shaping and facilitating interactions and transactions between patients and professionals (see Mechanic and

Meyer, 2000), but, as a limited amount of research has highlighted, also amongst doctors and between healthcare professionals and managers (Gilson *et al* 2005; Brown *et al* 2011).

### Levels of Trust

There are different levels at which trust operates and the common distinction is made between the system and the individual. Indeed, Luhmann (1979) makes a distinction between personal trust which is based on familiarity and taken for granted assumptions, and system trust, which is rooted in trust in the function of systems. Giddens (1990) similarly supposes the existence of two types of trust in late modernity, one that is disembedded (faceless trust in abstract systems) and another that is re-embedded (trust in individuals). His broad argument is that both types interrelate and that trust in the system is mediated by trust in individuals – because individuals perform ‘facework’ on behalf of the broader system as they are the access points for the abstract system. The key difference between these influential theorists is that Luhmann (1979) makes a distinction between trust and confidence (or system trust) (Willis and Pearce, 2015). Luhmann (2000) argues that we do not ‘trust’ in abstract systems in the same way that we trust in individual persons. Unlike interpersonal trust which is built on specific perceptions of individual competence, system trust requires continuing positive feedback to function (Brown and Calnan, 2016b), and it is only posthumously if and when this affirmative feedback discontinues that social action occurs, rather than with interpersonal trust, which shapes meaningful action as a bridge between present and future (Barbalet, 2009). However, whilst Giddens and Luhmann differ here, both agree that both interpersonal and trust in systems may influence the other (Brown and Calnan, 2016b).

The empirical evidence about the implications of trust relations within organisations and between professionals and healthcare workers for patient care is in short supply, although Gilson *et al* (2005) and Brown and Calnan (2016a) have both suggested certain ways that relations and levels of trust may be interconnected in healthcare. Indeed, exploring healthcare delivery in South Africa, Gilson *et al* (2005) put forward a conceptual framework that suggests

that relations and levels of trust are interconnected. The authors argue that workplace trust shapes the attitudes and behaviours of healthcare workers towards patients which subsequently shapes patient (dis)trust in healthcare workers. Workplace trust is rooted in micro and macro level trust relations, including trust in employing organisation, trust in supervisor and trust in colleagues. Patient trust in healthcare workers is grounded in interpersonal trust, including, as noted, attitudes and behaviour but also individual characteristics of the healthcare worker. Patient trust also reflects institutional trust, which is rooted in various elements that ensure healthcare workers are able to provide care (for example, qualifications, professional codes). Whilst the authors are cautious about confirming the interconnectedness of workplace and patient-healthcare worker trust, their empirical examinations as guided by this conceptual framework suggest that the two are indeed interconnected.

Brown and Calnan (2016a), drawing from the conceptual approach of Gilson *et al* (2005), also argue that relations and levels of trust are interconnected, in what they call chains of (dis)trust, which provide an explanatory link between trust relations at the organisational level with the quality of patient care. The authors attempt to specify the processes and procedures which account for the nature and structure of these chains of trust relations. Their empirical work was carried out in the clinical setting of the management and treatment of people diagnosed with psychotic mental health problems where there is considerable uncertainty and vulnerability, and thus trust relations tend to be fragile. This research shows how relational-communicative and instrumental- strategic approaches shape the extent to which trust chains could be characterised in terms of a vicious spiral of distrust, or a virtuous cycle of trust. The authors argue that the conceptual tool of 'trust chains' should not only be characterised as 'link by link' through interpersonal relations, but that in some contexts, institutional and policy directives shaped trust relations between managers and professionals, even when there was little direct social interaction. Though this work goes beyond strictly doctors, and includes other clinicians, managers and social workers, the authors again reiterate

(as in Calnan and Rowe, 2008) notions of professionals as both trusters and trustees, where trust serves simultaneously to help manage uncertainty and vulnerability.

