

**Trust relations in the ‘new’ NHS:  
theoretical and methodological challenges**

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## **Introduction**

Trust is believed to be particularly salient to the provision of health care because it is a setting characterised by uncertainty and an element of risk regarding the competence and intentions of the practitioner on whom the patient is reliant (Alaszweski 2003; Titmuss 1968). The need for interpersonal trust relates to the vulnerability associated with being ill as well as the information asymmetries and unequal relationships which arise from the specialist nature of scientific, medical knowledge. In the UK NHS trust has traditionally played an important part in the relationship between its three key actors: the state, health care practitioners, and patients and the public. The post-war consensus was underpinned by trust in the 'altruistic' values associated with medical professionalism (Newman 1998) with the state and patients tending to trust the norms of professional self-regulation and state licensing procedures to ensure that health professionals and health care institutions operated in the best interests of patients and citizens. Service users trusted the judgment, knowledge and expertise of health professionals to provide a competent service which met their needs and they trusted the state to ensure equity in the allocation of public goods and services.

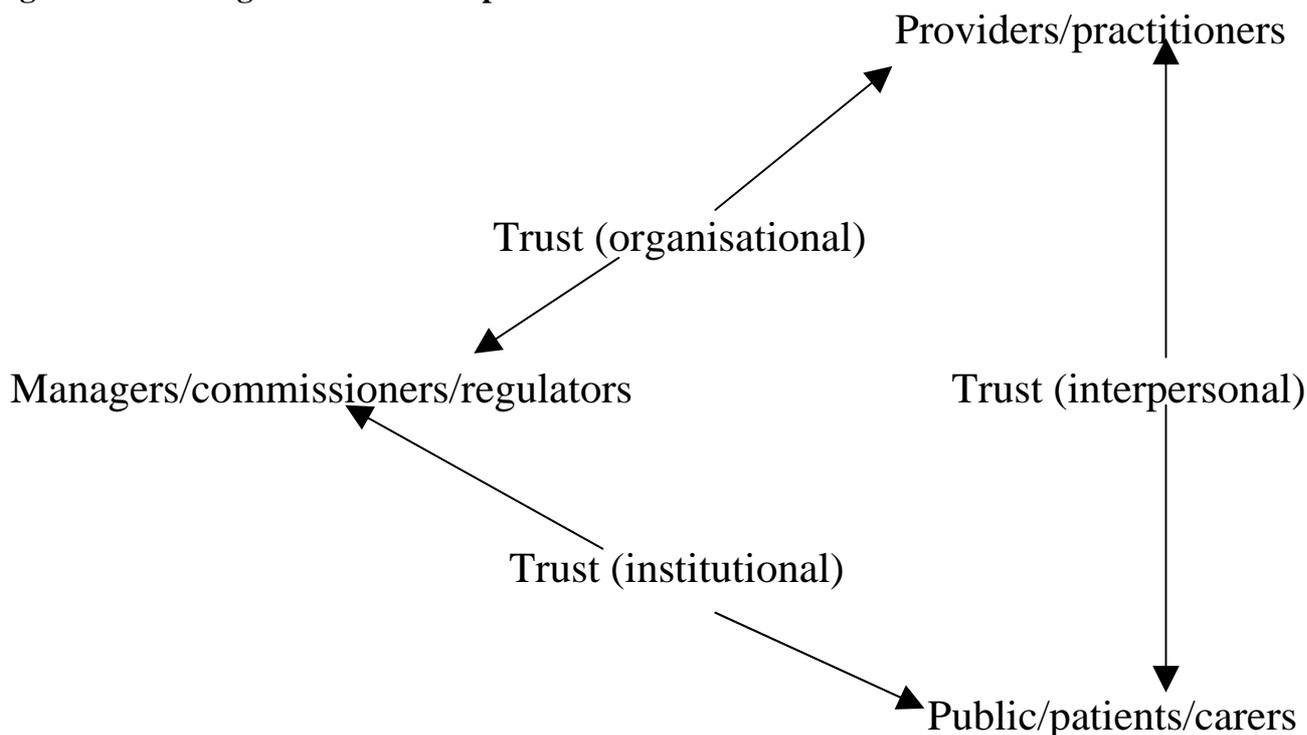
These presumed or taken for granted trust relationships have, it is claimed, been challenged as a result of the introduction of changes in the organisation and funding of the health service, in the regulation and performance assessment of health professionals, and in public attitudes to health care and scientific medicine. This paper seeks to explore how and why trust relations in the NHS may be changing. It presents a theoretical framework for investigating them in future empirical research and considers some of the methodological implications of trying to operationalise these concepts.

