

Trust in Clinical Practice: A Systematic Review

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Abstract

Background: The aim of this study is to gain a better understanding of the true importance of trust in clinical practice by looking at how it is formed, how it affects clinical practice, and how to improve it. **Methods:** Using the PRISMA-ScR checklist, a review of the literature was performed to identify research evaluating the importance of trust in the doctor-patient relationship. After thorough screening and removal of duplicates, 21 articles were used in the literature review. **Results:** The classifying themes that emerged in the selected articles were What Makes Trust and Effects of Trust. The theme of What Makes Trust garnered two subthemes as well: Impact of Doctor-Patient Relationship on Trust and Impact of Shared Decision-Making on Trust. Further to that, the overarching themes found were slightly more specific. They were Traits of Trust, Mistrust and Barriers to Trust, Positive Effects of Trust and the Effects of a Lack of Trust. We found that the best way to improve trust was to improve communication between the patient and the doctor. Additionally, we found that the biggest barrier to a trusting doctor patient relationship was a stigmatised condition, followed by a perception of a financially-motivated doctor. Finally, we found that a lack of trust can prevent patients from seeking and receiving proper treatment. **Conclusions:** With a better understanding of how trust is built and the extent of the role it plays in clinical practice, we hope that this growing knowledge can improve the practice of many doctors in the future. It is certain that more research needs to be done in this area, especially focusing on vulnerable and stigmatised populations such as chronic pain patients.

Keywords

Trust, Patient, Clinical Practice, Doctor or Physician, Doctor Patient Relationship

1. Introduction

Trust is a fundamental pillar in the practice of medicine. When we consider the

basics of a medical consultation—a doctor and a patient having a conversation—we know that the patient is relying on an assumption that they can trust their doctor, while the doctor must trust that the patient is willing to tell them the truth and trust them in return.

Things have changed over the years, and now anyone can access information about medicine—true or not—over the internet. It seems that among the younger population, patients may be less willing to trust their doctors [1]. More and more we then find that trust in medicine and doctors in general is diminishing with the advance of social media and the access to information online, so we must question whether trust between the patient and the doctor is becoming lost, and what consequences might entail if it is.

It is essential to examine the importance of trust in clinical practice by looking at how it is formed, how it affects clinical practice, and how to improve it. With a better understanding of how trust is built and the extent of the role it plays in clinical practice, we hope that this growing knowledge can improve the practice of many doctors in the future. The aim of this study is to perform a systematic review of the literature regarding trust in clinical practice.

