To trust or not to trust….. that is the question

Paul Ward
Professor of Public Health
Flinders University
Adelaide, Australia

Outline of presentation

- My interest and trajectory in research on trust
- Definitions of trust
- Importance of trust in modern society
- Conceptualisations of trust
- Case Studies
  - Examples from my research
- Summary

Research interests and trajectory on trust

- Professional-client interactions (centrality of trust)
  - GPs, Dieticians, Pharmacists, Dentists

- Health and social care needs of marginalised groups (different trust issues)
  - MSM
  - Female sex workers
  - Culturally and linguistically diverse groups
  - Aboriginal Australians
  - Low socio-economic status
  - People with mental illnesses

- Sociology of trust (empirical and theoretical research)
  - Food system, health care system, Governments
  - Theoretical development

Research interests and trajectory on trust

- ALL of this leads to the stock standard questions
  - WHAT – what is trust?
  - WHO – who do clients/patients/consumers trust or distrust?
  - WHERE – where is the trust won, lost, sustained - individual and/or system?
  - WHY – on what basis do people make decision to trust or distrust?
  - HOW – how do providers, clients and/or organisations win, lose, re-gain, broker, or sustain trust?

So what – why study ‘trust’?

- Plethora public health policy and research using concepts of social capital and social inclusion
  - trust is central but largely untheorised

- Trust is widely documented as essential to effective therapeutic encounters
  - increase willingness to seek care/use health services
  - encourage uptake and adherence to treatment
  - enhance quality of client-provider interaction
  - facilitate disclosure by clients
  - may grant patients more autonomy in decision making about treatment

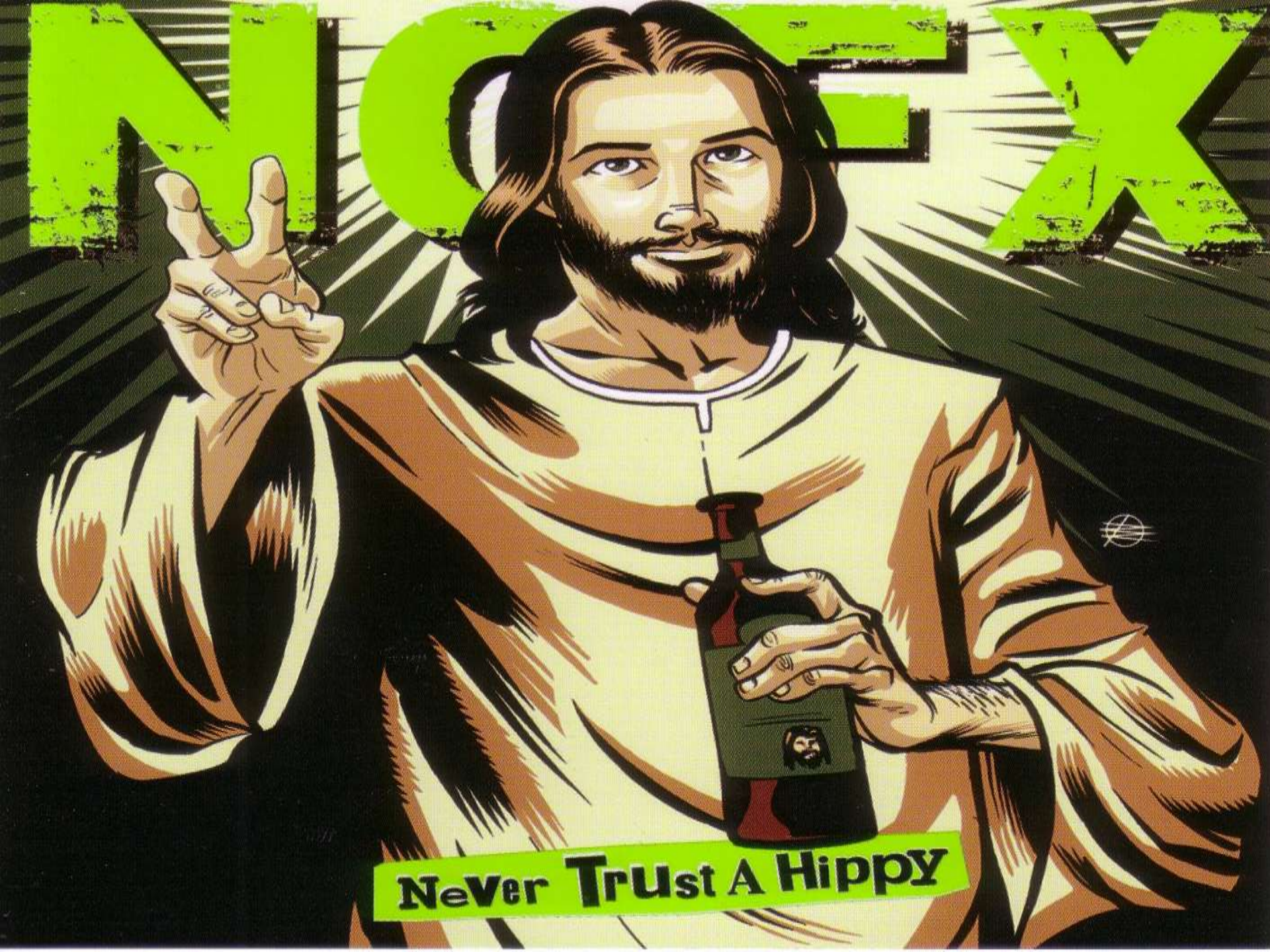
- However, trust is often seen as variable to be measured – but little recognition of ‘what it is’ and hence how to interpret the findings

- It is also used widely and varyingly…..