### *Medical Professionalism and the Social Position of Doctors*

The argument in this paper is that trust for doctors in and of itself is uniquely important in healthcare delivery and in the management of uncertainty and complexity in the practice of modern medicine. Both Gilson et al and Brown and Calnan have at their core a focus on the consequences of trust for patients and/or the workings of specific organisational settings. These elements are also important to some extent to the framework proposed in this paper. However, what these analyses neglect is a focus on the role of trust in contemporary medical professionalism.

Sociological narratives traditionally characterised medical professionalism as either trustworthy because of the predominant altruistic values of doctors or lacking in trust because doctors were driven by self-interested motives (Calnan, 2015). However, medical professionalism, it is argued by some, has grown into a complex phenomenon, with claims that new professional identities are emerging (Checkland, 2004; Freidson, 1994; Freidson, 2001; Harrison, 2009). Although others dispute these claims (Evetts, 2009; 2011; Spyridonidis and Calnan, 2011), broadly the medical professionalism literature here points to a role for doctors in mediating between the public and the state, as well as acceptances of market logic and clinical governance mechanisms, and as a result, a degree of curtailment of individual medical autonomy.

The focus of the analysis here is with the extent to which (dis)trust acts a mechanism in facilitating the role of the doctor in contemporary healthcare delivery. In other words, the extent to which, on the one hand, it facilitates the doctor, where a doctor appears to conform to the 'new professionalism' (Evetts, 2009; 2011), to perform their professional role in and as a result of various relationships that involve significant complexity and uncertainty, including relationships with patients, state bodies, and the commercial sector. (Dis)trust in various

individuals (including themselves), entities and processes by doctors, many of them relatively recent in inception and designed to govern medical practice (Pilgrim *et al* 2011), may be vital in facilitating acceptance of new professional identities, and thus in facilitating contemporary modes of healthcare delivery and practice as imagined in policy and institutional directives. For other doctors, (dis)trust (in a different sense) may also be an important factor in a rejection of or resistance to the imposition of policies or institutional arrangements designed to foster this 'new professionalism' within medicine, and thus the (partial) resistance to new professional identities and managerialism in favour of more traditional notions of self-governance (Freidson, 1970; Saks and Allsop, 2007). (Dis)trust, as such, may also be key in explaining why some have suggested that medical professionalism is constituted not by wholly new identities, but instead by certain aspects of continuity and change (Evetts, 2009; 2011). (Dis)trust, thus, may facilitate the doctor acting as a doctor, perhaps in ways reflecting an individual doctor's perceptions of what the role of the doctor should be (for instance, in terms of clinical autonomy potentially reflecting a doctor's distrust in organisational processes or trust in their own individual competencies and decision-making), or as impacting on specifics of practice (such as high levels of self trust in their own professional competencies resulting in more individualized modes of decision-making, and/or distrust of the mass applicability of national guidelines manifested in the resistance to offering/prescribing a particular drug, and/or potentially in distrust of patient ability to fulfill treatment expectations).

Whilst debate exists in the professionalism literature about the extent of the changes in medical professionalism, it seems that increasingly professional discretion must now be seen in the context of organisational professionalism (rather than portrayed in terms of individual autonomy) and that doctors' decisions are influenced by social, economic and organisational elements as well as their clinical judgment (Evetts, 2006, Cheraghi-Sohi and Calnan, 2013). Associated with these changes in the position of professional medicine arguably come changes in the importance and nature of trust relations with patients, within organisations, in institutions and systems. These trust relations might manifest at a number of different levels.