## **Definitions**

Trust has been characterised as a multi-layered concept primarily consisting of a cognitive element (grounded on rational and instrumental judgments) and an affective dimension (grounded on relationships and affective bonds generated through interaction, empathy and identification with others) (Gambetta 1998; Gilson 2003; Lewicki & Bunker 1996; Mayer, Davis, & Schoorman 1995). Trust appears to be necessary where there is uncertainty and a level of risk, be it high, moderate or low, and this element of risk appears to be derived from an individual's uncertainty regarding the motives, intentions and future actions of another on whom the individual is dependent (Mayer, Davis, & Schoorman 1995; Mishra 1996). Trust may vary in terms of its quality. For example in elaborating on the nature of social capital (Putnam 2000) makes a distinction between 'thick' trust associated with close family relationships and 'thin' trust for more casual contacts.

In the context of health care the evidence suggests the concept seems to embrace confidence in competence (skill and knowledge), as well as whether the trustee is working in the best interests of the trustor. The latter tends to cover honesty, confidentiality and caring, and showing respect (Hall et al. 2001; Mechanic & Meyer 2000) whereas the former may include both technical and social/communication skills. The vulnerability associated with being ill may specifically lead trust in medical settings to have a stronger emotional and instinctive component (Coulson 1998; Hall et al. 2001). Trust relationships are therefore characterised by one party, the trustor, having positive expectations regarding both the competence of the other party (competence trust), the trustee, and that they will work in their best interests (intentional trust).

**Figure 1 - Framing trust relationships in health care**



In the NHS we can distinguish between trust relations (see figure 1) at the micro level between an individual patient and clinician, between one clinician and another or between a clinician and a manager, and those at the macro level which include patient and public trust in clinicians and managers in general, in a particular health care organisation, and in the NHS as a health care system. The former are broadly categorised as interpersonal and organisational trust relations whilst the latter constitute different types of institutional trust.

A review of the literature of trust relations in health care (Calnan & Rowe 2004) highlighted that most empirical research (mainly carried out in the U.S) has addressed threats to patient-provider relationships and trust in health care systems from the patient's perspective, but studies in the organisational literature suggests that trust relations in the workforce, between providers and between providers and managers, may also influence patient-provider relationships and levels of trust (Gilson, Palmer, & Schneider 2005). This approach suggests that trust is not primarily dispositional or an individual attribute or psychological state, but is constructed from a set of inter-

personal behaviors or from a shared identity. These behaviors are underpinned by sets of institutional rules, laws and customs.

Research into trust has been conducted from a variety of disciplinary perspectives. Studies in social psychology and economics has tended to focus on the attributes of the trustor (beliefs about or calculations of trustees motives; past experiences of health care and providers) and the characteristics of the trustee (their ability, competence, benevolence, integrity, reputation, communication skills). Taking the rational choice economics approach, trust may be reduced to instrumental risk assessment by individual actors, i.e. a rational gamble that the personal gains from trusting will outweigh the risks and costs involved. For example, an economic analysis of why the public place trust in voluntary associations (Anheier & Kendall 2002) might suggest that voluntary associations are run by those who have a stake in services provided to meet their needs and because they are non-profit making and less likely to exploit user vulnerability.

In contrast, the sociological literature stresses that theoretical models must also consider contextual factors: the organisational context; the stakes involved; the balance of power within the relationship; the perception of the level of risk; and the alternatives available to the trustor (Barber 1983; Luhmann 1997; Mayer, Davis, & Schoorman 1995; Tyler & Kramer 1996). In this paper we take a sociological approach seeking to understand how the meaning and enactment of trust is influenced by wider social structures and in particular how changes in the organisation and delivery of health care as well as broader social changes may have affected trust relations in the UK NHS.