IN GOD WE TRUST

WE TRUST

ONE


NOFX
Never Trust A Hippy


Trust
Love


LOVE All...
Trust
A
Few.
QUOTESBUDDY
.COM
- William Shakespeare

Varied definitions of trust in sociology

Definitions of trust

- For Giddens – ‘trust’ satisfies the partial understanding we have about the world – a combination of ‘good reason’ (based on past experience) and a ‘bracketing out of ignorance or lack of information’ (a removal or compensation for what we are lacking)

- For Luhmann, ‘trust’ satisfies the need to reduce complexity, both for individuals and social systems

- Both theorists recognise
  - two levels of trust - Inter-personal and systems-based
  - their relationality - the impact of one on the other
  - trust is no longer a ‘given’ – it has to be worked on and won

- Giddens views trust as a social lubricant for cooperation (and hence social order) because it mutually reinforces expectations of reciprocity.

- Luhmann views trust as a stabiliser of social order because it reduces social complexity.

Definitions of trust

- Therefore, trust may be seen as
  - "the mutual confidence that no party will exploit another's vulnerability" (Sabel 1993: 1133)

- …. with the *truster* being required to
  - "accept the risks associated with the type and depth of the interdependence inherent in a given relationship" (Shepard and Sherman 1998: 423).

- Khodyakov (2007) sub-divides inter-personal trust into:
  - Thick – family, close friends – people of similar backgrounds which makes trust less risky (familiarity and similarity with trustee) – default is trust?
  - Thin – people who are not known well – unclear about intentions, common goals therefore more risky – default is distrust? (until proven otherwise)

- Many definitions of trust view it as an inter-personal outcome
  - Purely my trust in another person and vice versa
  - Ignores trust in institutions, social systems, bodies of knowledge etc.
  - Mostly ignores trust in self (or trust in trust)

Importance of ‘trust’ in modern society

- A core dimension of modern society
  - Demarcation between ‘pre-modern’ and ‘modern’ society (Giddens 1990)

Importance of ‘trust’ in modern society

- Increasing public scepticism and mistrust: “culture of anxiety”; “era of insecurity”; “existential anxiety”
  - Many examples – BSE (mad cow disease), Chernobyl disaster, current economic crisis, medical scandals

- Declining trust linked to
  - Epistemological challenges to authenticity of ‘expert’ knowledge
  - Increase of ‘lay expertise’ and ‘knowledgable narratives’
  - Decreasing confidence in the power of science

- In the future “one should expect trust to be increasingly in demand as a means of enduring the complexities of the future which technology will generate” (Luhmann 1979: 16)

Importance of ‘trust’ in modern society

> Claims to expertise no longer sole provenance of medical practitioners
  - Scambler & Britten (2001) - shift in Drs status from ‘legislators’ to ‘interpreters’ - no longer able to be “unchallenged to prognosticate on matters of health”

> Multiple sources of conflicting and contradictory evidence

  – Epistemological uncertainties – what is authentic/valid knowledge, what knowledge (or evidence) do we trust?
    - GP vs internet site(s) vs peers vs family vs ……

  – Deconstruction of traditional ‘lay’ and ‘expert’ – multiple truth claims to expertise around knowledge – who are the experts?
    - Clinicians, peer groups, advocates?

> “When the life-world is colonized by medical insecurity, medicalized subjects come to suspect the messenger and the knowledge they bear” (Crawford 2004: 524)

Importance of ‘trust’ in modern society

- Critical distance opening up between ‘lay knowledge’ and ‘expert knowledge’
  - “all knowledge is tentative, corrigible and therefore open to subsequent revision or abandonment… Systems of expertise come to represent multiple sources of authority that are frequently contested and divergent in their implications” (Williams & Calnan 1996: 262)

- Implications for what we do, who/what we trust
  - “people are left wondering about the efficacy of medical advice: as the map of danger is filled in, safe passage appears all the more difficult; but as the map of safe passage becomes illegible, people do not know what to believe or how to act in order to be safe” (Crawford 2004: 511)

Conceptualisations of trust

- Temporal aspect – trust is situated in the future
  - ”To show trust is to anticipate the future. It is to behave as though the future were certain” (Luhmann 1979: 10)
  - “trust is historical, but it is not so much tied to the past as it is pregnant with the future” (Solomon & Flores 2001: 15)
  - Based on experiences in the past with the expectation of some future rewards (i.e. a trust is a risk)
  - Notion of ‘imaginative anticipation’ – since we cannot accurately predict the future, we make hypotheses/ predictions about the actions of others (which may prove to be good or bad decisions – involve an element of risk)

Conceptualisations of trust

> Giddens (1990) distinguishes between facework commitment and faceless commitment

> Facework commitment – heavily dependant on demeanour of operator
  - Fits in with socialised expectations
  - Cheerfulness of air cabin crew, solemn professionalism of GP

> Faceless commitment
  - Given these are abstract systems – require trust to be re-embedded
  - Trust is sustained and/or transformed through facework commitments
  - E.g. GPs are conduit for medical system - required in order to re-embed trust

> "Access points" – meeting ground for faceless and facework commitments (in a GP surgery, GP is seen to represent or be responsible for the medical system)
  - "although everyone is aware that the real repository of trust is in the abstract system, rather than the individuals who in specific contexts "represent" it, access points carry a reminder that it is flesh-and-blood people (who are potentially fallible) who are its operators" (Giddens 1990; 85)

Expectations met at the ‘access point’?

Would you trust a young genius?

He has the white coat and stethoscope…..would you trust him?

3 Case Studies

Case Study 1 – (dis)trust of GPs in a marginalised community

- Health-care needs assessment in a materially deprived community in UK
- Participants in study had a different view of the research agenda
  - Re-shaped into exploring the myriad ways in which many organisations had let them down, broken promises and withdrawn services in the past
- Over-riding theme running through, and dominating, narratives was mistrust
- Ward PR, Coates A. "We shed tears, but there is no one there to wipe them up for us": narratives of (mis)trust in a materially deprived community. *Health* 2006: **10**; 283-301.
- Ward PR, Coates A. Health and happiness in a materially deprived, ethnically-mixed locality. *Journal of Epidemiology and Community Health* 2005: 60; 87.

