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Trust, trustworthiness and health

ANGUS DAWSON

Trust is an essential component of good healthcare. If patients trust their physicians, then the relationship between them can be a richer and more meaningful one. The patient is more likely to feel confident and able to disclose symptoms, helping diagnosis and future care. If public health and community workers are trusted, not only is it likely that their work will be easier, in that their actions will be respected and accepted, but their advice will also be sought spontaneously. Trust, can, therefore, be thought of as something that is of benefit to all: healthcare workers, individuals and communities. Trust is, generally, something to be prized and we need to do anything we can to strengthen it.

However, trust can also be misplaced (1) Individuals may be trusted because of their social position and role, rather than because they necessarily deserve it. A doctor's advice may be followed, because the patient trusts her/him, even though the doctor stands to gain personally from the transaction. For example, a corrupt physician may refer a patient for an unnecessary test, knowing that the patient's trust will lead them to go for that procedure. In this case the intervention is not because it is beneficial to the patient, but because the doctor will receive a payment from a colleague at the clinic as a reward for the referral. Healthcare workers need to be aware of the potential problem of misplaced trust, and guard against it in all their actions. Those with responsibility for the education and the registration of healthcare workers need to ensure that healthcare workers are aware of the dangers of such trust and take action where trust is abused. Another example of possible abuse of trust is in certain cases of conflict of interest.For example, physicians working in occupational health may be perceived by employees as acting in their interests as patients, as that is the way that they understand the nature of being a doctor. However, even though the physicians may be aware of this, they may have chosen to put the interests of the company above those of the employees, dismissing symptoms of an occupational disease or even suggesting an alternative diagnosis.

Author: **Centre for Values, Ethics and the Law in Medicine (VELiM), University of Sydney**, Level 1, Medical Foundation Building, 92-94 Parramatta Road, Camperdown, Sydney, AUSTRALIA – Angus Dawson (angus.dawson@sydney.edu.au), Professor of Bioethics and Director.

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Some writers on trust, such as Russell Hardin, have argued that it is not trust that should be at the centre of our discussions, but rather the idea of trustworthiness (2). The idea is that we ought to focus on the properties of the individual or institution that are interested in invoking trust. As a result, we may be able to characterise the kinds of dispositions, structures or behaviours that we know tend to encourage and consolidate trust. This has led other writers to link the idea of trust and trustworthiness to that of the necessary virtues of particular social roles (3). The idea of trust has long fascinated writers, but there has been much theoretical work done on trust in the last 20 years. However, exactly how we conceptualise trust, trustworthiness and related obligations is subject to on-going debate. In addition to this more conceptual work there is beginning to be broader interest in studying trust empirically. The three papers on trust in this issue of *IJME* are fine examples of this work.

In their paper Gopichandran and Chetlapalli use a structured questionnaire to elicit answers to questions so that five different dimensions of trust in physicians (eg perceived competence, treatment assurance, confidence, loyalty and respect) can be measured and evaluated (4). This study builds upon previous work by Hall et al (5) in high income countries that also identified five different dimensions of trust (eg fidelity, competence, honesty, confidentiality and global trust). The use of a similar method allows for comparisons to be made between different countries and contexts and for variances between the different settings in relation to trust to be noted. The ability to make such comparisons is a welcome one, but one disadvantage of this method is that it already commits us to a certain approach to trust, built around the five identified dimensions. It may, however, turn out to be the case that either the concept of trust or the way it is implemented in the particular social setting, is so different in some cases that this presents a challenge to the five-dimension model itself. This raises interesting issues about both the interaction between quantitative and qualitative methods, as well as the tension between empirical and conceptual research.

In the second paper, Anand and Kutty conduct research focused on measuring trust in a healthcare system itself (6). They chose not to use an existing measurement tool but developed their own. The first part of their paper explains how they went about this, developing their tool through a review of the literature, relevant empirical work, and an exploration of existing measurement tools. The second part of the project was to test the tool developed in the first part. The notion of trust that they are most interested in is that which exists within a community, and they build upon data provided by key informants about trust within the dynamic system of health relationships between patients and professionals. The qualitative interview data is particularly interesting because of the use of rich key terms to describe the nature of a good physician (eg patient, assertive, empathetic, efficient, competent etc.) and this gives us an insight into feelings about trust and those who are trusted.

In the third paper Kane et al use both interviews and focus groups to gather data on relations of trust between different parties involved in the health system within an urban setting in India (7). This allows for a rich discussion of the different perceptions of trust, including the idea that it is only a small number of "bad apples" that undermine trust in physicians and that this, in itself, does not undermine overall trust between patients and doctors. The data in this study suggest that there was, on the whole, far more concern expressed about wider governance mechanisms, particularly the inadequate regulation of healthcare and apparent complacency in relation to widespread corruption, rather than lapses relating to particular doctors.

It is heartening that such excellent work is exploring both the concept and social practice of trust in India. It will be important, in the future, to explore in more detail, and in different settings, what people understand by trust, to measure that trust, but also to explore more conceptual issues such as how trust relates to other moral issues. Is trust a principle, or is it, rather,a necessary but underlying requirement for other important ethical considerations? How exactly does trust relate to moral obligations? Is trusting a state of belief or is it more like an emotion? There is plenty more work to be done.

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