Situational trust and co-operative partnerships between physicians and their patients: a theoretical explanation transferable from business practice

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Summary

A model to explain interpersonal trust development, and its consequences for co-operative behaviour in doctor/patient partnerships derived from the context of business relationships is applied to patient/physician relationships. Threshold barriers exist against all human behaviours or actions and trust is the process by which barriers to co-operation and compliance are overcome. Dispositional trust (a psychological trait to be trusting) is dominant in the early stages of a relationship and contributes to the weight of subsequent trust development. Co-operative behaviour or compliance ultimately requires a secure situational trust emerging from consultations, which is carried forward as learnt trust and modified in each subsequent consultation. The model comprises three types of situational trust (calculus-based, knowledge-based, and identification trust) and five co-operation criteria from which to determine an individual’s tendency for co-operative behaviour. These model components can be identified and mapped from a range of qualitative data, with the aim of enhancing co-operative behaviour and efficiently achieving optimal patient compliance.

Introduction

A patient who is referred to a specialist consultant is always vulnerable and seeks help (incorporating evidence-based medicine, experience and wisdom) which is communicated in an expected manner of delivery, to address diagnosis, prognosis and usually treatment. Help must therefore be offered and accepted on trust, and the way in which the trust relationship develops beyond the first meeting will have a significant impact on the success or otherwise of the care provided. Effective management, particularly for chronic condition, is often assessed through ‘compliance’ with advice. Since ‘responsible patients and compassionate doctors are [its] pre-condition’, compliance requires the development of open, co-operative relationships between both parties. Research has examined the barriers to lifestyle or behavioural change, and models have been applied to predict behavioural change based on the motivational status of the patient, but the nature of trust between patient and physician and its impact on co-operation has not been formally evaluated. We propose a theoretical model of interpersonal trust and co-operation (partnerships or not as the case may be) between first-time entrepreneurs and their business ‘angels’ which appears to be transferable to the context of patient-physician consultations.

Diabetes is one example of a chronic disease of which lifestyle modification is the cornerstone of
clinical management. Approximately 75% of all diabetic patients have non-insulin-dependent diabetes (NIDDM). It is recognized that weight loss for the overweight NIDDM and physical activity for the remaining diabetic patients dependent on insulin both increase life expectancy. However, it is often difficult to communicate to patients the long-term benefits of lifestyle modification in the management of their condition. Inevitably, behavioural change will be accompanied by the level of trust in the diagnosis, the clinician, the advice and the urgency of co-operation. To secure patient-physician trust, the specialist must have empathy, ‘understanding chronicity from the patient’s perspective’.

Table 1 describes the different stages in a chronically ill patient’s care and where trusting relations or, better, trusting partnerships are required. Co-operative behaviours, or compliance with health professional demands, ultimately influence the progression of disease and its clinical consequences.

### The concept of trust

The concept of trust varies between disciplines. Trust as a personality trait is emphasized by some psychologists, (e.g. reference 9) or viewed as ‘expectations set within particular contextual parameters and constraints’ from a social psychological perspective. Sociologists have interpreted ‘trust’ as an individual characteristic ‘applicable to the relations among people’, and observable from the behaviour of individuals in situations that expose ‘the individual to the probability of risk’. Other work indicates that trust may be broadly categorized into three layers, dispositional, learnt and situational trust, as shown in Table 2. Situational trust is responsible for determining actions or behaviours at any time, emerging from experience. Situational trust changes as a result of individuals ‘comparing, finding again and designating’ the situational cues received. It is thus ‘a product of ongoing interaction and discussion’, over time, between individuals. The time required to establish situational trust between the individuals will depend both on disposition to trust of each of the individuals (a function of dispositional trust), on the history of the relationship (a function of learnt trust), and on the nature of the situation. Each individual, in a relationship entailing risk or demand, has positive expectations about the other’s motives with respect to him/herself—a context that, as Sheppard and Tuchinsky note, demands greater attention. Trust is also an ‘internal event... rather than something which can be directly observed’, dependent upon external determining factors, which ‘results in external physical actions from which one infers the internal’ event.