Inter-personal trust

- Trust was directly linked to a GP's familiarity with a person's social/personal circumstances in addition to medical histories (comparisons with 'old style family doctors')

- Perceived unwillingness of GPs to stay in the area
  - High number of locum GPs
  - Difficulty in developing inter-personal relationships
  - Made trust more difficult to 'win' or 'work on'

  - Participant A: *"People at my clinic have no idea who the doctors are. Today there is somebody, tomorrow is somebody else, there is no continuity."*

  - Participant B: *"No, 'cos if it's a locum doctor, you're not going to know him are you. If it's just your normal doctor who see regularly then yes, you should be more comfortable yeah, because they know you, saying about what problems you've had before, but if it's a locum doctor, he can just read the notes, they're not going to, you're not going expect him to talk to you much"*

Inter-personal trust

- Mistrust led to ambivalence in accepting GPs advice and to challenges to medicine
  - lack of ‘compliance’ with prescribed therapies and treatment recommendations (passive challenge?)

  - Participant A: *“Never seen him before, never seen him before at all. Explained to him a little bit about what happened and he went, no word of a lie, "what antibiotics do you want me to give you?". [raised voice] What antibiotics I wanted him to give me?…”*
  - Participant B: *“Well if I feel that I can trust the doctor to diagnose and treat whatever I have got or my daughters then I will be more inclined to do what he asks and take the medicine. If I don’t trust what the doctor says then I will be more inclined not to take the medicine because I don’t think it will make me better.”*
  - Participant C: *“They prescribed antibiotics and I said to 'em you can give them me but I'm not taking them. She gave me the prescription and I didn’t even go the chemist to go and fetch them”.*

Systems-based trust

- Perceived underinvestment and disinvestment in local services over the years, including health care services
  - Many examples of 'broken promises' by variety of agencies (education, environment, healthcare, employment etc)

- Feelings of social exclusion, disembeddedness and disillusionment

- Statements about rhetoric and reality:
  - *"The meeting I went to they were talking about having a dentist here, they were talking about having some kind of a chemist…..they are talking about bringing other services in and it all sounds great in theory but the downside is, which as we've found out before, it usually finishes up being one less person than what we thought we were going to get"*

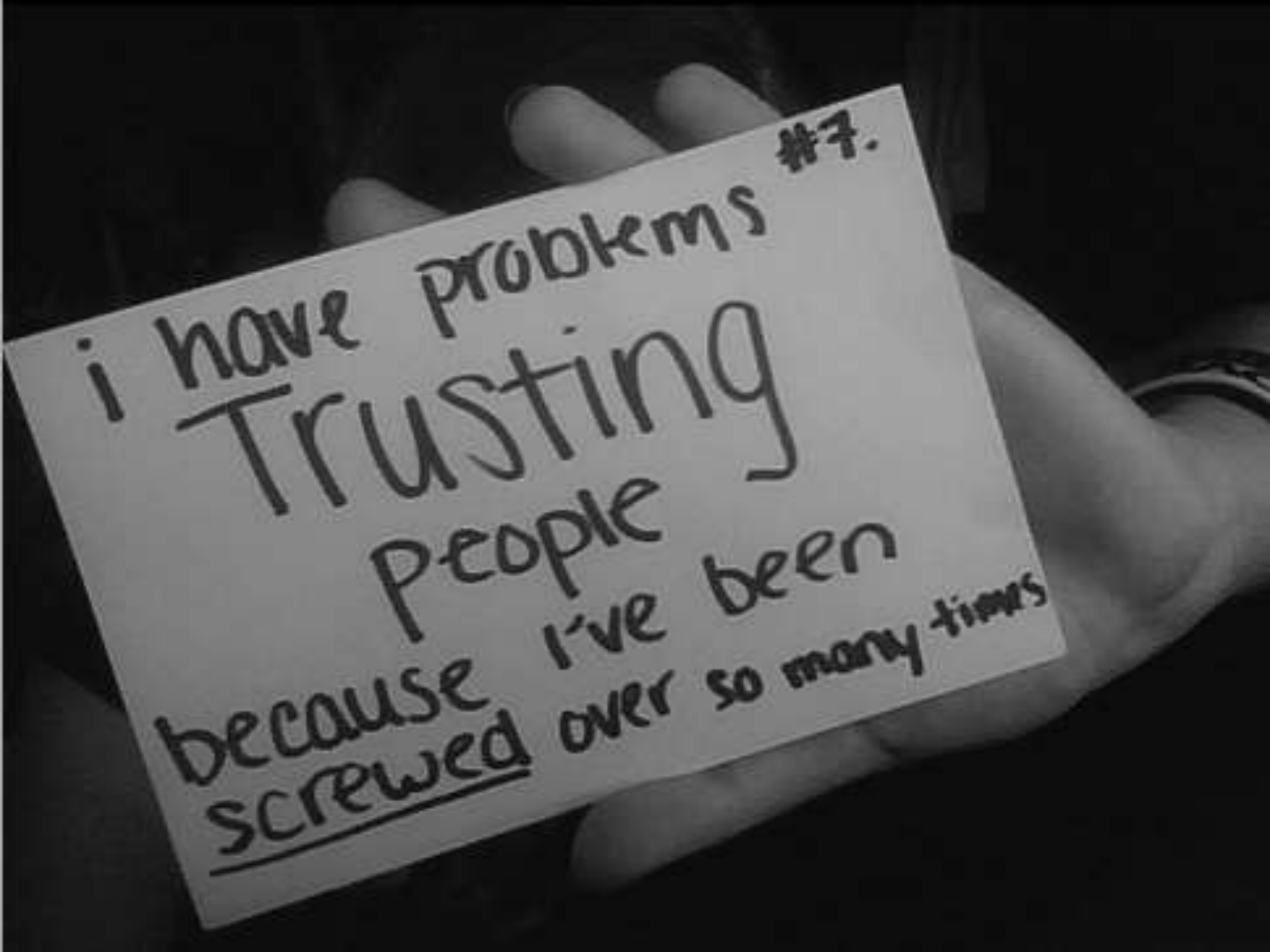
- Produced and reproduced general and enduring mistrust towards policy makers, government departments, NGOs etc (i.e. hierarchical forms of power and governance)

Systems-based trust

- Any ‘facework commitment’ (including inter-personal relationship with GP, researcher etc) was therefore viewed and constructed through this lens

- Led to understandably negative or fatalistic attitudes towards any proposed changes in policy or practice – built on prior experience of broken promises

  - “So, basically, if the Primary Care Trust can't change the environment, I mean, to me personally, this is a waste of time because I will live in the environment for so long and then I will have to run away from it. If the environment is killing us slowly then there's no point me personally being here talking to you saying I want a good doctor. A good doctor will give us medication, help us to die slowly but will not increase our lifestyle. Correct!”


