



# Perceived control over health, communication and patient–physician trust



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## ABSTRACT

**Objective:** Patient–physician trust is linked to higher medication adherence. To date, the relationship between trust and perceived control over health, a strong driver of patient health behavior, has not been tested. This study tested the contribution of patient perceived control over health to the explained variance in patient–physician trust, beyond the contribution of known antecedent. This study also tested the moderation effect of perceived control over health on the relationship between participative communication and patient–physician trust.

**Methods:** This cross sectional study is based on a representative sample of 820 Israeli respondents with identical healthcare plans. Measures were used in previous studies and hold good psychometric properties.

**Results:** Structural equation modeling supported study hypotheses. Patient perceived control over health uniquely contributed eight percent to the explained variance of trust. When perceived control over health was high and perceived communication was participative, trust was higher.

**Conclusion:** Communication with patients is to focus on the enhancement of patient perceived control over health.

**Practical implications:** Training programs should aim at creating awareness among physicians to the importance of perceived control over health and to their ability to enhance it. Training programs should also facilitate the adoption and implementation of participative communication skills.

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## 1. Introduction

Health psychologists have been studying the involvement of individuals in health promoting behaviors. One driver of patient involvement is health perceptions [1]. Perceptions ultimately affect whether one stays healthy or becomes ill [2,3]. In some cases health perceptions even affected mortality [4]. Moreover, the link between perceptions and health behaviors exists regardless of the truth of the perception [5–7]. The most frequently studied health perception is control over health [8] anchored in the social learning theory.

The social learning theory classifies people along a continuum of perceived control [9,10]. It relates to a general expectancy about whether outcomes are controlled by one's behavior or by external forces. The continuum ranges from internal to external locus of control (LOC). People with a strong internal locus of control (ILOC) believe that success or failure is due to their own efforts. External

believe that reinforcements are controlled by luck, chance, or others [11]. Therefore, internals support self-directed actions [12].

Traditionally, ILOC reflected personal mastery [10]. LOC referred to assumed internal states of individuals. Behaviors such as information seeking, alertness and decision making were attributed to people with ILOC who actively and willingly relied on internal resources to deal with difficult circumstances. In 2007, however, Moore [13] extended the concept of ILOC beyond personality attributes to one's perceived ability to resolve a problem while relying on internal and external resources (i.e., others). Relying on others, especially in psychological situations of vulnerability, involves trust.

To trust a person is a voluntary action based on one's expectations of how others will behave in the future [14,15]. The focus of this paper is on interpersonal trust of patients in their primary physician. Interpersonal trust, a defining element in any interpersonal relationship, is central between patients and their physicians. Since interpersonal trust develops overtime through repeated interactions, this study relates to trust in primary physicians in the community rather than in hospitals or secondary care [16–18]. Trust in physicians is the acceptance of a vulnerable

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situation in which the patient believes that the primary physician will act for the benefit of her or his interests [19].

The importance of patient–physician trust emerges from recent findings that link this trust to higher adherence to medication and therapeutic instructions [20–22]. A higher level of adherence results in better health [23,24]. The 2010 Pew Research Center report [25] shows low current levels of adherence. Twenty four percent of Americans turn to other sources for recommendations for alternative treatments. Fifty one percent of Americans turn to family and friends for quick medications, 46% of Americans turn to fellow patients for advice on coping with health situations. Forty six percent of caregivers for chronically ill patients look online for a diagnosis.

Over time, lack of adherence translates into the deterioration of patients' health and additional hospitalizations and treatments [26–27]. The report [25] stresses the need to promote health through the enhancement of patient–physician trust. This study tests the enhancement of patient–primary physician trust. Much has been studied on patient–physician trust. However, although the importance of both patient–physician trust and perceived control over health are well acknowledged, to date, the relationship between them was not tested. The direct effect of ILOC on

patient–physician trust was not yet tested. ILOC may reveal an additional path to enhance trust beyond the contribution of known antecedents. This paper focuses on patient–physician trust and ILOC. In the next section of the paper this author reviews known antecedents of trust, then moves forward to review studies on ILOC in healthcare and finally states two hypotheses concerning ILOC and patient–physician trust. Known antecedents of trust are demographics, health control variables, conduct of the physician, communication style, expectations of patients from the physician and patient satisfaction with the physician.