For example, an analysis of medical professional autonomy in relation to the UK state Harrison and Ahmad (2000) distinguished between the micro, meso and macro levels. *Micro level autonomy* is expressed in the clinical practice of the medical profession manifesting in the right of medical professionals to: 1) dominate the practice of diagnosis and treatment, 2) control the evaluation of care provided, 3) organize the form and amount of medical tasks to be overseen, and 4) maintain contractual independence from employers. It is here that it has been suggested that medical autonomy and discretion has been most obviously threatened (Freidson, 2001; Coburn, 2006). The consequences of diminishing responsibility and autonomy for doctors in these four areas means that doctors may require interpersonal trust in various actors, such as patients, to facilitate effective healthcare delivery (such as trusting a patient to follow advice). Distrust may also be present due to removal of autonomy or perceptions of the competencies and knowledge of these actors. *Meso level autonomy* relates to the dynamics of institutional relationships pertaining to the medical profession such as the state and other regulatory bodies. *Macro level autonomy* is typified through the general approach of medical professionals to the practice of medicine; currently through application of the biomedical model (Harrison and Ahmad 2000). In both of these latter levels trust may be important for doctors in terms of engagement with the overarching organisational processes and knowledge systems which guide contemporary medical practice, in the context particularly of clinical governance mechanisms – and it may be that (dis)trust of particular processes or bodies of knowledge shapes (dis)trust relations and/or healthcare delivery within micro-level interactions.

### **A Lattice of Trusting Doctor Relations?**

The argument in this paper is that the complexity of contemporary healthcare systems necessitates considering the interconnectedness of trust, with a focus on the interconnectedness of levels and relations of trust primarily for doctors – a professional group for whom the salience of trust has been underexplored in sociological literature. To do this, the idea of a 'lattice' of doctor trust is proposed (with the potential for application in a variety of

healthcare delivery settings). The 'lattice' refers to various trusting relationships that may be interrelated and impact on one another in mediating a variety of healthcare processes. This is different from the idea of chains of trust put forward by Brown and Calnan (2012a; 2016a) because it is concerned primarily with trust by doctors rather than with other actors, such as patients or managers, and how this reflects and shapes professional identities and engagement with certain modes of healthcare delivery by doctors. Unlike the notion of chains of trust, it also does not necessitate that trust relationships implicating doctors within the proposed lattice are necessarily connected in every research scenario, merely that there exists the potential for different trust relations to be interconnected.

The foundation of this conceptual endeavour is that medical professionals are *both trustees and trustors* (Brown and Calnan, 2012a). Take the example of the well-established role of patient trust in doctors in mediating treatment acceptance and adherence (e.g. to medications) (Lee and Lin, 2009; Elder *et al*, 2012; Tranulis *et al*, 2014), assessing only patient trust neglects the role of a variety of relationships of trust. In terms of acceptance/adherence to pharmaceutical treatment there are a variety of trusting relationships that hold relevance. Of course, patient trust in doctors is one part. However, trust for doctors is important too because they too are reliant on the types of information they gain not only from patients, but also from such sources (within the context of the NHS) as the Medicines and Healthcare Products Regulatory Agency (MHRA) (safety and regulation of drugs and other technologies) and National Institute for Health and Care Excellence (NICE) (cost/effectiveness). They may also need to trust, even though it may be a conditional or critical trust, in the objectives and aims of the pharmaceutical industry (Brown and Calnan, 2012a). Such trusting relationships beyond patient trust may impact on the decision to introduce or offer a pharmaceutical treatment – suggesting that trust in this way appears to be far more complex than has been considered and established in the existing literature on (patient) trust.

Overall the aim of this paper is to provide an examination of the interrelationship between trust relations by narrowing the focus specifically to trust by doctors and the

relationship between trust and their practice and professional identity. Figure 1 below sets out an initial depiction of the lattice of doctor trust as comprised by the four broad conceptualisations generated, delineating also the interconnections and links between the types and levels of trust. The remainder of the paper now turns to discuss the component parts of the lattice of doctor trust.