#7.
i have problems
Trusting
people
because i've been
screwed over so many times


TRUST THE LIES
NOT THE 'TRUTH'


trust
nobody

Case Study 2 – trust in individuals and institutions

> Asia-Pacific studies on 'social quality'
  - Questionnaire surveys in 6 Asia-Pacific countries (around 1000 respondents in each survey)
  - Some questions on who they trust or distrust
    - Individuals – family, GPs, politicians, police officers etc
    - Institutions – banks, hospitals, the press, the government etc

- Meyer S, Luong T, Mamerow L, Ward PR. Inequities in access to healthcare: analysis of national survey data across six Asia-Pacific countries. *BMC Health Services Research* (in press)
- Meyer S, Luong T, Ward PR, Tsourtos G, Gill T. Investigating Australians' trust: Findings from a national survey. *International Journal of Social Quality* 2012; 2 (2): 3-23.

> Ward PR, Meyer S, Verity F, Gill T, Luong T. Complex problems require complex solutions: the utility of social quality theory for addressing the Social Determinants of Health. *BMC Public Health* 2011: 11; 630.

Who do Australians trust?

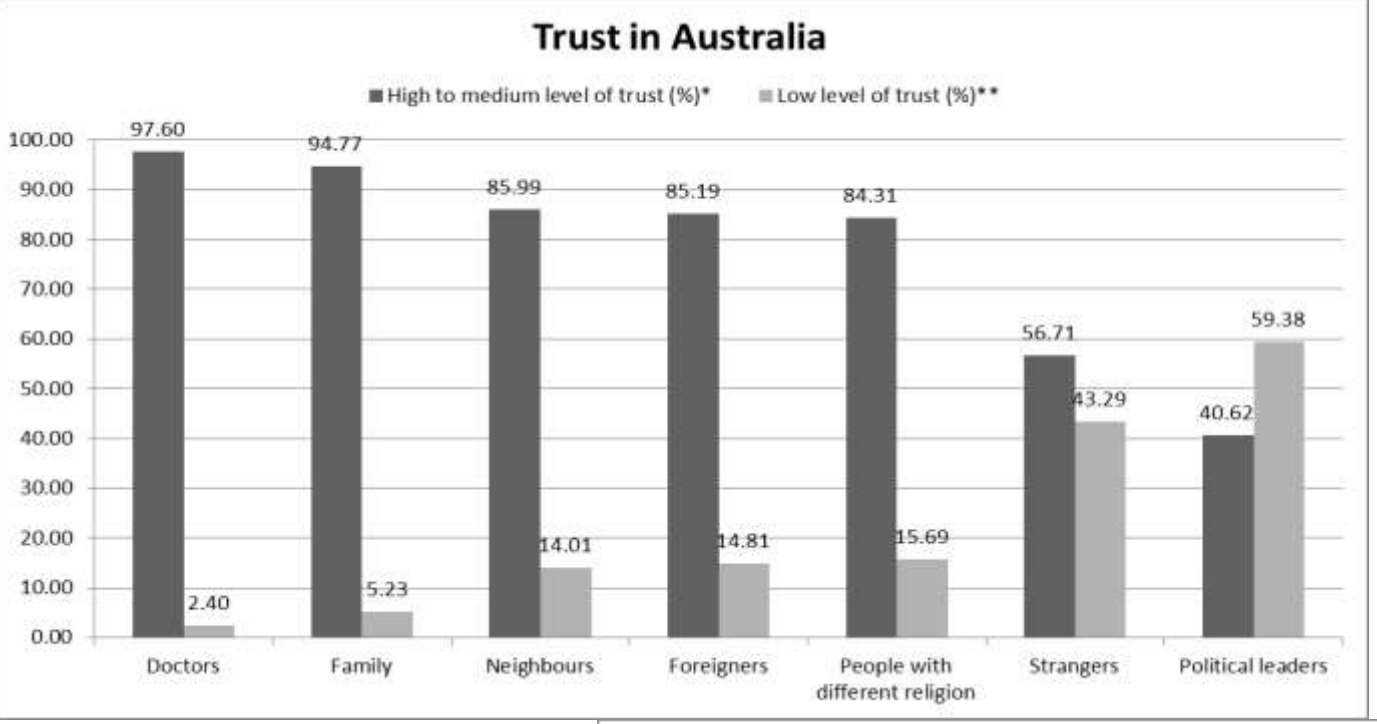
> In terms of the variables relating to trust in different groups of people
  - 82% trust family
  - 34% trust neighbours
  - 62% trust doctors
  - 18% trust people of another religion completely,
  - 15% trust people of another nationality completely,
  - 2% trust national political leaders completely
  - 25% trust police officers completely.