2. Methods

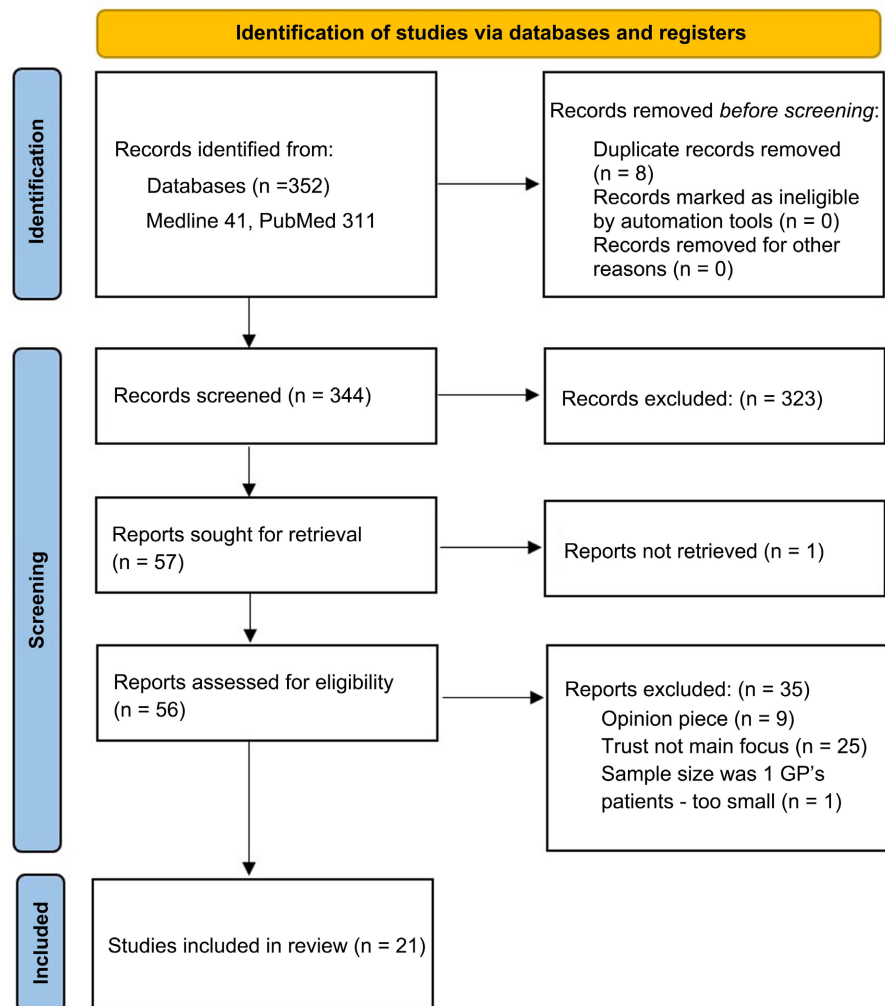
Two databases were searched following PRISMA-ScR guidelines. The databases searched were MEDLINE with Full Text accessed via EBSCOhost and PubMed. The search terms used were “trust” and “doctor or physician” and “patient” and “clinical practice” and “doctor patient relationship or physician patient relationship”. The searches were limited to articles both in English and available as full texts, as per the inclusion criteria. Additionally, the articles were all further screened by adhering to the inclusion criteria. No articles were excluded based on their date of publication, as trust is a subjective topic and all information pertaining to it was welcome. The inclusion criteria and exclusion criteria are outlined in **Table 1**. **Figure 1** outlines the selection process. Articles chosen were limited to those in English in order to ensure full understanding of the results of each article with English being the first language of the authors of this review. They were limited to full texts as well as abstracts would have only touched on the content of the article. Instead, full texts allowed proper understanding of rationale, methods, and more detailed results.

2.1. MEDLINE

MEDLINE’s initial search yielded 41 results, which became 40 after duplicates were removed. On the first screening, articles were eliminated based on their relevance as determined by titles, which left 35 articles remaining. On the second screen, each article’s abstract was read to determine their relevance. Those deemed irrelevant were eliminated, leaving 20 articles remaining. The third screening involved eliminating articles based on their relevance after reading the full text. At the end of this stage, five articles remained.

Table 1. Inclusion and exclusion criteria.

<i>Inclusion Criteria</i>	<i>Exclusion Criteria</i>
Articles written in English	Articles written in other languages
Full text available	Full text not available
Focus is on the concept of trust	Opinion pieces
Examines effects of trust and ways to develop it	No relevance to the concept of trust

**Figure 1.** PRISMA flowchart.

2.2. PubMed

A preliminary search on PubMed using the search terms and inclusion criteria yielded 311 results. This number decreased to 304 once duplicates were removed. The articles were first screened by title, leaving 171 articles remaining. Next the remaining articles were screened by abstract, which left 38. Finally, the remaining articles were screened based on their full text. At this stage, 16 articles remained.

Following the screening process, 21 selected articles were put into categories

based on emerging themes. The articles were then re-examined to determine the contributing evidence to each theme.

3. Results

3.1. Demographics

The articles focused on a diverse range of populations, with only a few papers examining the same ones. Three of the studies examined cancer patients, eight examined the patients as part of the general public, two examined chronic pain patients, and the rest examined different specific patient groups.

Interestingly, the three selected studies that used cancer patients as their population found that the patients' level of trust in their oncologists was higher than their level of trust in their GPs [2] [3] [4]. Each study acknowledged that their results might have shown trust to be higher in the patients' oncologists because of the life-threatening nature of cancer.