Among demographic control variables, when education was lower, patient trust was higher, and when age was higher, patient trust was higher [28–30]. Trust was also found to be higher among minorities [31]. Similar demographic attributes of the patient and the physician also affected trust [32]. When the physician and the patient were the same sex and race, patient trust was higher [33].

Health control variables also helped explain the variance of trust. Disease status affected trust: the poorer the physical health of the patient, the higher the trust in the physician [34]. Also, the longer the patient–physician relationship had been in existence, the higher the trust [35,36].

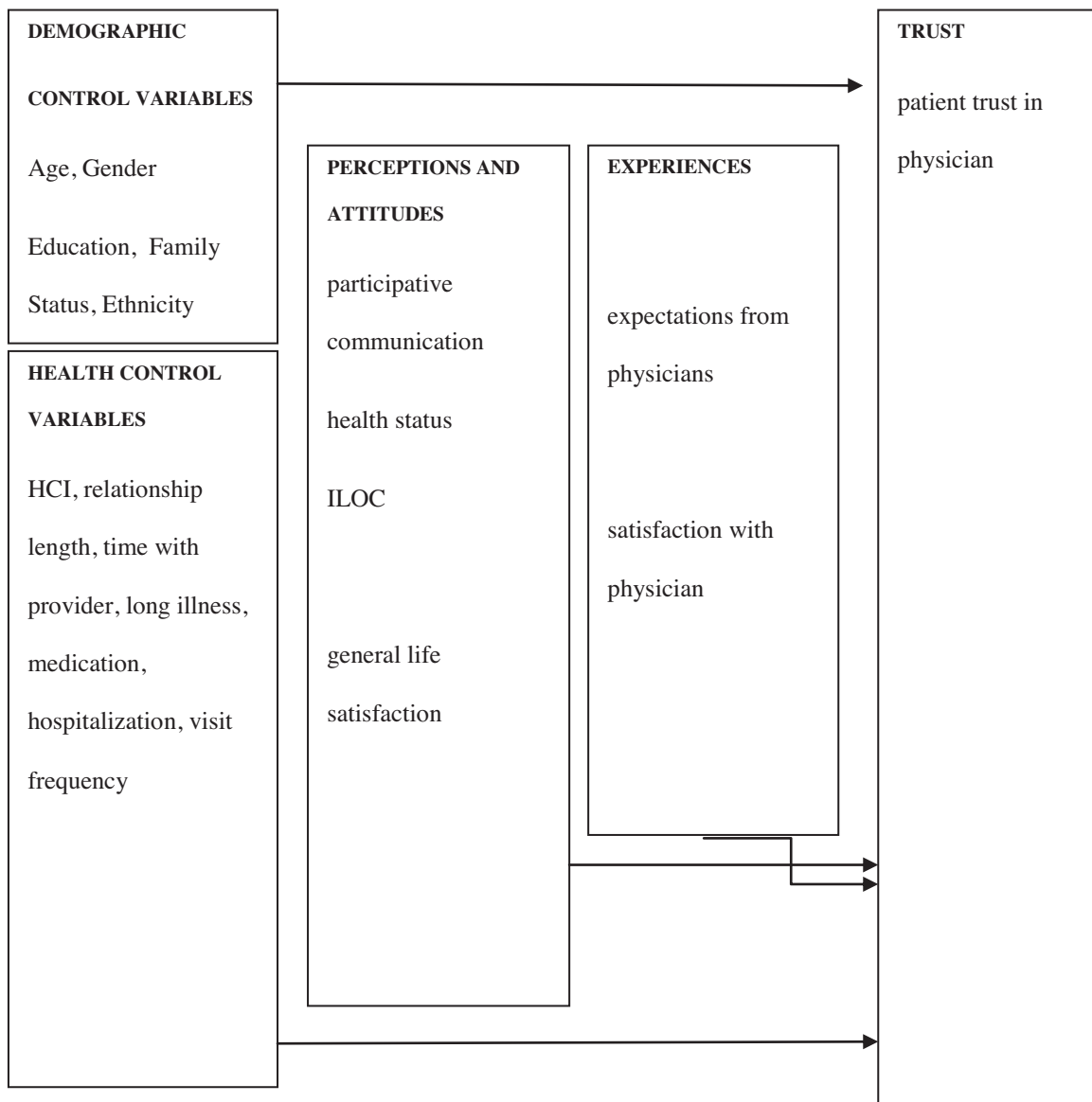


Fig. 1. Antecedents of trust by categories.

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