### **Trust By Doctors: Evaluating the Existing Literature and Posing New Questions**

**FIGURE 1 - INSERT HERE**

#### **Trust in Patients**

The first area of consideration is the nature of trust placed by doctors in patients. This aspect of trust by doctors is important because it may have the most obvious implications for treatment acceptance/adherence and health behaviours (as well as patient trust back in doctors as a result of benefits of mutuality). Indeed, the extent to which doctors trust their patients (felt trust) may

influence how they treat and manage them (enacted trust) (e.g. lack of trust may lead to defensive medical practice, asking for a second opinion or poor communication) which could in turn influence how patients respond and have consequences for subsequent disclosure and adherence and may lead to a spiral of distrust. Certainly, the need for mutual, interpersonal trust appears to be important not least because of the so called shift in the structure and nature of the doctor-patient relationship away from paternalism towards shared-decision making with an emphasis on patient involvement and self-care and conditional and earned trust rather than assumed or blind trust (Calnan and Rowe, 2008). For example, evidence from the limited empirical research available (Calnan and Rowe, 2008) show doctors recognised the need for greater mutual trust given their more respectful relationship with patients. A case study of care for patients with diabetes in primary care by Calnan and Rowe (2008) highlights how doctors' trust in patients was earned by their ability to take medication as advised and make dietary changes as well as their behaviour in the surgery, whether they turned up for appointments, were polite, and honest about their symptoms. The need for mutual trust was also expressed by hip surgery patients and hospital-based doctors, with both identifying the need for doctors to trust patients to follow clinical advice after discharge in terms of what activity should be undertaken to allow the new hip to bed in and avoid dislocation. However, in contrast to diabetes patients, the interdependence between patient and clinician was described less as a partnership and more in terms of a forced reliance which was not necessarily justified in the long term. Hospital clinicians expressed scepticism as to whether they could trust patients, due to experience of seeing patients not following medical advice or feeling they did not know them enough to be able to trust. Trust here then in various ways is shaping professional work.

Beyond notions of mutuality, Thom *et al* (2011) establish a wide ranging twelve-fold set of measures for establishing levels of and the salience of physician trust in patients termed the physician trust in patient scale (PTPS). Though the study was based on trust in HIV-infected adults in San Francisco in whom the authors argue trust is likely to be lower than in other populations, their work still might be useful for assessing trust in other health and illness

settings. The authors intend for the measures to be utilised in quantitative work, however, the initial model of physician trust was established through qualitative analysis of a prior study (Stepanikova *et al*, 2009), and as such may also be useful as a starting point for further qualitative work concerned with trust by physicians, thus complementing our analysis. The twelvefold model established by Thom *et al* covers whether physicians trust that patients will: provide all relevant medical information needed by the physician; disclose any and all major changes to health; disclose information about medications and other treatments that are being undertaken; understand what the physician tells them; follow the established treatment; actively manage their own condition/health; disclose whether or not they are following the established treatment path; respect time; respect personal boundaries; realise what constitutes a reasonable demand; not attempt to manipulate the physician for personal gain, and keep appointments.

Pilgrim *et al* (2011) theorises that doctors lack of trust in patients is common and revolves around several problems. First, the assumption is that many patients do not properly take care of themselves (primarily in a lifestyle choices sense). Second, patients are broadly ignorant about the consequences of such lifestyle choice. Next, certain patients do not present themselves for assessment at the most opportune moments, this is particularly so for men who avoid going to GPs, for example, and thus the opportunity for early diagnosis/treatment is compromised. The authors also suggest that some patients present themselves overly often and thus waste the professional's time and resources. Patients may also be demanding and instruct the doctor what they need to do about the health problem, perhaps through checking symptoms or treatment options on the internet. This can cause problems for the professional role of doctors. Finally, some patients do not complete treatment processes correctly. Such notions may habitually limit, suggest the authors, the opportunity for doctors to fully trust patients because there can be in no way the sorts of processes ensuring patient competence and behaviour as can be imposed on professionals.