Two of those studies focused on using the Trust in Oncologist Scale (TiOS) to assess patients' trust in their oncologists and found it to be a valid assessment tool [3] [4]. One [3] developed and validated the original TiOS and explored what they found to be the principal dimensions of trust: fidelity, competence, honesty and caring. While they found that patients do distinguish between the different dimensions mentioned above, they also found that the patients still see trust as a one-dimensional concept [3]. The other [4] shortened the 8-item TiOs [3] into a 5-item TiOs—short form (TiOS-sf) and found they were still able to properly assess patients' trust, this time without worrying that the patient may find the long questionnaire to be tedious or tiring [4].

3.2. Themes

There were clear themes emerging in the literature that identified aspects that make up trust, how to improve it, the effects—positive and negative—of trust on clinical practice and patients, and the importance of the doctor-patient relationship and shared decision making in building trust.

These led to the broad classifying themes of *What Makes Trust*, and *Effects of Trust*. The theme of *What Makes Trust* garnered two subthemes as well, *Impact of Doctor Patient Relationship on Trust*, and *Impact of Shared Decision-Making on Trust*. **Table 2** outlines how many articles fell under each category.

Table 2. Classifying themes identified in the literature and how many articles fell into each category.

<i>Themes</i>	
What Makes Trust	15
○ Doctor Patient Relationship (3)	
○ Shared Decision Making (4)	
Effects of Trust	6

Further to that, the overarching themes found to complement those classifications were slightly more specific. They were *Traits of Trust*, *Mistrust and Barriers to Trust*, *Positive Effects of Trust*, and the *Effects of a Lack of Trust*.

3.3. Traits of Trust

In a study assessing osteoarthritis patients' views of communication with their GP, they found that empathy fostered trust most of all [5]. The same study found some other traits of trust included: the clinician being knowledgeable, kind, respectful, patient, and an active listener [5]. Patients also suggested having more personal chatting to make the relationship friendlier, but identified time constraints on the consultation as a big barrier to trying to further trust between the doctor and patient in that way [5].

Another study looked at traits of trust as determined by general practice patients and found that the main source of trust identified was good communication [6]. This was supplemented by caring—as seen in a few other studies [3] [4]—and the doctor having knowledge of the patient. Interestingly, this study found that the length of the relationship with their GP was *not* independently associated with the patients' trust in their GP [6]. This contradicts other studies pertaining to the doctor patient relationship [7] [8] [9] which noted that the length of their relationship with their doctor did affect the patients' trust in their GPs.

A study done in Lebanon [9] found that patients associated their level of trust in their physician with more professional traits such as the status of doctor's workplace, their hygiene/appearance, gender, professional experience, and country of training—with Western Europe and North American training being preferred. The patients also mentioned the length of their relationship with their doctor as being a factor in trust, as they would not fully trust a doctor the first few times they visited them [9]. It should be investigated whether the focus on professionalism could be due to cultural norms, as none of the other studies placed such an emphasis on the same professional traits aside from one other study [10] that focused specifically on attire. Additionally, the patients paid special attention to clinical competence and seemed to find it equivalent to trust. Clinical competence as defined by the patients included getting diagnoses correct, having good rapport, compassion, honesty, and respect [9]—with the last four traits being similar to what was described in other studies [3] [5] [6] as being traits of trust.

One study involving the patients of hand surgeons saw the patients given examples of male and female hand surgeons dressed in either a white coat, professional clothes, casual clothes or scrubs [10]. They were then asked to rate their trust in the surgeon based on their attire. The overwhelming majority rated the white coat as the most trustworthy, with casual attire or scrubs in males being rated very low. The patients added that the attire would not make much of a difference to them if the doctor did not possess good clinical skills [10]. This slightly relates to the study of the Lebanese population that highly valued profes-

sional traits such as clinical competence and appearance of the doctor [9]. An important point here is that they provide an objective practice that could be employed to increase patient trust. Wearing professional attire or a white coat seemed to have greatly improved the trust of the patients in their surgeons [10]. Altering a doctor's attire is a much easier change to make to increase trust than adopting different ways of consulting with patients.