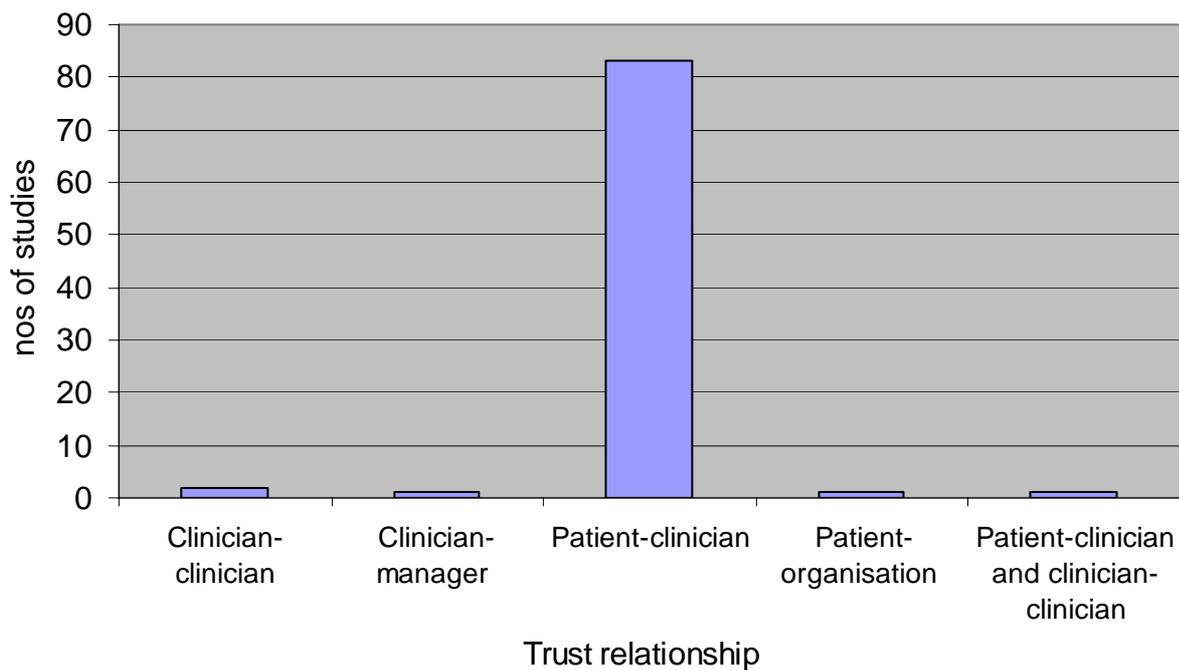
### **Does Trust Matter?**

The case for examining trust in health care tends to hinge upon theoretical arguments sometimes complemented by empirical evidence. At the level of interpersonal trust between patient-practitioner it has been argued that trust is important for its potential therapeutic effects (Mechanic

1998) although evidence to support such claims is still in short supply mainly because of the lack of intervention studies or quasi-experimental studies examining the effect of trust on outcomes (Calnan & Rowe 2004). However there is a considerable body of evidence that shows trust appears to mediate therapeutic processes and has an indirect influence on health outcomes through its impact on patient satisfaction, adherence to treatment, and continuity with a provider, and that it encourages patients to access health care and to make appropriate disclosure of information so that accurate and timely diagnosis can be made (Calnan & Rowe 2004).

Trust also appears to matter to patients as well as health care providers. In a number of studies investigating patients' experience of health care trust emerged spontaneously as a quality indicator, with patients suggesting that high quality doctor-patient interactions are characterised by high levels of trust e.g. see (Safran et al 1998). Trust, although highly correlated with patient satisfaction (Thom & Ribisi 1999) is believed to be a distinct concept. Trust is forward looking and reflects an attitude to a new or ongoing relationship whereas satisfaction tends to be based on past experience and refers to assessment of providers' performance. It has been suggested that trust is a more sensitive indicator of performance than patient satisfaction (Thom, Hall, & Pawlson 2004) and might be used as a potential 'marker' for how patients evaluate the quality of health care.

**Figure 2 – Focus of studies identified in literature review (Calnan and Rowe, 2004)**



In contrast to the sizable literature assessing trust from the patient perspective studies examining either the value and impact of trust from the practitioner perspective and from a managerial or organisational perspective are very limited (see figure 2). In research that has considered the impact of trust on workplace relations in health care settings, trust facilitated commitment to the organisation, enhanced collaborative practice between clinicians and was associated with employee satisfaction and motivation (Gilson, Palmer, & Schneider 2005). From an organisational perspective trust is believed to be important in its own right i.e. it is intrinsically important for the provision of effective health care and has even been described as a collective good, like social trust or social capital. Specific organisational benefits that might be derived from trust as a form of social capital include the reduction in transition costs due to lower surveillance and monitoring costs and the general enhancement of efficiency (Gilson 2003).

What are the costs or dangers of trust? The abuse of power on the basis of trust is a widespread danger (Warren 1999). As trust usually involves a relationship between trustor, trustee and a valued

good it sets up a potential power relation. Trust may provide legitimacy for the exercise of power but 'blind trust' without caution, may also enable the abuse of power, in the form of exploitation or domination. This is a danger for health care given the vulnerability of patients, particularly patients from 'deprived' circumstances. Also for groups living in poverty the consequences of misplaced trust can threaten livelihoods and lives (Coulson 1998) and it may be easier to trust if you are powerful and wealthy. Thus, given the potential benefits and cost of trusting relationship research may need to explore what levels and forms of trust contribute to positive health outcomes and health care performance.

Certainly, there may be tension between the development of trust and other policy goals, in particular the development of patient empowerment. The notion of more active service users empowered to both actively manage their condition and to participate in decision-making regarding their treatment has been vigorously promoted for the positive benefits that such participation may produce. This may be contrasted with the more traditional patient role which involved a passive approach and high, possibly blind trust in their clinician's decisions. If trust relations between patients and clinicians are becoming more conditional can they still contribute positively to health outcomes? Patient empowerment is a key goal of the UK government's current approach to chronic disease management and it forms part of the changing context for trust relations in the NHS, to which we now turn.