The work of Pilgrim *et al* (2011) and particularly Thom *et al* (2011) can be a strong starting point for assessing both the extent of doctor trust in patients and in establishing the importance of certain facets of doctor-patient interaction and doctor perceptions of patients and the public. Rogers (2002) offers similar categorizations to Thom *et al* (2011) and Pilgrim *et al* (2011), broadly discussing doctor trust in patients as comprising trust in the motives underpinning help seeking behaviours, health biographical information, and patient competence. However, as with the majority of research considering solely patient trust, the work reviewed suffers from a focus that is too limited in terms of interconnections between different levels and types of trust. Research must set doctor trust in patients within a context of broader trust relations, as established partially by Gilson *et al* (2005) and Brown and Calnan (2016a). The argument within this paper so far has been that trust for doctors at a variety of levels and in terms of a number of relationships may be salient in facilitating the identity and professional work of the doctor. This implicates doctor trust in patients, but necessarily sets this within a broader lattice of trusting relationships, as we have discussed above in relation to offering/implementing a pharmaceutical treatment regimen. Research must also attempt to gauge where certain perceptions shaping trust stem from and how the micro and macro level may shape how and why doctors trust patients within a lattice of trust – for example, the extent that doctor trust is shaped by individual and/or broader social characteristics (for example, class or ethnicity).

### Self-Trust

A further level is self- trust or intra-personal trust. Barbalet (2009) argues that expectations regarding the action of another actor are only part of what constitutes trust. Defining trust solely in terms of the expectations of the action of another neglects a self-referential trust in the abilities of the individual trustor to assess and evaluate the qualities of the object of the individual's trust. The application of this to the role of the doctor is clear – in terms of their own self-referential trust in their ability to gauge whether what patients are claiming is true, but also

in terms of evaluating available evidence or the credibility of the source and thus placing trust in these actors and processes. Self trust in this way may be important for less experienced doctors who have clinical discretion but feel vulnerable as they have not sufficiently developed trust in their own competence and evaluative abilities (Brown and Calnan, 2012b). In addition, more experienced doctors may have had their trust in their competence challenged by a clinical mistake and/or patient complaint. For such individuals their threshold of risk may be relatively low so they will be more likely to follow protocols or guidelines, seek second opinions and rely more heavily on biomedical test results which may lead to a lack of personalised care, which is necessarily related to professional identity and clinical practice.

In terms of treatment, for example, it may be salient for research to assess whether self-trust impacts on the types of treatment that are advised/prescribed, with more low risk or more guideline-centric procedures being advised to patients, perhaps at the expense of patient-centeredness. Certainly, in the current organisational context in the NHS with its emphasis on performance management, auditing, accountability and risk management there is a low trust culture (and blame culture where mistakes are not acceptable or admissible) which may compromise clinical practice (Calnan and Rowe 2008). As such, it may be that for those doctors with low self trust doctors that they place greater trust in broader organisation and institutional arrangements. For example, a GP with only a general knowledge of an illness area may place trust in the actors and processes that have constructed the recommended pathway due to a low level of self trust in their own ability to evaluate evidence, to comprehend alternate pathways, or for fear of medico-legal repercussions.

Self trust takes its place in a broader lattice of doctor trust relations, both as facilitating trust in other actors within the lattice of trust relations, but also as a self-evident phenomenon. As noted this may include greater or unquestioning trust in protocols and guidelines, but it may also contribute to more problematic trust relations between doctors and commercial industry. Such notions may be a contributing factor in the 'dark side' of trust. This is where trust that is unquestioning is placed in entities who may have (potentially) self-interested motives, such as

the pharmaceutical industry who have been shown to have various mechanisms for hiding data, manipulating biomedical knowledge production systems and influencing regulatory bodies (Abraham, 1995; 2009; Brown and Calnan, 2013; Lexchin, 2006). Self trust may also be important in understanding the development of mutual trust between doctors and patients.