3.4. Mistrust and Barriers to Trust

A few studies [6] [11] found that a strong barrier to trusting their doctor was the perception of the doctor as a business and financial-oriented. These patients said it made the consultation feel less personal, which decreased their trust in their doctor.

Another barrier to trust could be found in doctors disclosing conflicts of interest, which has the potential to erode a patient's trust in their doctor. One study used a focus group to determine patients' opinions of their doctors having and disclosing conflicts of interest and found that preformed trust in their doctor affected how they felt [12]. Some patients said that they would be less upset about errors if they trusted their doctor, while they also mentioned that the doctor not disclosing the error and them finding out another way could severely erode their trust in their doctor [12].

One particular population studied that provided an insight into stigma as a barrier to trust was chronic pain patients. The biggest barrier to trust for them was the stigma of the nature of their medical problem [13] [14]. Most patients found that it was very difficult to build trust because chronic pain is a subjective symptom and the treatment carries big risks. On the other end, GPs who had had drug-seeking patients before had a hard time trusting chronic pain patients to be honest about their symptoms, while some other GPs gained an interest and began to specialise in chronic pain management [13] [14].

Another example of stigma as a barrier to trust is illustrated by a study [15] that found that stigma associated with obesity affected patients' trust in their doctor. They felt that the stigma of their condition would prevent their doctor from treating them properly [15]. It also affected the way the doctor perceived the condition, as some doctors viewed the condition as the patient's responsibility alone to treat [15]. This falls in line with other studies showing that stigmatised conditions present a barrier to a trusting doctor patient relationship from the start [13] [14] [15] [16].

3.5. Positive Effects of Trust

A study on HIV patients and their trust in their GPs showed that a better doctor patient relationship led to a decrease in risky behaviour such as injecting drugs frequently or at all, and sharing needles [16]. The study found that this was due to an improved doctor patient relationship making the patients feel less like drug addicts and more like HIV patients being seen for follow-up [16]. This is also

congruent with the studies concerning chronic pain patients and obese patients and the effects of stigma on their trust in their doctor [13] [14] [15], however, in this case, the study emphasised how the barrier of stigma was overcome in some patients.

Some other studies examined the effects of trust on clinical interactions in general practice in different scenarios. Trust ended up being an important factor in patients feeling safe in primary care according to a study by [17]. Patients reported that they could not feel safe if they did not trust their doctor to have good intentions and competence. Additionally, similar to two other studies [6] [11], the patients in this study were worried about the business side of medicine taking over, which they felt they wouldn't have to worry about with a doctor that they trusted [17].

Another study affecting the safety of patients [7] explored what encourages deprescribing in a vulnerable population—patients with dementia and patients with multimorbidity. The main theme they found was trust. It was described as a “foundational” concept for deprescribing, as the patients more readily accepted the suggestion of deprescribing from their doctor if they trusted them beforehand because they believed their doctor would only act in their best interest [7]. In a vulnerable population like this, making the patient feel safe is very extremely important in garnering trust, which encouraged patients in this study to accept deprescribing practices, ultimately leading to better health outcomes.

Another scenario where trust in their doctor would reassure patients of their safety is one in which their doctor searches the internet to help choose the patient's treatment. A study by [18] examined the opinions of patients on doctors using the internet to help treat them. The main finding was that patients were less upset by their doctor showing a gap in their knowledge if they already trusted their doctor and found them to be competent. One patient said they trusted their doctor “regardless of her competence...unless...it's preposterously incompetent” [18]. Other factors that improved the patients' attitude toward this practice included a general trust in medicine [18].

Other studies examined the direct benefit of a trusting doctor patient relationship including one study that looked at the GP's opinion of trust in clinical practice and the way they balanced it with power to achieve better patient interactions. The three main methods they used to balance the two were respect for the patient's autonomy, professional authority, and mutual respect [19]. The study found that pre-existing trust between the GP and patient increased the GP's ability to satisfy all 3 areas [19]. The findings expressed that trust balanced with power allowed the GP to control the consultation more easily while still taking into account the patient's perspective.