### **The context – the 'new NHS'**

Public and patient trust in health care in the UK appears to be shaped by a variety of influences. From a macro perspective, any changes in levels of public trust in health care institutions appear to derive partly from top-down policy initiatives that have altered the way in which health services are organised and partly from changes in public attitudes to healthcare. The latter may be linked with how the NHS is run and financed and the pressure on NHS budgets due to increased demand by an

ageing population, the rising costs of technology and increases in public sector pay (Taylor-Gooby & Hastie 2003). Or it may be linked with broader social and cultural processes which are claimed to have produced a decline in deference to authority and trust in experts and institutions, increasing reliance on personal judgments of risk (Beck 1992; Giddens 1991; O'Neil 2002), and which may be linked to an overall decline in social trust due to the breakdown of communities, social networks and cohesion (Putnam 2000). Institutional trust may have also been affected by negative media coverage of scandals over medical competence in the 1990s such as the enquiry into paediatric cardiac surgery in Bristol, the conviction of the G.P. Harold Shipman and the removal of organs from children at Alderhey hospital (Davies 1999).

The change in public attitudes towards professionals and the emergence of more informed and potentially demanding patients that may have occurred as a result of these broader cultural processes provide a context for government policy which has positioned itself as seeking to make the NHS both more responsive to patients' needs and more efficient. Any change in interpersonal and institutional trust relations can be understood as the natural outcome of these wider changes in both government policy and social attitudes. In this section we will examine how a variety of policy initiatives including intense performance management with heightened scrutiny of clinical activity, increasing patient choice and involvement in decision-making regarding their care, and wider social changes may have changed the context for trust relations within the NHS.

### ***Trust and Performance Management***

The post-war consensus in the UK NHS in which trust in professionalism underpinned the relationships between the public, health professions and the State (Newman 1998) is believed to have been undermined by the growth of consumerism, an erosion of the public service ethos due to the promotion of entrepreneurial values in the public sector (Brereton & Temple 1999), and by political and media portrayals of professional activity as paternalistic. This high trust system of

governance has been replaced by the gradual introduction of new public management with its emphasis on regulation, audit and monitoring which is believed to have brought with it a 'culture' of 'low trust' (Gilson 2003; Rowe 2003). Since the Labour government came into power in 1997 performance management has been a central mechanism for reforming the way that services are delivered in the NHS. This target-driven approach has been applied to both managerial and clinical domains with the introduction of assessment of clinical activity through the clinical governance initiative. Increasing managerial monitoring of clinical activity has obvious consequences for trust relationships between providers and managers (Davies 1999). (Harrison & Smith 2004) argue that the new policy framework of clinical governance has sought to achieve a shift in focus from trust relationships between people to confidence in abstract systems, such as rules and regulations. The more behavior is constrained by such systems, so uncertainty is reduced and visibility is increased (Giddens 1990) and the less is the need to rely on trust (Smith 2001).

However, whether credible external performance measurements build up confidence in organisations, requiring less trust in them, has not been explored empirically. As Sheaff et al noted in their scoping exercise for the SDO (2004) there has been limited empirical research evaluating the impact of external performance measures, particularly from the perspective of service users. Those studies that have explored this problem have reported quite negative findings. Mannion and Goddard's (2003) evaluation of the impact of the CRAG clinical outcome indicators in Scotland reported limited use of such data by patients and GPs and also within hospital Trusts. Similarly studies of the use of US report cards have found on the whole that published performance rarely stimulates quality improvement and the public distrusts and fails to make use of it. As (Power 1997) argues, the growth of performance measurement and audit may merely result in 'certificates of comfort' offering reassurance that performance is being measured without resulting in change. Where trust is low the reliability of information published may be questioned and any uncertainty in the data and what it means may do little to increase public confidence in health care institutions.

Obtaining a performance measure that is credible to providers, commissioners, and service users and that enhances confidence in health care organisations is particularly pertinent in the context of Patient Choice (Department of Health 2004b).