### Trust and co-operation

In any given situation, including the medical consultation, co-operation is essential for effective partnerships, since it enables co-ordination between individuals for the attainment of mutual reward and co-operation requires trust ‘whenever the individual... places his fate in the hands of others’. Trust and co-operation within a relationship are constantly re-defining and moulding each other. When partners do not co-operate, the trust between

<table>
<thead>
<tr>
<th>Stage</th>
<th>Domain</th>
<th>Trust relations</th>
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<tbody>
<tr>
<td>Stage 1</td>
<td>GP screening</td>
<td>GP—Patient—Practice Nurse</td>
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<tr>
<td>Stage 2</td>
<td>Initial referral</td>
<td>Patient—Physician—(Interviewing doctor)—(Nurse)—Hospital infrastructure</td>
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<tr>
<td>Stage 3</td>
<td>Subsequent consultations</td>
<td>Patient—Physician—(Interviewing doctor)—(Nurse)—Hospital infrastructure</td>
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<tr>
<td>Stage 4</td>
<td>Long-term care</td>
<td>GP—Patient—Physician—Patient family</td>
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<tr>
<td>Stage 5</td>
<td>Ward care</td>
<td>Patient—Physician—House doctor—Nurse(s)—Hospital infrastructure</td>
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### Table 2 The three layers of interpersonal trust

<table>
<thead>
<tr>
<th>Layer</th>
<th>Description</th>
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<tr>
<td><strong>Dispositional trust</strong></td>
<td>The personality trait or disposition of an individual to be trusting or not; not modifiable</td>
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<tr>
<td><strong>Learnt trust</strong></td>
<td>A individual’s general tendency to trust, or not to trust, another specific individual; modifiable</td>
</tr>
<tr>
<td><strong>Situational trust</strong></td>
<td>That which is dependent on the situational cues that modify the expression of generalized tendencies; modifiable</td>
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</table>
them is violated. Yet violations of trust, with failure to co-operate, requires both parties to be willing to commit themselves to the trust repair process by re-engaging in co-operation.\cite{10,22} Mutual trust, therefore ‘plays a central role in a successful co-operation’,\cite{23} reducing ‘the need for monitoring behaviour and [providing] greater speed in making decisions.’\cite{24} Conversely, ‘co-operation breeds trust’.\cite{25,26} A recent study suggested that male and female GPs both used high amounts of co-operative language in consultations.\cite{27}

The conjunction of situational trust and co-operation threshold, therefore, will enable co-operative behaviour in a given situation, or medical consultation, since where trust is deemed to be greater than the co-operation threshold for both individuals co-operation should ensue, and vice-versa.\cite{14} Where trust is higher than the co-operation threshold for one of the individuals but not the other, then the relationship would be expected to undergo a period of stress or fragility during which the co-operating individual’s trust may be felt to be being violated by the unco-operative individual.\cite{28}

This theoretical relationship between trust and co-operation threshold is shown graphically in Figure 1, and may be distinguished from the concept of ‘active’ distrust, which recent studies have clarified as being a distinctly separate phenomenon from that of trust.\cite{29,30} Previous studies have generally concentrated on either investigating the determinants of trust itself or on providing general illustrations of the role trust plays in society.\cite{31} The role of trust in interpersonal interaction involving professionals has been largely ignored, and there is no recognized paradigm from which to define or map the process of trust development in medical consultations.

**Lewicki and Bunker’s model of trust**

Acknowledging the notion of trust as residing within the individual, Lewicki and Bunker\cite{10,32} draw on the work of Boon and Holmes\cite{17} and Shapiro\cite{24} to propose a typology of trust in professional relationships which focuses on the familiarity with each other of the individuals involved. They argue trust development to be an iterative process that ‘takes on a different character in the early, developing and mature stages of a relationship’,\cite{10} as knowledge of the other person grows, and thus elicit three categories of situational trust. These are, respectively, Calculus-Based Trust, Knowledge-Based Trust and Identification-Based Trust, which ‘are linked in a sequential iteration in which the achievement of trust at one level enables the development of trust at the next level’,\cite{10} as described in Figure 2.