#### Workplace or Organisational Trust

This sub-area of doctor trust, broadly concerned with trust between doctors, in other healthcare professionals, and the organisations they work in has been perhaps the most empirically researched of all of the subsections comprising our conceptual framework (see, for example, Calnan and Rowe, 2008; Gilson *et al*, 2005; Brown *et al*, 2011). Examinations of trust here take place in terms of micro-level interpersonal interactions and meso-level investigations of trust in specific organisations (as conceptually distinct from the system/macro level). Calnan and Rowe (2008) in work broadly concerned with mapping out trust relations in the contemporary NHS, consider the importance of trust in clinician-clinician relationships and in clinician-manager relations. Trust relations in the past were built on an assumed trust rooted in professional status (peer trust). However, with widespread organisational changes and the reliance on non-doctor healthcare professionals, trust between clinicians Calnan and Rowe argue is now grounded in a conditional earned trust. The authors highlight that conditional trust is rooted, first, in competence. This alone, however, is not enough to establish a trusting relationship between clinicians. Also of importance are confidentiality, honesty, reliability, personal manner, and acting in the best interests of others. Trust between clinicians can be lost as a result of perceptions of inadequate treatment of patients, lack of honesty and failure to adequately respect clinical colleagues.

Indeed, Calnan and Rowe also consider trust relations between clinicians and managers. Though doctors have always needed assistance in the administrating aspects of healthcare delivery the importance of managers has rapidly grown since the late twentieth century. Managers are now required to have a diverse skill set and have enhanced roles in the NHS. Whilst in the past, trust relations seemed to be rooted in status trust. In the contemporary NHS,



however, Calnan and Rowe show that increasingly the relations between clinicians and managers must be based on a conditional trust earned by both sides. As with trust between clinicians, trust is rooted in competence, honesty, accessibility and acting in the interests of others. Calnan and Rowe establish that trust by clinicians in managers was rooted foremost in whether they perceived them as having shared interests. One potential issue here is whether doctors perceive managers to be putting meeting government and financial targets ahead of clinical care and healthcare need.

The above notions point to the need to understand clinical practice and the salience of trust in terms of multiple levels and relations. Indeed, empirical research concerned with workplace trust has pointed to interrelations between the different layers or dimensions of trust – for example, where doctor-manager trust impacts on workplace environment and interactions between professionals (Calnan and Rowe, 2008). Gilson and colleagues' (2005), as noted, suggest that organisational trust can be summarised into different layers – where 'trust in the employing organisation', 'trust in supervisors' and 'trust in colleagues' are all crucial for 'workplace trust' and may impact on patient-professional trust.

As such, the literature shows that it is salient for trust research to assess if and how trust underpins and shapes doctor trust in inter and intra professional relationships (workplace trust), whether professionals trust their colleagues, what type of trust this is based on in a variety of clinical settings and the multilevel impacts of trust (with an overlap here with system trust, see below). Further research is required, however, to foster a greater understanding of if and how trust in colleagues and the broader organisations within which professionals are working shapes and impacts on other trust relations for doctors, their professional identities, and the impacts on clinical practice. In terms of the broader lattice of doctor trust relations, it may be pertinent to explore if and how the financial priorities of the government (potentially in a cost-cutting sense that may be perceived as impacting on patient care) reflect and shape trust in managers because managers may be seen to embody and stand for the system (see further below). Or whether self trust shapes relations with other professionals.

A final point of consideration here is that a focus on workplace trust also highlights the limitations of much of the existing analysis of trust relations in terms of focusing on healthcare workplaces in high income countries. For example, evidence from studies of trust relations in health systems in low to middle income countries such as in India (Kane et al, 2015) suggests that any assumptions about confidence in the competence of doctors and their training and in the altruistic intentions of doctors by colleagues cannot be taken for granted. This evidence suggests the erosion of trust between doctors, as unethical practices were believed to be carried out by what was claimed to be a 'minority' of doctors who were receiving informal payments for patient referral to other services and between doctors and those entrusted to regulate or steward them where there was mutual distrust, as both parties were seen to be driven by financial and self-interested concerns. In addition, there was distrust of or lack of confidence in the competence of doctors trained in certain, privately funded medical schools where there was a suggestion that qualifications may have been purchased rather than earned (Kane et al 2015).