Another study examined why patients would accept or decline a copy of their referral letter from their doctor. It was found that the majority of patients who said they would decline the letter did so because they trusted their doctor enough to do what is best for their health and felt the doctor would have informed them of everything they needed to know [20]. In this case, trust allowed

the patients to feel comfortable with their doctor and feel that their health care is in the right hands.

A few studies closely examined the effects of trust in relation to shared decision making. In diabetic patients, the use of collaborative goal-setting (or shared decision making), was found to be associated with increased trust and higher perceived competence in their doctor as well as improved glycaemic control [21]. Consequently, they found that using trust to enable shared decision making improved the doctor patient relationship and led to better patient outcomes [21].

In a systematic review of rheumatology patients and their perspectives on trust in their doctors, the authors looked at the consequences of improved trust. They found that higher trust in their doctor increased rates of shared decision making, which led to an improved doctor patient relationship, which in turn led to lower disease activity, better global health, less organ damage accrual, greater treatment satisfaction with fewer side effects from the medication, more positive beliefs about control over the disease, and about current and future health [22]. This demonstrates an important effect of trust on the health outcomes of patients.

3.6. Effects of a Lack of Trust

A lack of trust demonstrated in multiple studies was shown to cause patients to seek second opinions and care elsewhere [9], forgo treatments and withdraw from care altogether [11] and hesitate when choosing to seek help [8].

Interestingly, only one study [11] found that the patients felt like mistrust led them to believe that they were involved in a research study as “experiments”, thus eroding their trust further. Like the study on the Lebanese population, it would be worth looking into whether this reaction had to do with racial biases, as the study population was African American patients in America.

4. Discussion

The literature demonstrated the importance of communication between doctor and patient as the path to achieving trust through all sorts of methods. Empathy, caring, honesty, communication, clinical knowledge and competence, and listening were all mentioned in multiple studies as traits that patients felt garnered trust in their doctors.

As for barriers to trust, a strong theme was stigmatised conditions [8] [13] [14] [15] [16] causing patients to feel that they cannot trust their doctor and their doctor will not trust them from the start. The other common barrier to trust was the feeling that the doctor is prioritising financial gain and the business aspect of medicine [6] [11].

The positive effects of trust were expressed in many ways and contributed greatly to the common view that trust is an important factor in improving clinical practice. The negative effects of a lack of trust were found to be harsh and pushed patients away from getting proper treatments for their conditions.

4.1. Study Limitations

There are potential limitations, such as publication bias, selection bias, and the subjective nature of trust, which could impact the validity of the systematic review.

4.2. Future Implications

The next step is to do a study on a specific population that may be influenced to a further extent by the doctor patient relationship. This would apply to patients who are in a vulnerable position where the trust between themselves and their physician is the most important driving factor in their care. This case is particularly true for chronic pain patients as the nature of their illness subjective, and the treatment can carry a high risk. In one study [13] the point is made that chronic pain management “promotes, but does not necessitate, a default attitude of distrust among patients and clinicians”.

Trust facilitates therapeutic alliance which improves patient outcomes.

As mentioned, multiple studies in this literature review focused on trust in the context of specific populations. Only two of the selected studies [13] [14] focused on trust pertaining to chronic pain patients. More research is needed in this field to improve the complicated trust dynamic between these patients and their doctors.

5. Conclusions

Trust is known to be a vital component in clinical practice and, in order to ensure its importance is not understated, research must continue to be undertaken on the topic, especially focusing on vulnerable and stigmatised populations such as chronic pain patients. With better understanding of how trust is built and the extent of the role it plays in clinical practice, it is hoped that this growing knowledge can improve practice.

Communication skills are required. Patience is required with frustrated patients with stigmatised conditions. Trust facilitates therapeutic alliance which improves patient outcomes.

Declarations

Ethics Approval and Consent to Participate

Not required.

Consent for Publication

Not required.

Availability of Data and Material

The datasets used and/or analysed during the current study are available from the corresponding author on reasonable request.

Competing Interests

None.

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None.

Authors' Contributions

Both authors developed the theme, performed the analysis and scripted the manuscript and associated material.

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Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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