Concepts of trust in patients with serious illness focused on physician interpersonal and technical competence


QUESTION: How do patients with serious medical conditions conceptualise and assess trust in their physicians?

Design
Exploratory descriptive study.

Setting
New Jersey, USA.

Patients
30 women (mean age 56 y) with breast cancer, 30 patients (mean age 48 y, 83% women) with Lyme disease, and 30 patients (mean age 43 y, 53% men) with a serious psychiatric illness.

Methods
In semi-structured interviews, patients were asked about various aspects of their interactions with their physicians, medical institutions, and healthcare plans. The interview schedule was based on a conceptualisation of 5 dimensions of trust that were identified from a literature review (competence, fiduciary responsibility and agency, control, confidentiality, and disclosure). Interviews were audiorecorded and transcribed; individual phrases were coded using the above conceptualisation.

Main findings
Patient responses to the question “what does trust mean to you?” ranged across the dimensions of competence, agency, and confidentiality; control and disclosure were seldom mentioned.

The dimension of competence included both interpersonal and technical competence. Patients put most emphasis on the interpersonal competence of their physicians, which was predominantly described in terms of listening. Other descriptors included caring, concern, and compassion. Technical competence related to a physician’s experience, thoroughness, and knowledge. Patients assessed technical competence based on their experiences and how they felt their illnesses were progressing under treatment. Individual patients had different levels of knowledge and resourcefulness in learning about their diseases, and therefore developed different expectations about the nature of technical competence, which were subsequently compared with their unfolding experiences. With regard to fiduciary responsibility and agency, most patients had difficulty accepting that their physician might need to weigh their personal gain; most, however, did not feel it appropriate to ask their physicians to make such disclosures.

Conclusions
Patients with serious illnesses such as breast cancer, Lyme disease, and psychiatric illness viewed trust as an iterative process in which they tested their physicians against their own knowledge and expectations. Interpersonal competence focused on listening was a major dimension of trust; technical competence and agency were other important dimensions. Control, confidentiality, and disclosure were less common concerns.

COMMENTARY

The study by Mechanic and Meyer provides valuable evidence in revealing the dimensions of trust inherent in physician-patient relationships. Similar studies have shown the importance of technical and interpersonal competence. Previous research, however, has also highlighted patient control or autonomy—expressed as the building of partnerships, reciprocal trust, or patient decision making. This lack of emphasis on patient autonomy may be the result of using a sample that consisted wholly of patients with serious illness. These patients have been found to desire less autonomy in medical decision making. Patients in the previous studies were receiving various healthcare services including primary care, natural health care, and home care or were described as having a chronic illness and thus many might not have been seriously ill.

Several recommendations for nursing can be drawn from the findings. The centrality of interpersonal competence in building patient trust supports continued efforts to promote and sustain the interpersonal skills of nurses. The authors emphasise that some of these skills are teachable, such as listening and communicating clearly. The results of this and previous studies suggest that nurses should be sensitive to the degree of autonomy desired by patients, which may be dependent upon the seriousness of their illnesses.

Elizabeth Peter, RN, PhD
Assistant Professor, Faculty of Nursing
Member, Joint Centre for Bioethics
University of Toronto
Toronto, Ontario, Canada

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