### ***Trust and Patient Choice***

The introduction of patient choice illustrates how changes in the way services are commissioned and delivered can affect trust relations between patients, clinicians and managers. Patient choice has moved to the centre of the UK government's programme of health system reform which is well illustrated in the recent papers on public health (Department of Health 2004b) and adult social care (Department of Health 2005). However, choice has long been a problematic concept at least in the arena of health care. Debates have focused on whether an effective market for healthcare as a commodity can be established given the existence of externalities, uncertainty and information deficits regarding the cost, quantity and quality of care, and difficulties in entering and exiting the health care market (Calnan, Cant, & Gabe 1993). Irrespective of whether the government's choice initiative is a pragmatic attempt to make health services more responsive or is tied to 'new Labour' values of applying 'what works' in the private sector to 'modernise' public services, it raises new issues in relation to trust. A core part of this programme is "choose and book", which aims to give patients more choice on how, when and where they receive treatment for elective care (Department of Health 2004b). By the summer of 2004 all patients waiting more than six months were to be offered an alternative hospital for faster treatment and by December 2005 all patients in England were to be offered four or five places for elective care. The rationale for greater patient choice increasing appeared to be aimed at the responsiveness of the NHS to service users (Appleby, Harrison, & Devlin 2003). Rather than passively trusting GPs' recommendations regarding referral for specialist treatment, patients would be able to participate in decisions about where to go for treatment and when.

Instead of negating the need for trust, the individualisation of commissioning through “choose and book” makes both institutional trust and trust in specific health care practitioners even more salient. Where choice is a meaningful option, secondary care hospitals may find that their financial viability may depend upon levels of patients’ and GPs’ trust in them as institutions. Patient choice will influence financial flows in the NHS as choice is being linked to “payment by results” (Department of Health 2003) whereby payment of providers is linked to activity, with money flowing with the patient. As providers in the USA have experienced, sustaining trust may be something hospitals need to actively facilitate in order to encourage patient loyalty and ensure financial survival (Mechanic & Rosenthal 1999). A patient’s trust in their individual GP will be all the more important, not just for the potential therapeutic benefits, but because they may rely on them to interpret performance data in making referral decisions. Data regarding the waiting times and clinical outcomes of different providers may need to be explained before patients are able to use such information to make a decision as to choice of referral.

Choice also requires GPs to have increased trust in patients, that they are able to make an informed decision about where to go for a referral and in some cases that they will make the referral themselves (if they decide to book an appointment electronically after their GP consultation). In a feasibility study of GPs offering choice for routine adult surgical referrals, Taylor and colleagues (Taylor, Pringle, & Coupland 2004) found that there were significant delays in making the referral while patients considered their options. The same study showed that only 22% of doctors in the study offered choice all or most of the time and that most patients still opted for their local hospital. Research is needed to identify the extent to which patient trust in their local health care organisations and in the recommendations of their GP influences choice; such decisions could be an expression of trust as much as an expression of choice. Empirical research is also required to understand how institutional trust can be generated and sustained as the financial viability of

secondary care providers may depend on their ability to develop trust building activities with primary care providers and the communities they serve.

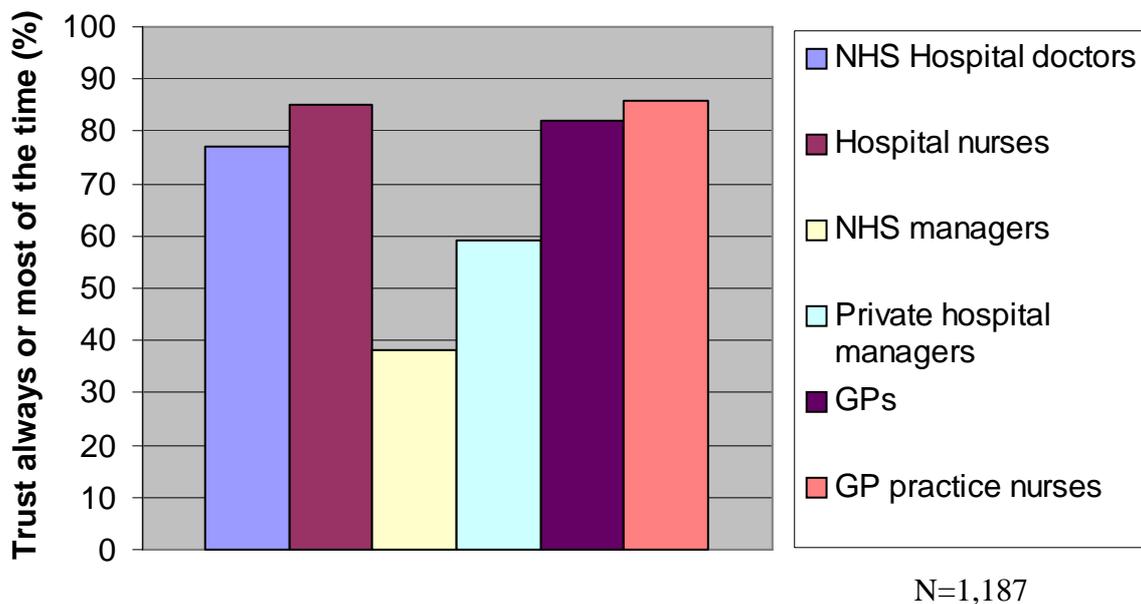
### *Trust and patient participation in disease management*