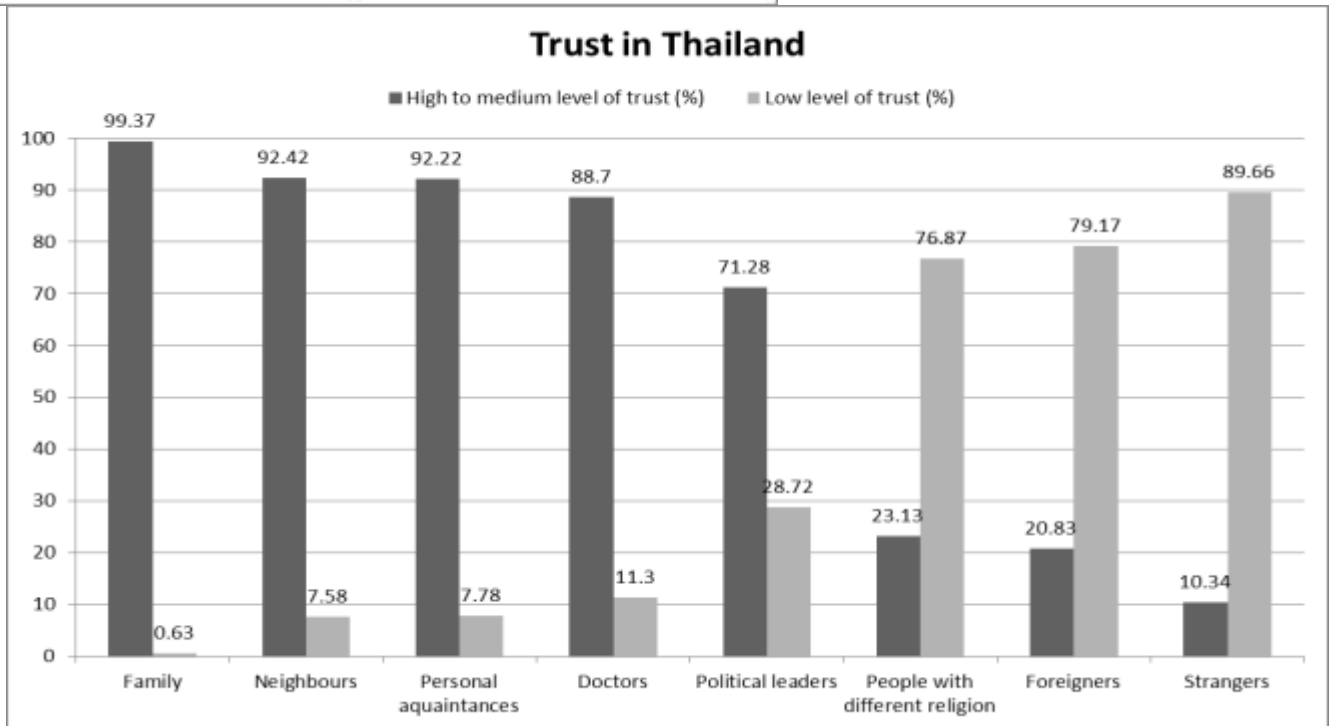
Levels of trust in different countries

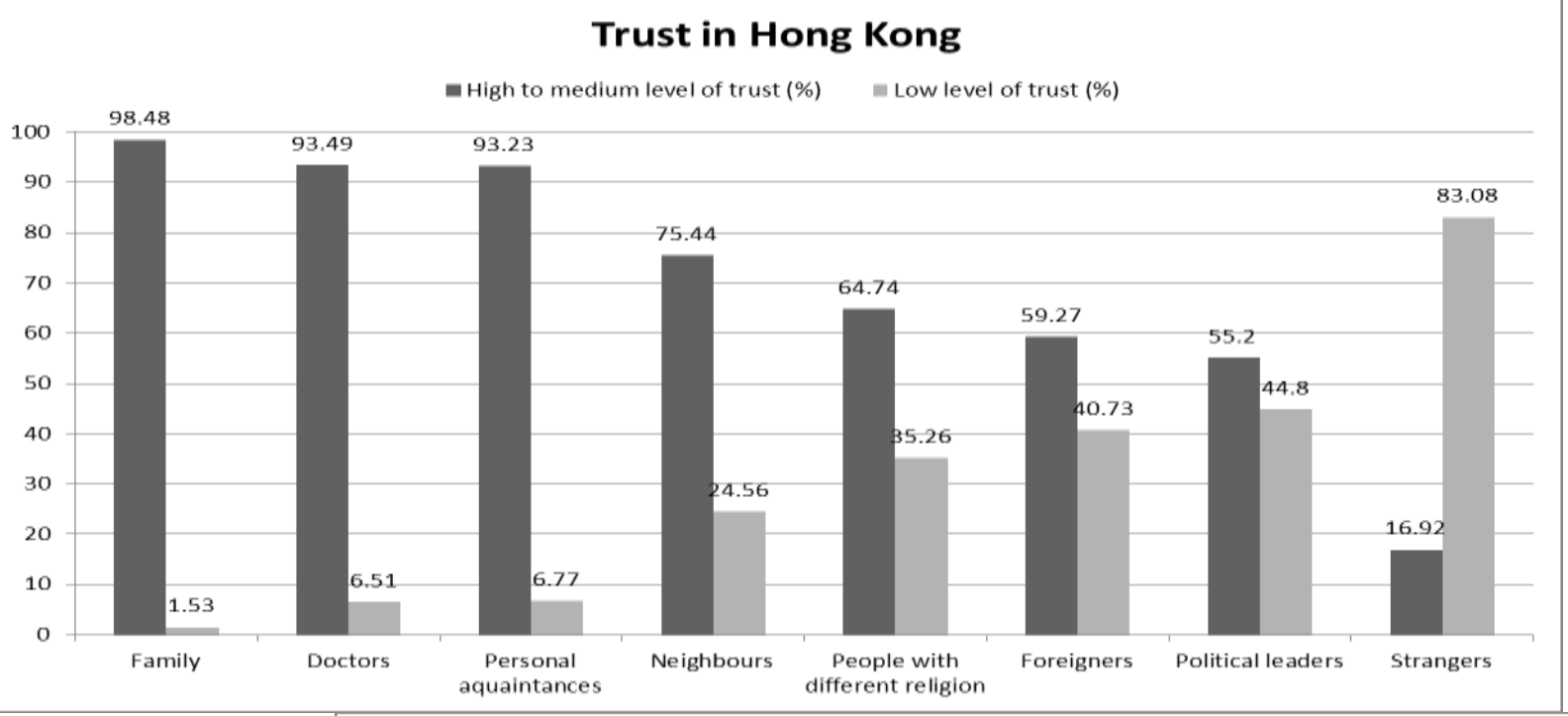
What % of respondents had complete or high trust?

