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Review article

Measuring physicians' trust: A scoping review with implications for public policy

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ABSTRACT

Increasingly, physicians are expected to work in productive, trusting relationships with other health system stakeholders to improve patient and system outcomes. A better understanding of physicians' trust is greatly needed. This study assesses the state of the literature on physicians' trust in patients, other health care providers, institutions, and data systems or technology, and identifies key themes, dimensions of trust considered, quantitative measures used, and opportunities for further development via a scoping review. Peer-reviewed, English-language research articles were identified for inclusion in this study based on systematic searches of the Ovid/Medline, Pubmed, Proquest, Scopus, Elsevier, and Web of Science databases. Search terms included "trust" along with "physician," "doctor," "primary care provider," "family practitioner," "family practice," "generalist," "general practitioner," "general practice," "internist," "internal medicine," or "health professional," and plausible variants. Among the relevant articles identified (n = 446), the vast majority focused on patient trust in physicians (81.2%). Among articles examining physicians' trust, rigorous investigations of trust are rare, narrowly focused, and imprecise in their discussion of trust. Robust investigations of the effects of trust or distrust—as opposed to trust's determinants—and studies using validated quantitative trust measures are particularly rare. Studies typically measured trust using the language of confidence, effective communication, or cooperation, rarely or never capturing other important dimensions of trust, such as fidelity, the trustee's reputation, social capital, vulnerability, and acceptance. Research employing new, validated measures of physicians' trust, especially trust in institutions, may be highly informative to health system leaders and policymakers seeking to hone and enhance tools for improving the effectiveness and efficiency of the health care system.

1. Introduction

A more comprehensive understanding of the workings of trust throughout the health care system can benefit patients, physicians, and other stakeholders alike (Gilson, 2003; Mechanic, 1998). Social scientists have long regarded trust as a key, multidimensional component of interpersonal relationships, financial interactions, organizations, social networks, and in society more generally (Giddens, 2013; Luhmann, 2000; Meyer et al., 2008). In health care, seminal studies by David Mechanic (Mechanic, 1998; Mechanic and Meyer, 2000) and others have identified the importance of trust in the doctor-patient relationship, demonstrating that trust is critical for encouraging open and frank communication and promoting treatment compliance (e.g., Maxwell et al., 1999; Rogers, 2002; Thom et al., 2011).

Notably, most of these studies have focused on patients' trust in their doctors, and not vice versa. The focus on patient trust is arguably a reflection of historically high levels of trust in physicians. Until the 1980's, physicians were clearly the "dominant" profession in health care with near complete autonomy over their scope of practice and broad claim to expertise. This essentially obviated overhead management and limited the autonomy of "subordinated" professions, such as nurses and allied health professionals. It was expected implicitly that physicians, as the dominant professionals, would act in the best interests of their patients, manage "subordinated" professionals fairly, and use health care and health care financing resources responsibly. In exchange, physicians were free to exercise considerable autonomy and self-regulate (Pilgrim

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et al., 2010). Whether physicians trusted patients, nurses, managers, and other health system stakeholders was moot because they were free to negotiate relationships through the exercise of control, power, and authority and not based on trust.

However, whether physicians trust others has become increasingly relevant. Today physicians regularly find themselves in complex relationships with patients, fellow care providers, and others, wherein shared decision-making and coordinated, team-based care processes are encouraged or demanded (Selby et al., 2012; Agoritsas et al., 2015); in these relationships, physicians are no longer sole decision-makers. Additionally, physicians are often employees, subject to managerial authority, utilization management protocols, and quality measurement regimes integrated into electronic health record systems and reporting tools. Thus while the literature focuses on the patients' risk, vulnerability, and dependence in relationships with their physicians (Egede and Ellis, 2008; Meyer and Ward, 2013; Brown and Meyer, 2015), physicians themselves are now frequently at risk, vulnerable, and dependent in numerous, diverse relationships.

Whether physicians trust their counterparties in these diverse relationship can significantly affect the effectiveness, efficiency, and longevity of these relationships (Succi et al., 1998; Rogers, 2002; Gilson et al., 2005; Fulton et al., 2011; Moote et al., 2011; Martin et al., 2014) and, ultimately, the quality of care patients receive (Kaasalainen et al., 2007; Moskowitz et al., 2011; Martin et al., 2014). Moreover, the overall success of many policy and operational interventions may hinge on physicians' trust in the intervening authorities. For example, in the United States, where physicians may grant access to patients differentially by insurer, different patient groups' access may be affected by associated changes in physicians' trust in select payer entities (e.g., public insurance agencies) and regulators (Wilk and Jones, 2014). Together, the increasing relevance of physicians' trust and the growing appreciation for the potential consequences of physicians trust (or distrust) in patients, other health care providers, health care system institutions, and technology highlight the need for a review to establish what is known and what remains to explore in efforts to understand physicians' trust.

