

Measuring Patients' Trust In Physicians When Assessing Quality Of Care

Every reason for measuring other aspects of quality applies with equal force to measuring trust.

by **David H. Thom, Mark A. Hall, and L. Gregory Pawlson**

PROLOGUE: It's been broken, misplaced, abused, shaken, and violated. Occasionally it's repaired and rebuilt. Trust is a vulnerable and fragile commodity, vaunted in the marketplace, acknowledged in every profession, yet perniciously difficult to quantify. Marketers measure its value in brand loyalty, customer retention, product satisfaction, and sales. In the health care marketplace, the absence or presence of trust in patient-provider relations can have life-changing consequences. A person who trusts a provider is more likely to seek care, to comply with treatment recommendations, and to return for follow-up care than a person who has little trust in a specific provider or health care system. Doesn't that alone make it something worth measuring?

If one reads the paper by David Thom, Mark Hall, and Greg Pawlson, the answer is unequivocal: If we do not measure trust, we can ignore it, fail to cultivate it, and ultimately lose it. Measuring levels of trust between patient and provider can reveal systemwide failings or individual communication hurdles. Low levels of trust can be changed, and improved trust might well reduce disparities, increase access, and improve health outcomes. Who doesn't want that?

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ABSTRACT: Trust is a fundamentally important aspect of medical treatment relationships. Studies have established that patient trust predicts instrumental variables such as use of preventive services, adherence, and continued enrollment at least as well as satisfaction does, and is more salient for measuring the quality of ongoing relationships. Measuring trust would help to inform public policy deliberations and balance market forces that threaten the doctor-patient relationship. Several validated measures could be easily included in surveys. While further studies to evaluate the cost-effectiveness of measuring trust and test interventions to improve trust are desirable, the action merits serious consideration.

TRUST IS WIDELY RECOGNIZED as being central to the doctor-patient relationship. It is a concept that resonates strongly with both doctors and patients, is highly valued by both, and is distinct from satisfaction. Given these qualities, the question arises, Should health care organizations be measuring patients' trust in their physicians?

Interest in patient trust has increased dramatically since 1979, when Russell Caterinicchio published the first study measuring patients' trust in their physicians.¹ Since then, several measures of patient trust have been developed, and qualitative research studies using patient interviews or focus groups have expanded and solidified our understanding.² In this paper we review this burgeoning literature to address the argument for incorporating measures of patient trust more widely into the evaluation of quality of care. We first assess reasons for measuring trust and then evaluate the current status of trust measurement.

What Is Patient Trust?

Although a variety of definitions of *interpersonal trust* have been proposed, a core concept is that trust is the acceptance of a vulnerable situation in which the truster believes that the trustee will act in the truster's best interests. For purposes of measurement, physician attributes identified by patients as engendering trust may be grouped into domains of technical competency, interpersonal competency, and agency (also called fidelity, loyalty, or fiduciary duty).

The attribute of technical competency is fairly self-evident, although the physician behavior used by patients to judge technical competency may be quite different from behavior that would be judged by a colleague. Interpersonal competency refers primarily to communication and relationship-building skills—listening, understanding, providing complete and honest information, and expressing caring. The third domain, agency, is more specific to trust. It refers to acting in the patient's interest—for example, putting the patient's welfare ahead of costs or other considerations. An additional domain, confidentiality, is rarely mentioned by patients and is more weakly associated with the concept of trust as defined by the other domains.³

Despite several attempts to develop separate subscales for each of these domains, all trust measures to date have a single-factor structure, indicating that

these domains are all part of a single “global” concept. One way to understand this close relationship between the three principal domains is that all three are aspects of trust, but none are independent from the other domains or from trust more generally. To correctly apply technical competency to the patient’s problem also requires interpersonal competency—to understand the patient’s needs and preferences, to communicate effectively, and to build a working partnership for carrying out treatment. Agency is the third necessary component, providing the motivation to make the effort needed on the patient’s behalf. A patient’s positive or negative view of one dimension tends to spill over to the view of the other aspects of trust. This global characteristic of trust differs notably from measures of satisfaction, which tend to be much more compartmentalized.

Should We Value Patient Trust?