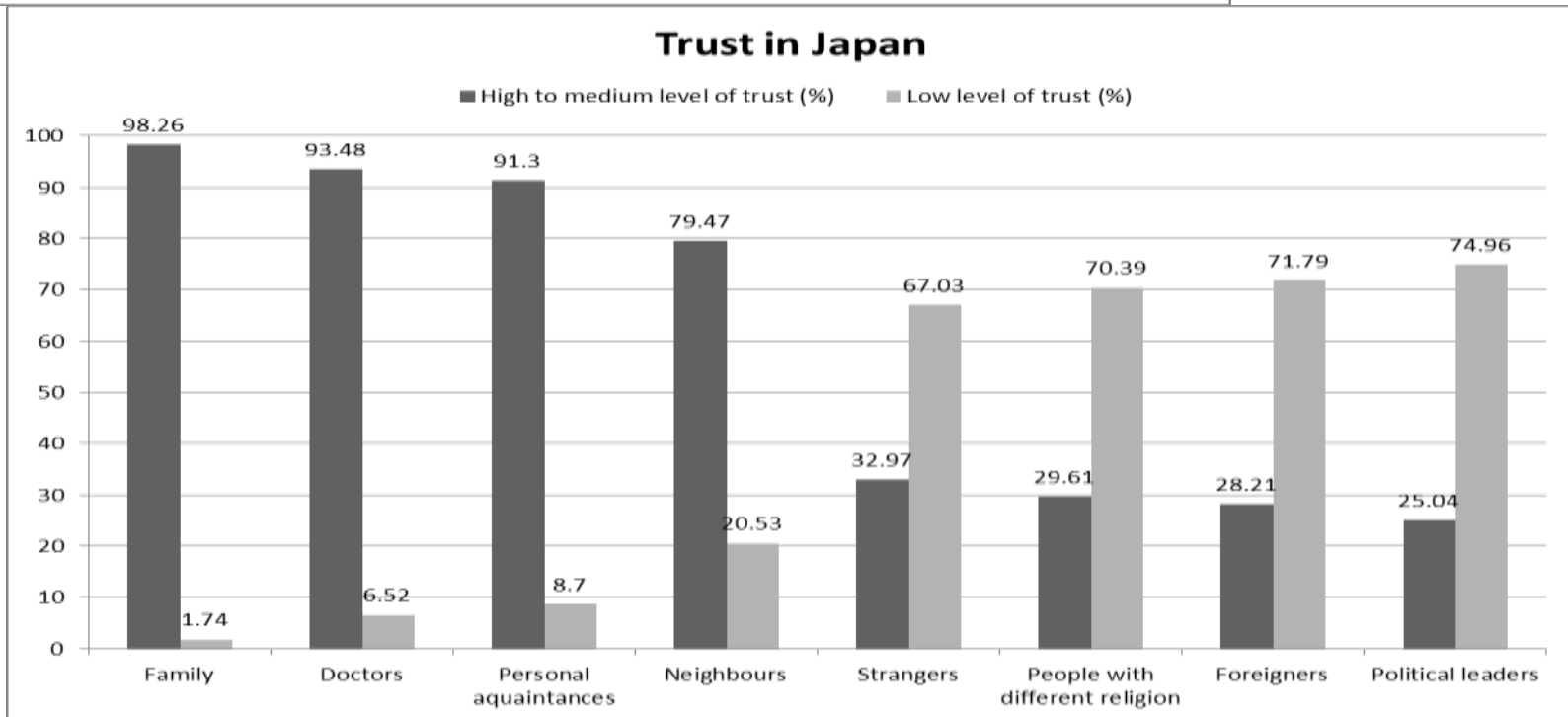
	Political leaders	Doctors	Migrants	Different religion
Australia	2.2	61.5	15.4	17.7
Hong Kong	5.9	51.2	4.8	5.0
Japan	0.6	30.7	1.1	0.9
South Korea	1.3	15.7	1.7	7.8
Thailand	21.9	57.5	1.2	0.8
Taiwan	4.8	25.9	2.5	2.4

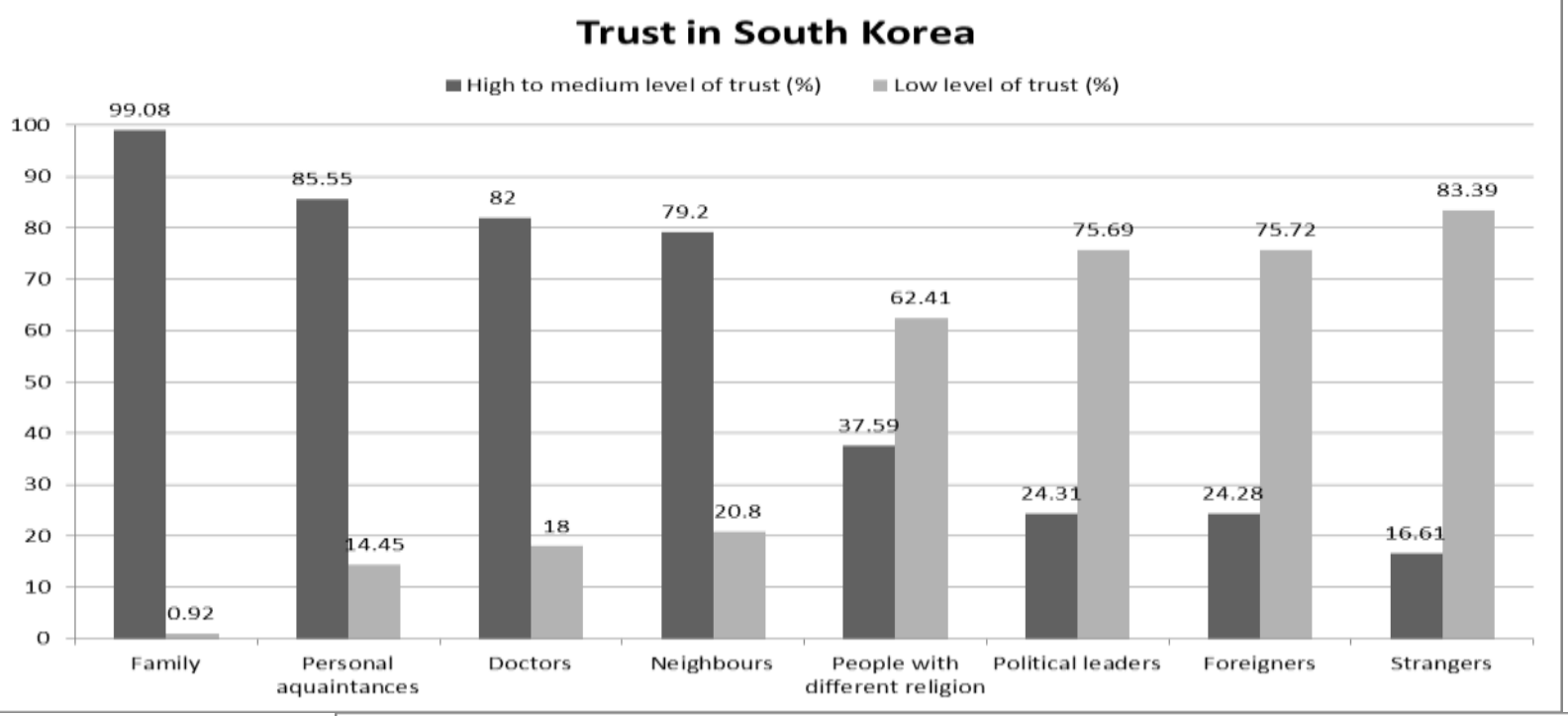
Unpublished data from surveys in each country