Whilst Labour's policy of involving patients in commissioning decisions regarding secondary care referrals is relatively new, initiatives to involve patients in decision-making about managing their condition, particular those with chronic health problems are well-established. Trust relationships are particularly important in chronic disease management as trust is known to be important for adherence with medical advice in the chronically ill (Lukoschek 2003; Mosley-Williams et al 2002) and it is considered a core component of effective therapeutic relationships (Dibben & Lena 2003). Successful management of many chronic diseases depends at least as much on changes that the patient can make as it does on specific medical interventions, and as a result requires a partnership between patient and health professional.

Studies have explored the evolving nature of trust relations between clinicians and patients with chronic disease, seeking to identify how trust is built and sustained in the therapeutic alliance (Thorne & Robinson 1988; Thorne & Robinson 1989). Their findings suggest that trust in clinicians depends not just on a provider's demonstration of care and concern for the patient as an individual, it also requires providers to show confidence in a patient's ability to manage their disease (Henman et al. 2002; Kai & Crosland 2001; Thorne & Robinson 1988). Being viewed as competent by a health care professional encouraged patients to feel more confident in their ability to control and manage their illness and at the same time increased patient trust in the provider. These findings are highly pertinent to current UK policy which is encouraging patient self-management as part of its programme to reduce the burden of chronic disease (Department of Health 2004a). In order to stimulate activity in this area, chronic disease management has been identified as key to improving the quality and performance of general practice. This is reflected in the new GMS contract which

includes specific payments for practices to proactively manage patients with chronic disease through its new quality framework (Department of Health 2003). The Government’s chronic disease management programme has important implications for trust relations: requiring providers to increase their trust in patients’ ability for self-care, encouraging more integrated approaches to service delivery between providers involved in disease and case management; and involving managers from primary care organisations who are responsible for assessing and rewarding practices’ standards of activity in this area (Department of Health 2002). The success of this policy is of course dependent on patient’s willingness and ability to participate in decision-making, which in turn reflects wider changes in public attitudes and expectations of health professionals.

**Figure 3: Levels of trust in health services staff: putting interests of patients above convenience of organisations.**



The policy initiatives outlined above, we would argue, have produced a new context for trust relations within the NHS. Little empirical research has been conducted to investigate the nature of trust relations within the UK health system, instead most studies have focused on assessing levels of trust. These suggest that while patients retain high levels of trust in individual clinicians ('your own doctor') (Calnan & Sanford 2004; Calnan & Williams 1992; Mainous et al 2001; Tarrant, Stokes, & Baker 2003), lower levels of trust are found for healthcare institutions ('doctors in general'), although trust in the wider health system is higher than in other European health systems (van der Schee et al 2003). For example, evidence from a recent national survey (Calnan and Sanford 2004) shows that trust (Figure 3) in doctors is still relatively high and much higher than that for national health service managers although how salient health service managers are to the public or users is difficult to judge. Certainly, stress levels in health service managers have been shown to be higher than other members of the health service workforce (Calnan & Wainwright 2002). Lower levels of trust in managers might reflect attitudes to the health system as a whole. There is evidence of a decrease in satisfaction with the NHS over the last decade or so (Appleby & Rosete 2003). However, there is no evidence available about whether there has been a parallel decline in public trust. In the Netherlands results from a national panel study showed that public attitudes to trust remained stable between 1997 and 2003 with a small increase in 2004 (van der Schee, Groenewegen, & Friele 2005) but there is no evidence about trends in public satisfaction.

Given the lack of empirical evidence currently available a theoretical framework has been constructed which might explain the nature of different forms of trust relations in the new NHS.

### **Theoretical framework for explaining trust relations in the 'new NHS'**

The framework (see Table 1) is based on the proposition that changes in the organisational structure of medical care and the culture of health care delivery have changed the experiences of health care for individual patients and affected trust relations between patients, providers and managers. These

changes, have in part been initiated by health care professionals, in part by the government, with clinical governance requirements that benchmark clinical performance, and in part by patients or patient groups (Baggott, Allsop, & Jones 2005), some of whom wish to be equal partners in treatment decisions. It is not proposed that these changes have cumulatively achieved a shift from trust in people to confidence in abstract systems. The provision of health care is still characterised by uncertainty and risk and there is evidence that not only are patients sceptical of institutional confidence building mechanisms such as performance ratings, but that interactions between managers and clinicians continue to rely on informal relations and unwritten rules rather than performance management (Goddard & Mannion 1998). Rather, it is proposed that new forms of trust relations are emerging in this new context of health care delivery, reflecting a change in motivations for trust from affect based to cognition based trust as patients, clinicians and managers are encouraged to become more active partners in trust relations.