Focus groups with patients reveal that trust is often a defining characteristic of their relationships with physicians and other care providers.⁴ Because these relationships are deeply personal and can be profoundly life-altering, a case can be made that the essential quality of these relationships is a fundamental good worth pursuing, regardless of the demonstrable connection with hard, measurable health outcomes. This is borne out by the importance that medical ethics and law place on maintaining and justifying trust between doctors and their patients. Patient trust can be considered a collective good, similar to “social capital,” that is necessary for an effective health care system.⁵

■ **Links to treatment adherence.** In addition to its intrinsic value, there is increasing evidence that patient trust is linked to intended or reported patient adherence to treatment recommendations. In a 1999 study by David Thom and colleagues, 62 percent of patients in the highest quartile of trust reported that they always took prescribed medication and followed their doctor’s recommendation, compared with just 14 percent of patients in the lowest trust quartile.⁶ Similarly, Dana Safran and colleagues found that patients with higher trust in their physician were significantly more likely to report engaging in eight recommended health behaviors, including exercise, smoking cessation, and safe sexual practices.⁷ Trust in the physician was also found to be one of the strongest predictors of patients’ decision to enroll in a study of a new treatment for cancer.⁸

■ **A predictor of continuity.** Trust is also a strong predictor of continuity with providers. For example, the 1999 study by Thom and colleagues found that after six months, only 3 percent of patients in the highest trust quartile had left their physician, compared with 24 percent of patients in the lowest quartile.⁹ Other studies have found a similar, strong association between trust and actual or intended change in providers.¹⁰

■ **Implications of lack of trust.** Several researchers have suggested that lower levels of trust among people of color, particularly among African Americans, may help to explain their lower rates of care seeking, preventive services, and surgical

treatment compared with whites.¹¹ Most studies that have compared levels of trust among white patients and patients of color have found lower levels of trust among the latter groups.¹² Studies have found that lower interpersonal trust is associated with poorer care among patients of color. For example, in a large community study by Ann O'Malley and colleagues, trust in a personal physician was the strongest predictor of willingness to initiate antiretroviral treatment for HIV infection in a population of primarily African American and Hispanic inmates and was a strong predictor of preventive services use among African Americans.¹³

■ **Trust versus satisfaction.** Patient trust is related to, but conceptually distinct from, the more familiar concept of satisfaction with the physician. Satisfaction looks backward, based on past experience, while trust looks forward, an expectation of future behavior. Although *satisfaction* refers to the patient's opinions of the physician's actions, *trust* refers to the relationship between the physician and patient that is based largely on perceptions about the physician's motivations. Trust also has a strong emotional component not present in satisfaction.

In focus groups, patients readily differentiate trust from satisfaction, describing trust as a reflection of a commitment to an ongoing relationship. Patients may report being satisfied with each visit but still not feeling they have established a sense of trust. Conversely, trust in a physician may be maintained even if a particular visit is not satisfactory.¹⁴

The case for monitoring satisfaction as a performance measure has been built primarily on instrumental grounds: Satisfaction has been shown to predict important health-related behavior, such as adhering to treatment recommendations and maintaining continuity of care. However, at least one study found that compared with satisfaction, trust is more strongly associated with adherence and continuity of enrollment; when trust and satisfaction were placed in the same multivariate model, only trust remained independently associated with these two factors.¹⁵ These findings suggest that increasing trust may be even more important than increasing satisfaction for improving these outcomes.

■ **Impact on costs, use, and efficacy.** The relationship of trust to overall costs and use of services has not been studied. In theory, greater patient trust may lead to more efficient care in at least two ways. First, patients with higher trust may be more willing to disclose sensitive information to a physician, which may help the physician provide more appropriate care. Second, trust may reduce the costs associated with verifying physicians' opinions and recommendations. This could translate into fewer unnecessary referrals or diagnostic tests than patients would otherwise request.

It has also been suggested that trust can improve therapeutic response, either through better adherence to treatment or by mechanisms similar to the action of placebos. In the words of Galen, one of the founders of modern medicine, "He cures most in whom most are confident."¹⁶ In support of this position, one study found a modest but significant association between patient trust and reported im-

provement of symptoms two weeks after the visit, even after controlling for multiple patient, physician, and visit characteristics.¹⁷

It can be argued that in some circumstances, patient trust in the physician could actually lead to poorer care, as patients would be less likely to seek a second opinion or question inappropriate medical advice. This possibility has not been studied, but it merits investigation.