### System Trust

It has been argued that in terms of abstract systems that continual unproblematic functioning may result in system trust (Luhmann, 1979). The inherent complexity involved in the practice of modern medicine means that systems trust is important for doctors in managing such uncertainty, because trust is particularly important in traversing and gauging the unknowable (Möllering 2006). Pilgrim et al (2011) suggest that there has been a cultural shift that has fostered a variety of governance mechanisms, challenges to professional autonomy, and a reconfiguration of relationships of doctors with others, not just the interpersonal level, but also at the level of the healthcare system. System trust for the public and patients is grounded in accountability, ensuring competence, and the removal of malignant intents (Pilgrim et al, 2011), which then obviously underpins individual interpersonal interactions with and trust in medical professionals. Trust in the system for doctors, particularly the rank and file of the profession may be grounded in much the same way, although it may comprise additional elements. Indeed,

there now exists a large variety of governance mechanisms and professional bodies designed to maximise public trust (for example in the context of the NHS, the Quality Care Commission (CQC), and NICE). What is interesting from the perspective of this paper is the degree to which doctors trust in these governance mechanisms and institutional arrangements and the relationship of these understandings to their professional identity. Beyond this (and overlapping to some extent with the macro-level notions partially comprising workplace trust), doctor system trust may also relate to the functioning and funding of healthcare systems, systems protecting or reducing clinical autonomy and self-regulation, or the epistemic assumptions and knowledge production of the systems of biomedicine.

Focusing on the last of these elements in more detail, system trust here facilitates the management of biomedical uncertainty and complexity both as an abstract phenomena and as mediated by those who facilitate the creation of biomedical knowledge (for example, researchers and commercial industry) and by those who serve to protect the validity of biomedical knowledge (particularly regulators). Doctors may draw on a critical appraisal model of evidence based medicine (Harrison, 2009) but cannot understand all of the technical and scientific processes that provide justification for the development and advocacy of a certain drug treatment, for example. Proceeding with a particular drug treatment often involves system trust in the validity of the epistemic assumptions of biomedicine and the mediating systems that facilitate and protect such validity. An example here is the use in the UK of NICE guidelines surrounding drug treatments (drugs will also have been assessed for safety and efficacy by the MHRA). Such guidelines are in place to guard against variation in practice and to encourage evidence-based practice. NICE is predicated on the notion that it offers evidence based judgements that ensure cost effectiveness for the NHS and its patient population (Brown et al 2015). The evidence-based approach that underpins NICE, as such, is reflected in doctor system trust when following the guidelines – though, research has shown that there is no one way in which doctors make use of guidelines (Spyridonidis and Calnan, 2011). As such, following such guidelines reflects a system trust by a doctor in the endeavours of biomedicine as pursued by

the pharmaceutical industry, the production of valid evidence, and the assessment and use of this evidence by regulatory bodies who ensure safety, efficiency and cost-effectiveness.

In their role as evaluating the cost effectiveness of certain medicines and healthcare technologies, NICE purport to ensure that scientific endeavour is not contaminated by corporate priorities. Brown and Calnan (2013) discuss three epistemic assumptions upon which NICE's engagement with the pharmaceutical industry seems necessarily to be mediated by trust – and which, as such, trust by doctors in NICE and the epistemic assumptions they protect is, can also be argued, necessarily predicated. These are, first, trust in empirical science and the epistemological certainties attached to biomedicine. This refers to the unquestioned philosophical reality purported by biomedicine and its attempts to develop effective knowledge. System trust is a way to make sense of the complexity of biomedicine. However, this may be deeply problematic when the nature of the flaws of randomised controlled trials (RCTs) and NICE's apparent unquestioning assumption of the validity of the knowledge they herald. Second, system trust in publications. This refers to the systems surrounding publishing evidence – that they are objective and ensure quality through peer reviewing systems. Third, suspending doubts about industry interest. This refers to casting aside doubts about the industry's influence as producing negative or skewed results. Of course this is problematic because it assumes that such processes have the capability to manage elements such as selective publication and burying of evidence. It may be in a number of examples that doctors have systems trust in biomedicine as mediated by industry and regulators, reflecting, too, the dark side of trust noted earlier. However, it should not be assumed that doctors always trust in the purity of the actualities of biomedical knowledge as fostered by industry and protected by regulators, nor its application in a way that violates a patient-centred approach. As such research must also be sensitive to a low or lack of system trust by doctors in the same way.