**Table 1: Conceptual framework for explaining trust relations in the new NHS**

Relationship	Trustor		Trustee		Context	Type of Trust
	Affect based	Cognition based	Reputation based on status	Reputation based on performance		
Traditional clinician – patient	X		X		Paternalistic medicine	Embodied trust
Traditional Clinician-clinician		X	X		Autonomous self-regulation/ hierarchical	Peer trust
Traditional clinician-manager	X		X		Prof autonomy/ expertise	Status trust
New NHS clinician-patient	X	X	X	X	Expert patient	Informed trust

New NHS Clinician- clinician		X		X	Shared care	Earned trust
New NHS Clinician- manager		X		X	Clinical governance	Performance trust

It is proposed that provision of information and greater patient involvement in their care, through the attempted shift towards shared decision-making in doctor-patient relationships, has produced greater interdependence between patients and clinicians. Certainly, in the context of primary care embodied trust (Green 2004), arising out of an enduring relationship with the ‘family doctor’ may be less relevant not least because of the structural changes which may have increased the range of points of access to primary health care and reduced the opportunities for continuity of care.

How can informed trust (see Table 1) be characterised from a patients perspective and in what ways would it differ from patients’ perspectives on embodied trust? There are a number of possible dimensions. One is clearly in the area of decision-making where there would be an increasingly active patient involved in decision-making who might expect doctors to trust their ability/competence to self manage compared with the more passive and deferent role associated with paternalistic medicine. The second dimension involves the use of information. Informed trust might be associated with the use of information to calculate whether trust is warranted whereas with ‘embodied’ trust information may have been valued for the respect it shows rather than its content. In this way, patients may display a more rational response rather than emotive response to information. Thirdly, perspectives may differ on the willingness to take risks in that informed trust may involve the patient carefully weighing up the situation whereas embodied trust may involve the patient basing their judgement on the reputation of the organisation or individual. Finally, embodied trust implies a clinicians altruism is unquestioned and the other party is well intentioned. This may

be contrasted with informed trust where the patient may express greater suspicion and scepticism about 'others' intentions.

This shift towards informed, conditional trust may also depend on the patients circumstances, needs and preferences and the context in which care is provided. For example in Mechanic and Meyer's study (2000) patients with illnesses such as breast cancer were more likely to describe their trust relations as being unconditional than those with Lyme disease who had experienced difficulties in obtaining a diagnosis. Trust relations are also dynamic and may change during the pathway of care. For example, Thorne and Robinson (1988) reported that patients went from a naive, unconditional trust in diagnosis through to a more conditional, negotiated relationship as their treatment became more established. Similarly, the nature of trust relationships and the balance between affect and cognitive based trust may vary according to the social position of the patient. The ability to adapt this more 'active' stance may depend on the extent to which patients have access to appropriate resources (finance, time, energy) to do it (Gilson 2003). It might also be argued that all trust relationships have a conditional element to them and that traditionally there has been widespread ambivalence about scientific medicine and medical practitioners (Calnan, Montaner, & Horne 2005). The suggestion here is that conditionality has now become more explicit.

For GPs and hospital doctors, trust relations (see Table 1) may have changed between themselves and in their relations with other practitioners as the health service has emphasised the need to be primary care led and other health care professionals have become responsible for delivery of services, creating new relations in which trust has to be earned through collaboration rather than relying on peer trust. Thus, 'earned' trust might be characterised by: an individual clinicians' authority and reputation being based on their proven skills and competence, and being up to date with medical technology; there may be some limits to clinical freedom with trust gained by

following agreed team-based protocols; successful relations between clinicians would be based on mutual respect for their different competencies and knowledge; and communication skills and providing information would be important in building trust. This stands in marked contrast to more traditional relations of 'peer trust' where an individual clinician's authority and reputation are based on their position in the medical hierarchy, personal networks and word of mouth recommendation. Hierarchical relations dominate as clinical freedom is unquestioned as are senior clinician's views and decisions, performance is self-regulated and successful relations between clinicians are based on conforming to traditional roles. Trust may be generally higher between clinicians of the same profession and specialism.

Finally, what of the changes in trust relations between managers and practitioners created primarily by the government's clinical governance policy. We argue that this has led to a change from a relationship characterised by status to one characterised by 'performance' (see Table 1). The former might be depicted as a one-way relationship with clinicians having little need to trust managers where as managers have to trust clinicians. A clinician's authority relates to their position and role within the organisation and managers act as administrators, trusting strategic decisions as to how services are to be delivered and how resources are to be used to clinicians. There would be minimal monitoring of activity and managers would not be involved in such assessments. In contrast, performance trust might involve a two-way relationship as clinicians need to work with managers to secure resources and to develop services and managers have to work with clinicians to achieve their performance goals and to meet government targets. A clinician's authority would be related to their involvement in managerial activity, their ability to meet targets as well as their position within the organisation and clinical skills. Trust would be important in successful clinician-manager relations as it reduces the need for monitoring and may produce greater job satisfaction, higher staff retention, and more efficient organisational performance.