Should We Measure Patient Trust?

If we accept that trust is important, should it be measured and potentially publicly reported, or, perhaps more like trust in intimate relationships, is it better left to individuals to discern and monitor on their own? We make the case for measurement, based first on the aphorism in public policy that what is not measured can easily be ignored and can never be adequately understood. There is widespread concern that patient trust is declining under various threats to the doctor-patient relationship, including aspects of managed care.¹⁸ Others, however, remark on how high trust remains and how resilient it is to various imagined threats.¹⁹ These differing accounts of reality are used to argue for various legal, ethical, and public policy positions regarding trust, such as managed care patient protections. But without measuring trust, we will not know if such actions are necessary, effective, or counterproductive.

Measuring trust would also be an important complement to market forces. It could help focus market forces on sustaining or improving trust as an aspect of health care quality. Trust is often implicitly or explicitly used in marketing hospitals, health plans, and physician groups. However, if patient trust is not measured, it is unlikely to be valued sufficiently to balance the economic forces believed to reduce the strength and quality of medical relationships. Measures of patients' trust in particular physicians and other providers can be aggregated to create a measure of patients' trust in their providers within a clinic or health plan. Such a measure would allow provider and payer organizations to monitor and provide an incentive to change organizational and physician behavior to promote patient trust.

In short, every reason that exists for measuring other aspects of quality applies with equal force to measuring trust. Indeed, for some purposes, trust may be a more encompassing and revealing measure than any of the others, either alone or combined. One would undoubtedly still want to measure physicians' behavior that is believed to be related to trust, in part to assess whether physicians deserve the level of trust they are receiving. However, knowing about this behavior is not the same as knowing the level of patient trust.

Despite its seminal importance, trust remains neglected in the array of current performance evaluations. This may be due to a belief that it is not feasible to measure trust or that even if it were measured, it is not feasible to improve trust. Therefore, we review the existing literature on these two remaining questions: (1)

Is it feasible to measure patient trust? (2) Can patient trust be changed?

■ **Feasibility.** A recent review of the literature located five measures of patient trust in physicians, ranging from eight to eleven items in length.²⁰ All scales have a single-factor structure and high internal reliability. All scales have also been shown to have good construct validity in that they show expected associations with other measures, such as being positively correlated with length of the relationships, and are separate from related measures such as patient satisfaction. Several scales have been found to have good predictive validity for outcomes expected to be sensitive to trust, such as adherence and continuity.

The single-factor structure common to all measures suggests that a shorter scale, or even a few individual questions, can be used to characterize trust. A shortened version of the Wake Forest Trust Scale, with only five items, performs similarly to the full ten-item scale.²¹ While short, even single-item measures of trust may be appropriate for some purposes, multi-item measures are useful for identifying specific areas for improvement by delivery systems or individual physicians. Specific items can also provide insight into changes in important aspects of the patient-physician relationship. For example, surveys of more than 2,000 Massachusetts adults seeing the same physician in 1996 and 1999 found a significant decline in patient-physician trust despite the increase in the length of the patient-physician relationship. This decline was driven by an increase in concern that the doctor cared more about holding down costs than about doing what was needed for the patient's health. However, over the same period there was an increased willingness to confide in the doctor, which suggests that concerns about privacy were not paramount during this period.²²

■ **Changeability.** Evidence from qualitative studies suggests that patient trust is a "state," not a "trait," and is therefore subject to change. In focus groups and interviews, patients readily recall events that they felt greatly increased or decreased their trust in a physician. Patient trust also appears to be specific to the particular physician, correlating only weakly with patients' trust in people in general. Moreover, there is much variation in the mean level of trust reported by patients of different physicians.²³ This provides evidence for the commonsense view that trust is influenced by patients' experience with their physician and that patients can have different levels of trust in different physicians. Levels of patient trust vary by type of delivery system, being somewhat lower among patients of health maintenance organizations, even after adjustment for other factors, and can change over time.²⁴

