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Is having a trusting doctor-patient relationship better for patients' health?

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The concept of trust has been systematically and empirically studied in economics by the trust game paradigm (Johnson & Mislin, 2011) and in neuroscience (Koscik & Tranel, 2011) by trust priming (Dunn & Schweitzer, 2005) and studies on the so-called trust hormone oxytocin (Kosfeld, Heinrichs, Zak, Fischbacher, & Fehr, 2005). Although in health care research different conceptual approaches have been formulated depicting the nature of the trust and health outcome relationship drawing on qualitative as well as statistical correlational data (Baloush-Kleinman et al., 2011; Bonds et al., 2004; Franco, Joseph, Fei, & Bickell, 2009; Gaab, Blease, Locher, & Gerger, 2015; Volkmann, Claiborne, & Currier, 2009), research in this domain is lacking experimental evidence drawn from prospective studies and randomized controlled trials, in which the trust level is systematically changed to test for causality. This is particularly exemplified by the patient clinician relationship (Kelley, Kraft-Todd, Schapira, Kossowsky, & Riess, 2014). Kelley and colleagues (2014) showed in a meta-analysis on randomized control trials that the nature of the patient-physician relationship has a small but statistical significant effect on the health outcome of the patient. Similar effects might be expected for trust.

Some attempts have been made to explain the mechanism by which trust might influence the health outcome: Trust has been shown to encourage patients to access health care and to support appropriate disclosure of medical information as well as to increase adherence and patient satisfaction (Calnan & Rowe, 2008b). Thus, trust may have an indirect effect on health outcomes mediated through the effectiveness of treatments. Moreover, patients are treated and managed in the social and psychophysiological context of the doctor-patient encounter, the meaning and expectations formed by the interaction of the doctor and the patient, might be of significance for the health outcome (Spiegel & Harrington, 2008). From an evolutionary perspective, the signaling theory of symptoms states that symptoms as pain, nausea, or swelling not only serve a defensive healing but also as a signaling function, indicating the need for treatment and care to potential helpers (Steinkopf, 2015). With regard to Steinkopf (2015) symptoms might not only defend the body, but also signal the need for

appropriate social support and treatment, in which trust might play a crucial role. In accordance with this evolutionary perspective, Lee and Lin hypothesize that trust creates a social context for patient and doctor resulting in increased physician's caring behavior, the doctor is more concerned about the patient, more eagerly diagnosing and treating the patient, which in turn influences the patients' health outcome (Lee & Lin, 2008). Furthermore, they emphasize that trust leads to an expectancy of better treatment outcome, which might result in better health (Kaptchuk et al., 2008; Lee & Lin, 2008). However, these theoretical propositions, which depict the direct effect of trusting relations on health outcomes, need to be supported by stronger empirical evidence.

In clinical practice, training programs have been developed in order to enhance trust relations, including interventions to improve communication skills, to enhance caring behavior and/or to demonstrate confidentiality. These interventions have failed to show any beneficial effects so far. Bearing in mind there are varying various definitions of trust, the simplest concept divides trust into confidence in professional competence and intentional trust, which implies working in the best interest of the patient (Calnan & Rowe, 2008a). It is argued here that with reference to the first part of trust (competence) skill trainings might improve the health outcome (although only in regard to facilitate a competent and efficient treatment). Regarding intentional trust, these specific training programs might be of little benefit for enhancing values such as honesty and confidentiality. On the contrary training particular skills on how to behave to appear trustworthy might harm the authentic patient-provider relationship. More specifically, it is proposed here that the value of intentional trust needs to be protected at the macro level of the health care system. As described in the medical ethical code, one major goal of the doctor is to build a trustful relationship (General Medical Council, 2013). In a context of increasing marketization and privatization (Stepanikova, Cook, Thom, Kramer, & Mollborn, 2009), coupled with financial cuts, it is necessary to actively create room for clinicians to pursue their altruistic values for patient-centered care and not be constrained by the goals of providers and commissioners which may not be in alliance with patient-centered practice (Douglass & Calnan, 2016). Practices that are associated with a higher level of patient trust such as allocating the time to listen to the patient and taking her/his problems seriously (Croker et al., 2013), are restricted by the new role of the doctor, who's duties now not only include improving the health of the patient, but also involves taking financial considerations into account. It might be considered a sign of the times that empathy skill trainings, patient-centered listening are subject of increasing research interest,

while on the other hand the health care system, due to cost pressure, restricts the space and time needed for empathy and trust.

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