CHAPTER 6

DISCUSSION

6.1 SUMMARY OF RESEARCH FINDINGS

This research was done to fill the much needed gap in understanding the concept of trust in physicians in a developing health care setting. A developing health care setting has been operationally defined for the purpose of this research as a setting where there is no universal access to health care, low public expenditure on health care, high out of pocket health expenditure by the community and unregulated health care practice. In such a setting it is highly likely that the dimensions of trust in physicians is different from what is already described in literature. The factors that influence trust in physicians are also likely to be different. Therefore to gain a conceptual understanding of trust in physicians this research was undertaken in three stages. Each stage of the research sequentially led to the next and the conceptual understanding of trust in physicians evolved organically.


**Dimensions of Trust in Physicians**

Trust in physicians is an abstract construct and requires certain observable dimensions through which it can be perceived. The exploration revealed five main dimensions through which trust can be perceived. These are –

- Competence of the physician as perceived by the community
- Assurance of treatment
- Confidence in the physician
- Respect for the physician
- Loyalty to the physician
- Willingness to accept drawbacks in the physician-patient relationship

It was further understood that the community placed more importance to the dimensions of respect to the physician, assurance of treatment and competence of the physician than the other dimensions. In the western literature of trust in physicians the key dimensions of trust that have been identified are fidelity, competence, honesty, confidentiality. There is a distinct difference in the way the trust is constructed in the resource poor and the developing health care settings. The discourse here seems to be dominated by emotional factors and uncertainties. Of the six identified dimensions of trust, three are formative and the other three reflective. It is evident that the dimensions of competence, assurance of treatment and confidence are formative in nature. They contribute towards the construct of trust. On the other hand, the dimensions of respect, loyalty to physician and willingness to accept drawbacks are reflective dimensions. This means that any change in trust in physicians will reflect in these dimensions.
These dimensions of trust were used in the construction of the tool to measure trust in the third phase of the study. It is the assumption that if these dimensions are measured well, they will give an indication to the level of trust. It is noteworthy that in the study, the dimension of willingness to accept drawbacks in the physician-patient relationship could not be carried forward as the community survey could not capture this dimension well. All the other give dimensions were explored and included in the trust in physician scale. The final twelve item scale of trust in physicians developed at the end of this study had components from all the key dimensions of trust.

**Factors influencing trust in physicians**

Factors determining trust in physicians were also explored in detail in this study. It was found that there are five important factors influencing trust in physicians. These are:

- Shared identity with the physician
- Comfort with the physician
- Personal involvement of the physician with the patient
- Behavior and approach of the physician
- Simplicity of the physician
- Economic factors
- Health awareness

The criterion used to distinguish between dimensions of trust in physicians and the factors determining trust was that the dimensions were contributing to define what trust in physicians is. The factors determining trust were a set of characteristics of the physician or the physician-patient relationship which are likely to influence the trust
Among the factors influencing trust that were identified, only two were found to be statistically associated with trust in physicians using quantitative analysis. These were comfort with the physician and behavior of the physician. This emphasizes the importance of communication in the doctor-patient relationship. It is important to note that several factors can influence trust in physicians as shown in the conceptual framework in Figure 6.1. In this study only physician factors and some patient factors were studied. Several important patient factors such as type of illness, duration of illness and severity of the illness, all of which could have an influence on trust in physicians have not been studied. Moreover health system factors which play an important role such as private versus public system of care, health insurance, health financing mechanisms, etc. have not been studied. There are a whole set of family factors such as presence of a sick person in the family, previous family experiences with the physician, family structure etc. which could also influence trust in physicians especially in settings like India. These have also not been studied.

A good understanding of the concept of trust in physicians emerged from the dimensions and determinants of trust. This was further evaluated using statistical models. It is noteworthy that the understanding of trust in physicians that emerged from these two phases of the study are different from what is already known from the Western literature. The whole construct is based on uncertainties and emotional factors. This is very different from the empowered communities in the western literature where there is a more objective evaluation of trust in physicians.

Based on this understanding the tool that was developed had items that represented the various dimensions identified namely perceived competence, treatment assurance, respect and loyalty. The original 31 item tool was assessed, modified, edited and a final 12 item scale developed and validated. The new trust in physician scale has undergone all the following validation processes.
1. Content Validity – The thorough review of literature and conceptual understanding of trust in physicians from previous studies led to identification of important domains of trust.

2. Face Validity – The questionnaire was circulated to ten experts from various fields who all rated the questions based on the extent to which they represent trust in physicians.

3. Construct Validity – The scale is uni-dimensional by confirmatory factor analysis. There is very low local dependence of items. The structural equation model showed the complex, conceptually feasible interrelationships between trust in physicians, dimensions and factors which influence the trust in physician thus validating the construct.

4. Predictive validity – The performance of the scale in classifying individuals’ self reported ‘trust’ or ‘distrust’ in the physicians was assessed and the sensitivity and specificity of the scale calculated. This showed an acceptable level of predictive validity.

Thus the new trust in physician scale measures trust in a valid manner. There is a need to further study the predictive validity of this scale in a longitudinal manner. This can be done with the help of long term studies.

The final stage of the study assessed the the perceptions of health care providers about the factors influencing trust in physicians was studied. This study revealed that health care providers felt that technical competence, and certain behaviors were very important factors influencing trust. This was very different from what the community perceived. This revealed a gap in the perceptions of the providers and the community which needs to be bridged. Figure 6.1 and Figure 6.2 show the final conceptual framework that emerged from the study.
The figure 6.1 above shows the physician factors, patient factors that influence trust in physicians as emerged in the study. It also represents the dimensions of trust in physicians. The factors that were not studied are represented within dotted boxes which include the health system factors, some patient related factors and family related factors.