This general typology of trust relations outlined in the framework (see Table 1) suggests that trust relations in all three types of relationship in the ‘new’ modernised NHS might, in general, be particularly characterised by an emphasis on communication , providing information and the use of ‘evidence’ to support decisions in a reciprocal, negotiated alliance.

### **Methodological implications**

The conceptual framework outlined above needs to be examined in empirical research although it does raise a number of methodological questions. If relations are typified by trust which is more explicitly conditional, what indicators could be used to recognize it in healthcare organizations? It might be possible to examine how trust relations vary along a linear continuum ranging from high, unconditional trust to low trust or distrust, with conditional trust placed somewhere along this continuum. Alternatively, rather than a linear relationship the curve may be U-shaped as has been shown in the case of chronic illness (Thorne & Robinson 1988).

Different levels of trust might be identified by examining a range of beliefs and attitudes, as exemplified in table 2, that individual patients, clinicians, and managers have about their relationships with other people and health care institutions that involve trust. Existing instruments which have been developed to measure levels of trust (see Calnan and Rowe 2004) may be able to identify levels that reflect more conditional trust relations. Negative as well as positive elements of trust might be more easily identified if conditional trust is more common but where trust is less conditional and assumed it might be easier to talk about it when it is lost or shown to be misguided (Giddens 1990). There is a further methodological question in that espoused levels of trust may vary from enacted trust levels. If trust is claimed to embrace both attitudes and behaviors then in order to allow for socially desirable responses, it may be more appropriate for research to focus on enacted trust behavior rather than espoused levels of trust. Following from this, what dimensions might reflect behavior that indicated conditional trust between individuals and between individuals

and institutions? Again, conditional trust may be identified by comparing observed or described behavior with behaviors associated with either end of the high/low spectrum, see Table 3.

**Table 2. Attitudes that reflect felt trust**

<b>High Trust</b>	<b>Low Trust</b>
Belief that others will not harm us	Belief that others might harm us
Low levels of anxiety, suspicion and scepticism	High levels of anxiety, suspicion and scepticism
Limits to knowledge are appropriate	Limits to knowledge are not appropriate
Lack of control is appropriate	Lack of control is a problem
Draw comfort from relations	Anxious about relations

**Table 3. Behaviors that reflect trust**

<b>High Trust Behavior</b>	<b>Low Trust Behavior</b>
Minimal checking	Constant monitoring
Informal, unwritten rules	Detailed and prescriptive regulations
Significant professional autonomy	Intense supervision and little delegation of authority
Willingness to take risks	Risk averse
Willingness to divulge information	Information is withheld
Passive, deferent role	Questioning, possibly sceptical role
Advice is accepted unquestioningly	Request for a 2 <sup>nd</sup> opinion or alternative source of treatment sought

Although survey instruments may be able to capture some of these dimensions of trust behaviour, the conceptual complexity of trust and the lack of empirical research that has examined trust relations within the context of the UK NHS does raise the question as to whether qualitative methods need to be employed first to inform our conceptual understanding of trust relations and trust behaviour and to refine the trust indicators used in quantitative instruments. In particular

research is needed to understand how macro-level processes, including provider-provider and provider-manager relations may constrain or enhance micro-level provider-patient trust relations, and how trust between individuals affects institutional trust. The relationship between felt trust beliefs and enacted trust also needs to be examined, exploring how different expressions of trust might manifest themselves in behaviour. It might be that trusting behaviour may be a product of a number of different types of attitude and not just attitudes about trust.

Finally, there is the question about how trust relations in health care compare with those in other sections of welfare and public sector services. Have the 'unique' characteristics of the health care setting proved more resistant to organisational and social changes that may have eroded or changed trust relations in other settings or is 'conditional trust' now common in service provision throughout the public sector? There is also the question of whether trust is still as politically salient now as it was in the late 1990's. The 1997 Labour administration had a distinctly 'communitarian turn' with its emphasis on the rights and responsibilities of citizens and citizen engagement in institutional governance, and the importance of inter and intra-agency co-operation in the production of social capital. In contrast, the current direction of government policy with its emphasis on individual choice and the marketisation of public services may have a cumulative negative impact on social capital. This new policy context is likely to change the nature of vulnerabilities and risks to which patients, clinicians, and managers are exposed, which in turn will affect both the relevance and nature of trust in healthcare relationships.

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