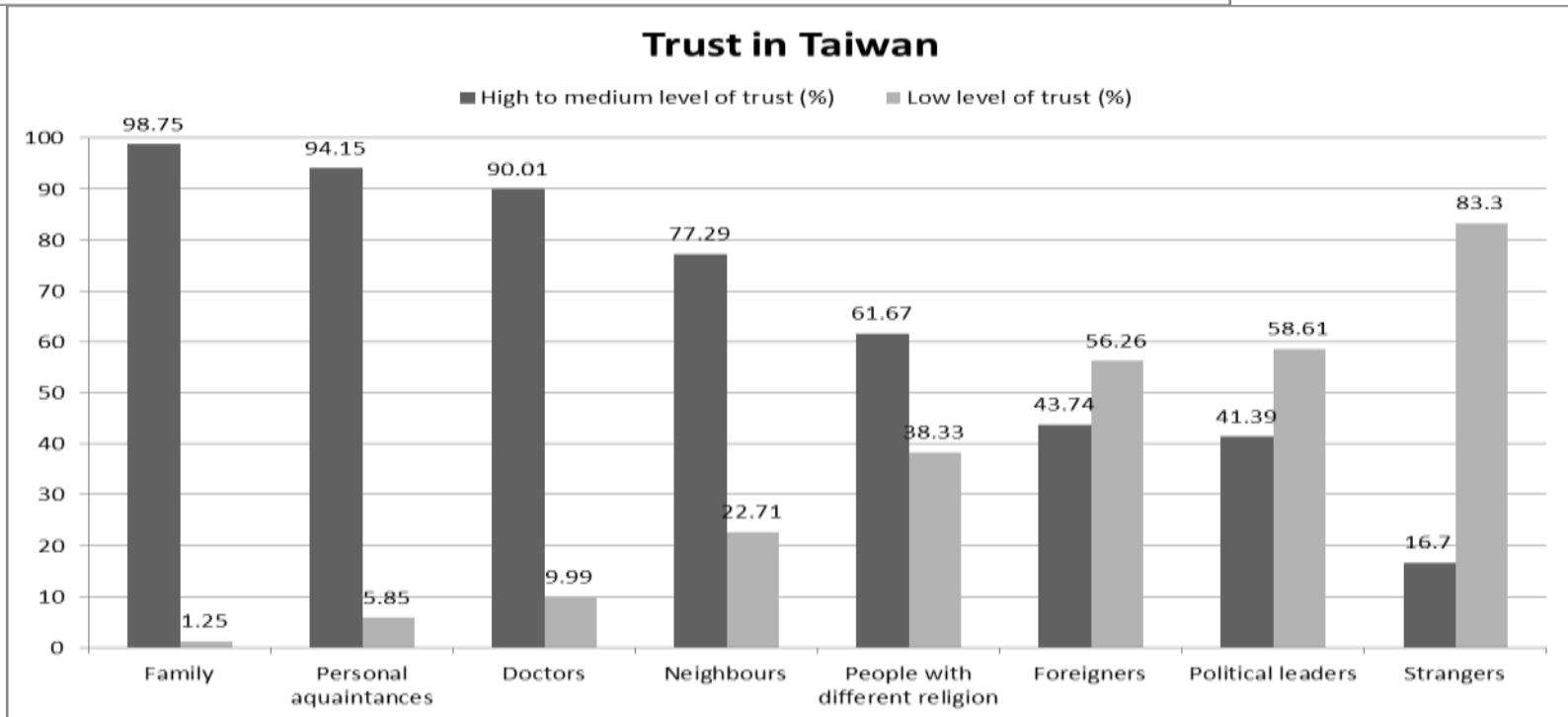

Trust in Australia
High to medium level of trust (%)*
Low level of trust (%)**
100.00
90.00
80.00
70.00
60.00
50.00
40.00
30.00
20.00
10.00
0.00
97.60
2.40
94.77
5.23
85.99
14.01
85.19
14.81
84.31
15.69
56.71
43.29
40.62
59.38
Doctors
Family
Neighbours
Foreigners
People with different religion
Strangers
Political leaders


Trust in Thailand
High to medium level of trust (%)
Low level of trust (%)
100
90
80
70
60
50
40
30
20
10
0
99.37
0.63
92.42
7.58
92.22
7.78
88.7
11.3
71.28
28.72
23.13
76.87
20.83
79.17
10.34
89.66
Family
Neighbours
Personal aquaintances
Doctors
Political leaders
People with different religion
Foreigners
Strangers