Likewise it will be valuable to more fully understand the complexities of trust and in what ways trust is context-dependent as it operates in relationships at and across individual, community, institutional, and system levels. The forms trust takes in these relationships are related to one another, but they are not equivalent (Anderson and Dedrick, 1990; Gilson et al., 2005). Trust is also multi-dimensional. It is frequently defined, for example, in terms of confidence (Coleman, 1990) when concerning trust between individuals and between individuals and systems. Other relevant dimensions of trust focused principally at the community level include the concept of social capital (Putnam, 2000), which has been applied in evaluating communities' value of social relationships and individuals' beliefs regarding the strength and reliability of relationships and may thus have a strong influence on trust in physicians' professional relationships. Other key trust constructs include fidelity, competency, integrity (Hall et al., 2001) and familiarity (Luhmann, 2000; Giddens, 2013). A more complete understanding of the relevant dynamics of trust in these different contexts—specifically in relationships where physicians are trustors rather than trustees only—could identify mechanisms that build or break down trust and significantly affect important outcomes (e.g., patient care quality) as well as expose factors underlying these mechanisms that should be the target of future research efforts or interventions.

To better understand the current scope of empirical studies of physicians' trust that could best inform hypotheses about relevant dimensions of trust and the impact of physician's trust in integrated and complex health systems, we conduct a scoping review of the peer-reviewed literature concerning physicians' trust and assess critically how this trust has been measured and analyzed. Scoping reviews such as this aim to map the existing literature and identify gaps to inform future research (Arksey & O'Malley, 2005). Specifically, we consider how trust is framed in studies of physicians' trust—that is, what dimensions of trust are included in trust metrics—discuss implications for public policy, and identify what researchers can do to better meet health care system leaders' needs for improved understanding of physicians' trust.

2. Methods

We followed an inclusive, inductive approach in conducting this review, seeking to identify all peer-reviewed, English-language research articles that investigate physicians and trust. We included articles published during 1980 and subsequently to capture research that would recognize the growing importance of physicians' trust following the decline of physicians' professional dominance during the 1970s (Timmermans and Oh, 2010). Using the databases Ovid/Medline, Pubmed, Proquest, Scopus, Elsevier, and Web of Science, we searched for the term "trust" along with "physician," "doctor," "primary care provider," "family practitioner," "family practice," "generalist," "general practitioner," "general practice," "internist," "internal medicine," or "health professional," using asterisk Booleans to ensure we captured plausible variants of these terms. We limited the set of physician specialty-specific search terms to the primary care-specific because these specialties have been particularly likely to see declines in their professional dominance in recent decades and because of the diversity of relationships these physicians maintain, relative to other specialties (Scott, 2000). Newspaper articles and book reviews were excluded from our results along with articles alluding to trust only obliquely, such that the word "trust" appeared only in the titles of articles cited. We completed this search in August 2014, identifying 720 articles that met our criteria.

We conducted an initial review of one third of these articles jointly (*AW and JP*), and we each completed reviews separately for an additional third. In these reviews, we first identified whether each article was relevant to our study of trust in physicians and, more importantly, trust by physicians. We defined relevance broadly. Articles with brief allusions to physician-patient trust dynamics in the context of patients' adherence to recommended treatments were classified as relevant, while we classified as irrelevant articles discussing trust and physicians in separate contexts and articles referring to trusts—that is, bodies of trustees—composed of physicians (e.g., England's Primary Care Trusts), as examples. Our Cohen's kappa statistic for inter-rater reliability in this assessment among articles jointly reviewed was 0.86, reflecting very strong agreement.

Because we found these relevant articles were diverse but often used imprecise language and classification schemes, we analyzed them inductively. To simplify our interpretations of findings related to trust in different physician relationships, we classified the relevant articles' discussions of trust and physicians as pertaining to:

(A) patients' trust in physicians,
(B) physicians' trust in patients,
(C) physicians' trust in other health care professionals, such as other physicians, nurses, nurse practitioners, pharmacists, and managers,
(D) physicians' trust in institutions, such as payer organizations and hospitals, or