■ **Physicians' behavior and trust.** Research has identified physician behavior associated with increased or decreased trust, based on patient focus groups and interviews, patient surveys, and psychological theory.²⁵ Physician behavior identified by patients as increasing trust generally falls into the categories of competency, communication, caring, honesty, and partnering. In addition, investigators in psychology and sociology have identified factors that promote interpersonal trust in experimental settings.²⁶ These include (1) greater perceived mutual interests; (2)

clear communication; (3) a history of fulfilled trust; (4) less perceived difference in power with the person being trusted; (5) acceptance of personal disclosures; and (6) an expectation of a longer-term relationship. All of these associations suggest approaches that would be expected to increase patient trust, such as emphasizing mutual interests (the patient's health); checking patients' understanding of communication; taking opportunities to fulfill trust (phoning with test results); reducing power differences (sharing information); responding to patients' self-disclosures in a supportive and nonjudgmental way; and promoting continuity of care.

■ **Impact of organizational factors.** Organizational factors are also important in establishing and maintaining patient trust.²⁷ These include allowing and encouraging patients to choose their physician; giving patients sufficient continuity with the same physician to allow for the establishment of an ongoing relationship; giving physicians control over decisions affecting their patients' care; and ensuring that physicians are not under economic or other pressures to act other than in their patients' best interests (although one study failed to confirm this).²⁸ In addition, organizational structures that allow better communication between physicians and patients—for example, reporting test results or answering questions outside of the office visit—may help build trust as well.

■ **Testing the strategies.** Although our knowledge about trust suggests multiple strategies for increasing trust, there have been few attempts to test them. One study that attempted to change patient trust, using a half-day workshop for physicians, found no effect.²⁹ However, another study found that trust by Spanish-speaking parents of children seeing five pediatricians increased after the physicians completed a two-week Spanish language immersion course.³⁰ For an intervention to be successful, it would likely require more than a single workshop and would ideally include changes to increase organizational support for and reinforcement of trust-building behavior.

Is Measuring Trust Likely To Be Cost-Effective?

Measuring trust imposes an additional burden on organizations, requiring resources that could be applied elsewhere. Thus, it is important to consider the likely costs and benefits of incorporating trust measures into the evaluation of health care quality. The direct cost of measuring patient trust depends on the specific context. At a minimum, it would mean adding one question to an existing patient survey. Adding a validated trust scale would mean an additional five to ten questions, possibly replacing existing questions related to patients' satisfaction with their physician. Thus, simply measuring trust requires a relatively small investment. Additional costs would come from interpreting the results and reporting them to physicians and organizations. If this were done as part of a larger evaluation of quality, these costs would not be large.

Establishing a new physician training program and organizational strategy to increase patient trust would incur sizable additional costs. However, to the extent

that this training could be incorporated into related existing or planned training programs (for example, programs to improve physician communication or cultural competence), the additional costs could be modest.

THE POTENTIAL FOR COST SAVINGS through increased efficiency, fewer demands for tests or referrals, better adherence to treatment, increased use of preventive services, and greater continuity has been outlined above. Whether measuring and improving trust will be cost-effective is a question that will need to be answered empirically. Although we believe that trust is an important social good, the motivation to measure trust will come only if there is a return on investment to the organizations conducting the measure. Such a return is by no means certain, but the potential for such a return clearly exists. Therefore, it would seem reasonable to begin incorporating measures of trust and interventions to improve trust into existing efforts, so that the costs and benefits of focusing on trust can be assessed more fully.

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NOTES

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4. Thom and Campbell, "Patient-Physician Trust"; Mechanic and Meyer, "Concepts of Trust"; and Goold and Klipp, "Managed Care Members Talk about Trust."
5. A view of trust as capital is nicely expressed by the following quote from a physician during a focus group: "I often feel like I'm spending a lot of saved up goodwill with my patients. Making little withdrawals and spending it...so the trust is there." See also E.D. Pellegrino, R.M. Veatch, and J.P. Langan, eds., *Ethics, Trust, and the Professions: Philosophical and Cultural Aspects* (Washington: Georgetown University Press, 1991); M.A. Hall, "Law, Medicine, and Trust," *Stanford Law Review* 55, no. 2 (2002): 101-163; and P. Illingworth, "Trust: The Scarcest of Medical Resources," *Journal of Medicine and Philosophy* 27, no. 1 (2002): 31-46.
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