Figure 6.2: Interactions between trust in physicians, quality of clinical care, satisfaction with care and clinical outcomes

This figure shows the complex inter-relationships between trust in physicians, utilization of services, quality of services, satisfaction with services and clinical outcomes. It is seen that trust is an important factor which influences utilization of services. The positive consequences of trust lead to better utilization of services and also better clinical outcomes. Satisfaction is an important intermediate in this relationship.
6.2 STRENGTHS OF THE RESEARCH STUDY

The study is probably the first of its kind in the Indian context. The sequential design of the study starting with the qualitative exploration, quantitative confirmation and psychometric development of scale is unique and each study design complements the other in providing different kinds of information. Each portion of the study has organically evolved from findings of the previous sub-study. Thus it has been an iterative process. There has been adequate complementing of findings and triangulation thus adequately confirming the validity of the findings. The judicious mix of qualitative and quantitative paradigms of analysis have enriched the content of the scale to measure trust in physicians. The psychometric method has also used the advantages of both classical test theory and item response theory for developing and validating the trust in physician scale. The data has been analyzed using different quantitative methods and this has helped in validating the findings. Strict grounding in literature, use of variety of research paradigms, research designs, data analysis techniques and a sequential and iterative development of the research study are its distinct strengths.

6.3 LIMITATIONS OF THE RESEARCH STUDY

The qualitative analysis gave rise to broad ideas about the concept of trust in physicians. It was limited by the fact that qualitative research findings are meaning centric and cannot be generalized. This was evident by the fact that some of the important findings in the qualitative study did not get validated in the quantitative survey. The quantitative survey was a cross sectional study. Therefore it was limited by the temporal ambiguity that usually is associated with the design. For example, it is not clear whether comfort with the physician leads to trust or whether trust in the physician leads to
comfort. The conceptual model did give some important ideas regarding the interactions between various determinants of trust in physicians, but cross sectional study designs are not powered to tease out the complexities involved in these. Moreover both the structural equation modeling technique and the item response theory technique used in the statistical analysis of the data, have very strong assumptions to be met in order to give valid results. Both the statistical models have to be assessed with caution and should be considered suggestive but not confirmatory. There was a strong ceiling effect on the responses to many of the questions relating to competence of the physician, respect, loyalty and confidence in the physician. This was probably due to a socially desirable response bias. This needs to be kept in mind while analyzing and interpreting the findings. However the conceptual findings are meaningful and lead to an understanding of trust in health care. The other important limitation of the study is that it has focused only on the community perspective largely. There is only a small perspective of the providers. Most trust factors with respect to the physicians have only been explored in detail. Trust in the patient-physician relationship is also strongly influenced by patient factors. These have not been explored in detail. Prospective studies are required to further validate these findings and add strength to the conceptual understanding of trust in physicians.

6.4 WAY FORWARD

This study has revealed some important knowledge regarding the dimensions and determinants of trust in the physician. But as described above these are limited to the physician related dimensions. There is a need to study the patient characteristics which influence trust in the physician. The following aspects of trust in physicians have to be explored in future studies:
• Trust in other health care providers such as nurses, allied health service providers
• Trust in providers of complementary and alternative systems of medicine
• Trust differences between private and public health service providers
• Trust differences in the various levels of health care – primary, secondary and tertiary levels
• A greater understanding on the evolution of trust from blind faith, to confidence to skeptical trust to strategic calculated trust
• Patient related factors that may influence trust such as
  o Age
  o Gender
  o Urban versus rural residence
  o Socioeconomic status
  o Chronic versus acute illnesses
  o Severity of the illness
• Can trust be built and nurtured?

There is a need to validate the trust in physician scale using longitudinal studies. The predictive validity of the scale can be assessed by looking at trust levels at baseline and clinically relevant outcomes such as adherence to treatment, seeking second opinion, perceived therapeutic experience, self reported health status and self efficacy.

Prospective studies will also help in understanding some of the finer nuances of trust in physicians which cannot be captured by the cross sectional study. Randomized controlled trials should be done to assess the efficacy of interventions on any of the identified determinants of trust and whether it leads to increased trust in physicians.
6.5 TRUST AND HEALTH CARE SERVICE UTILIZATION

Several studies have shown that high levels of trust leads to higher utilization of health services.[11,63] Therefore it is intuitive that building trust should lead to an increase in health seeking. The two formative dimensions of trust namely perceived competence and treatment assurance have to be increased if trust has to be built. An important intervention to increase perceived competence would be appropriate training to improve technical competencies of the physicians. Ordering appropriate diagnostic tests, prescribing rationally, and minimizing medical errors can be achieved by appropriate capacity building. Treatment assurance can be ensured by strict punctuality, accessible clinic, not refusing treatment to the patient at any time of the day and removing the need for pay-for-service model of health care either by strengthening the public system or by appropriate health financing mechanisms.

Interventions at the level of determinants of trust can also lead to increase in trusting physician-patient relationships. During medical education physicians can be trained on the key skills of communication, personal involvement with the patients, appropriate behavior and approach and other such soft skills. These can help the physician win the trust of the patients. Physicians should be sensitized to the social aspects of health care, which will help them effectively deliver patient centered services.

However, trust building in isolation can be a double edged sword. Being technically competent, available, accessible, and behaviorally competent may not always be in the best interest of the patient in isolation. For example, a doctor may be highly competent, may have all the right behaviors and attitudes, but may have a secret nexus
with the pharmaceutical company and a financial conflict of interest. Thus trust building has to happen in the background of a strong training in ethical practice of medicine.

At the same time a strong ethical training in isolation may also not be sufficient for trust building. A doctor may be highly ethical and may follow all the ethical principles, but if he/she does not engage in personal involvement with the patient, does not practice certain behavioral competencies, then utilization of services will still be poor.