Whilst the focus has been specifically on the epistemic assumptions of the systems of biomedicine in this section, the issues implicating trust raised in this section are also applicable beyond. In the most general sense do doctors display system trust in the abstract systems that

impact on their clinical activity and does this have impacts not only for patient care but for trust in patients? Do doctors see themselves as working within the system or against or outside of it, both in terms of mechanisms governing practice and also systems of biomedical knowledge generation, and how does this relate to understandings of professional identity and clinical autonomy? Beyond this, pertinently, how do specific institutional arrangements defend their decision-making in terms of evidence-based protocols and is this trusted by doctors? And do doctors have high or low trust in the biomedical validity of the types of evidence that underpin institutional directives – and indeed, the ability of institutional arrangements to guard against bias?

### **Conclusion: Towards a Research Agenda – The Key Questions**

The aim in this paper has been to assess the positioning of doctor trust within the wider literature, to stimulate debate about the importance of assessing trust for doctors, and to outline a conceptual framework concerned with developing research into doctor trust relations. Though mutuality between doctor and patient has been a concern for governments (Department of Health, 2010) and the medical profession for a number of years, doctor perspectives on the role of trust have been largely neglected. It has been argued in this paper that research must turn to analyse the importance of trust for doctors, not just in terms of expanding on analyses of trust and the interconnections with and impacts on doctor-patient relationships, but also in relation to professional identity and the consequences for practice (stemming from both micro-level interactions but also importantly beyond in terms of trust in organisations and systems).

Four conceptualisations of the types of trust have been proposed that may be relevant to doctors across a variety of healthcare settings, impact on their clinical practice, and necessarily shape healthcare delivery.

*Doctors' trust in patients:* Research could explore the extent of and types of trust in patients in a variety of clinical and organisation settings utilising notions put forward by Thom *et al* (2011) and Pilgrim *et al* (2011), exploring for example, trust in the information provided by patients as mediating decisions about treatment pathways.

*Self-trust:* Research needs to assess the level of trust a doctor has in themselves, potentially exploring how this might be shaped by career stage and experience. Self trust may connect with broader elements of systems trust because lower self-trust in clinical ability may be reflected in stricter adherence to guidelines and an unquestioning perspective on the system which in turn may impact on the quality of patient care provided. Self trust may also be important in understanding mutual trust between doctors and patients, for example, indecisive practice may result in low trust by patients, or low trust in patients who wish to pursue health practices beyond clinical guidelines.

*Workplace or organisation trust:* The assessment of workplace trust could explore if and how trust underpins and shapes a variety of inter and intra professional relationships, what type of trust this is based on in a variety of clinical settings, and whether doctors trust their colleagues – and, indeed, how broader relations of trust such as systems trust (or lack thereof) in, for example, NHS financial directives and the related politics is reflected in and shapes trust in colleagues.

*System trust:* Explorations of system trust within the lattice of trust need also to assess the ways in which this assists in managing the uncertainty and complexity involved in the practice of modern medicine. Doctor system trust may encapsulate a variety of phenomena and can refer to the functioning and funding of healthcare systems, systems protecting or reducing clinical autonomy, or the epistemic assumptions of the systems of biomedicine. The interconnections between the impacts of and interconnections between systems trust and other elements of the lattice of trust need also to be examined.

Whilst this is by no means an exhaustive set of themes, the framework aims to stimulate further conceptualisations and new research endeavours examining the nature of doctor trust, the impacts on clinical activity and the relationship to professionalism.

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