Trust in Hong Kong
High to medium level of trust (%)
Low level of trust (%)
100
90
80
70
60
50
40
30
20
10
0
98.48
1.53
93.49
6.51
93.23
6.77
75.44
24.56
64.74
35.26
59.27
40.73
55.2
44.8
16.92
83.08
Family
Doctors
Personal aquaintances
Neighbours
People with different religion
Foreigners
Political leaders
Strangers


Trust in Japan
High to medium level of trust (%)
Low level of trust (%)
100
90
80
70
60
50
40
30
20
10
0
98.26
1.74
93.48
6.52
91.3
8.7
79.47
20.53
32.97
67.03
29.61
70.39
28.21
71.79
25.04
74.96
Family
Doctors
Personal aquaintances
Neighbours
Strangers
People with different religion
Foreigners
Political leaders


Trust in South Korea
High to medium level of trust (%)
Low level of trust (%)
100
90
80
70
60
50
40
30
20
10
0
99.08
0.92
85.55
14.45
82
18
79.2
20.8
37.59
62.41
24.31
75.69
24.28
75.72
16.61
83.39
Family
Personal aquaintances
Doctors
Neighbours
People with different religion
Political leaders
Foreigners
Strangers


Trust in Taiwan
High to medium level of trust (%)
Low level of trust (%)
100
90
80
70
60
50
40
30
20
10
0
98.75
1.25
94.15
5.85
90.01
9.99
77.29
22.71
61.67
38.33
43.74
56.26
41.39
58.61
16.7
83.3
Family
Personal aquaintances
Doctors
Neighbours
People with different religion
Foreigners
Political leaders
Strangers

Case study 3

- Study in Glasgow, Scotland
- Focus groups with particular groups of people with health care needs – older, CALD, mothers etc
- Study set out to explore potential expanded roles for pharmacists – but a central theme was trust (or lack thereof) of pharmacists

- Highlights issues that Hep C workers may have – who are their clients trusting and why?

- Gidman W, Ward PR, McGregor L. Understanding public trust in services provided by community pharmacists relative to those provided by general practitioners: a qualitative study. *BMJ Open* 2012: 2; e000939. Doi: 10.1136/bmjopen-2012-000939

Interpersonal trust

Importance of familiarity and trust

> “I think the role of a community pharmacist, you would need to get to know, you know, going back to the same person and getting that rapport and trust”. R1

Familiarity and safety

> “the doctor knows you best. He knows what he can give you safely and what he can’t give you safely. The chemist doesn’t know that”. R13

Stability of relationship with GP

> “Surely a doctor knows your records, he knows your history, he knows you from when you were born till you’re ready to die. A chemist doesn’t. A chemist can give you something that can have an adverse effect on you. Just as easily as something that would help”. R13

Interpersonal trust and communication

> “If I go to my GP I’m so open about anything I need to say, but with the pharmacist there is that . You don’t feel like there is a personal relationship that enables you to open up and seek out more advice”. R15

Interpersonal trust

Pharmacist trusted in low-risk situations

> “I think they know a lot more than some of the doctors know. I’m thinking about my daughter with the head lice. The doctor didn’t really know what he could give her. He said, you can try this and you can try that but we had tried that and it didn’t work and she ended up with them again and again and again eventually the pharmacy was “well use this” and it worked, it was fine”. R18

Pharmacist not trusted in high-risk situations

> “It’s like they can go and say, ‘Oh it’s nothing’ and then go away and drop dead quick from trusting the chemist”. R24

Systems based trust

Familiarity with traditional roles

> “You see the posters about contraception and things like that but because you don’t feel inclined to go ahead and ask the pharmacist, ... you don’t feel that you are comfortable talking to the pharmacist about.. I am more comfortable talking about it with my GP and yet I access the pharmacy more often than I do the GP, but I’m not comfortable asking the pharmacist about that. Just because of the way.. The service they give, you just get it in your head, like you just go to pick up medication from there and you are out, you do not have that relationship that you have with your GP”. R15.

Personalised service systems

> “I wouldn’t say, you know, if somebody said to me ‘where is your community pharmacist?’ I’ll say, well if I go a mile that way I’ll get this one, if I go a mile that way, and if I go a mile, you know. So it just depends what’s convenient at the time, whereas I think the role of a community pharmacist, you would need to get to know, you know, going back to the same person and getting that rapport and trust”. R4.

> “The chemist in Renfew has now got a little cubicle and the only people that use that are the ones who’re getting the Methadone”. R1.

  – Linked to stigma – not wanting to use ‘methadone rooms’

Systems based trust

The service setting

> They do really need to get to know you. It needs to be a local thing. To actually get to know you personally. Normally, the pharmacist is not, he or she is not in what I call the serving area, they're in the back. You know, and although there are cameras, security cameras, if they're concentrating on doing their job, they shouldn't be looking at the cameras. They shouldn't actually know who you are. R12.

Hierarchies in healthcare

> "we're just not accustomed to going into a pharmacy and saying there's this wrong with us or that wrong with us, what can you recommend? We've always gone via the GP and the GP decides and tells the pharmacist what to do, you know, about it. So it takes a bit, I think, when you're a bit older to slot yourself into that system, so personally I think it comes down to a matter of trust, trust in what the person's telling you". R2.

Systems based trust

Medical education

> Doctors don't make mistakes (R23) ..they've had so many years at university to learn this stuff (R24)…Are they [pharmacists] going to go to university to learn about all the stuff doctors are and things like this? (R24)… Do you feel that sometimes some of the advice given in the pharmacist is not .? (facilitator)…It's not a hundred percent gospel (R24)… Or taken seriously because of the difference in the qualification thing. R23

Summary

- Many sectors and institutions have witnessed a decline in trust – linked to poorer health and less use of health services

- Need to see trust as both interpersonal and systems based
  - Based on risk, vulnerability, familiarity, expectations

- Solution not as simple as either developing relationship with professional or engendering trust in the medical system
  - Professional is at centre of a web
  - Many social systems are linked in the web
  - Trust or distrust in any of the links in the web may have a ‘ripple effect’ – and may break the web

- Only by adopting a comprehensive (inter-sectoral, cross-Government etc) approach can we hope to develop and foster trust in materially deprived or marginalised communities