The strength of this trust model lies in its ability to account for the development of trust over time in the form of perceived similarities and differences in both professional knowledge and individual character. The idea that trust in a patient-doctor relationship evolves from calculus-based to knowledge-based and finally to identification-based offers some explanation for the all-too-frequent occurrence of (apparently

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**Figure 1.** The theoretical relationship between co-operation threshold and trust (source reference 35), where low trust may be equated with (e.g.) calculus-based trust, medium trust may be equated with (e.g.) knowledge-based trust, and high trust may be equated with (e.g.) identification-based trust. A comparison of the trust and co-operation threshold for each of the individuals in the relationship will enable a prediction of the likelihood of co-operation between them.
Figure 2. The stages of trust development (source reference 10). $J_1$ and $J_2$ indicate the junction at which some relationships go on to based on the next level of trust. (Published in Kramer RM, Tyler TR. Trust in Organizations: Frontiers of Theory and Research 1996; 124. Reproduced with permission of Sage.)

irrational) lack of co-operation, such as non-compliance with drug therapy or recidivism over diet and lifestyle changes. In such cases, clinical consequences could be taken as a ‘failure’ of the expected trust development process; trust has remained at the calculus-based stage. Such characterization of trust and its characteristics may therefore offer specific opportunities to improve management of patients in such difficult situations.

The Lewicki and Bunker model described above is limited in its application to an investigation of doctor-patient relations or partnerships, on two accounts. There is an underlying assumption that the trust being considered has already arisen in a relationship that has already begun. As such, it takes no account of the particular circumstances that may affect the development of trusting relations at a first meeting between the parties. The peculiarities of the initial meeting between two individuals, especially where that meeting has been brought about by a third party—as is the case for example in a GP referral to a specialist, demands explicit attention. The role of the referring, or co-ordinating, party in the establishment of a relationship between two individuals has been discussed by Meyerson et al.26 For the first meeting to be effective, it is suggested ‘trust must be conferred ex ante experience telling an individual that another is trustworthy’.26 It is this type of trust, resembling blind faith (taken ‘on trust’), that is exhibited by patients in their initial meetings with health-care professionals.1 Such trust need only to be robust enough to serve the initial meeting, since ‘there is, quite literally, neither enough time or opportunity in an initial meeting for the sort of experience necessary for stronger forms of trust to emerge’.26 The failure-to-re-attend rates of hospital clinics give some indication that stronger forms of trust have not developed.

By concentrating solely on the development of familiarity with the trusted party, however, the Lewicki and Bunker model takes no account of a number of other factors identified as influencing trusting behaviour. For example Mayer17 stresses the perceived ability, benevolence, and integrity of the trusted individual, the perceived risk of the situation and the trustor’s propensity to trust as determinants of trusting behaviour. Our purpose now is to incorporate such influences in our theoretical explanation.

**Patient-physician partnerships: a new transferable model of co-operative behaviour**

An exploratory theoretical model was developed by Dibben, Marsh and Scott34 to elucidate the trusting, co-operative behaviour of individuals in grappling with the uncertainties of a new business interaction. In addition to situational trust, this study found that accurate predictions of trusting co-operation could be made by taking into account the following four determinants: (i) the perceived loss or risk from entering the situation for the trusting individual, (ii) the perceived personal economic importance of the situation for the trusting individual, (iii) the perceived personal social or non-economic importance of the situation for the trusting individual, and (iv) the
Modelling trust relationships

trusting individual’s perceived competence of the trusted individual. Further work by Dibben and Dibben, Harrison and Mason identified a further two determinants: (v) perceptions of co-ordinator judgement and (vi) perceptions of self competence. The work of Marsh, Dibben, Marsh and Scott and Dibben has been adapted to elucidate patient-physician partnerships. This adaptation is presented in Figure 3. The six determinants of an individual’s co-operation threshold (see Figure 1) are outlined below.

Economic importance

In research on recommendations by dental practitioners, Dawes found perceptions of potential income from, and potential cost of, treatment to play an important part in the recommendations of the practitioner, and the co-operative behaviour or otherwise of the patient, respectively. Economic importance is therefore necessary to consider the subjective opinion of the trusting individual regarding the potential economic importance to the patient in being declared disabled, and thus come to the wrong conclusion regarding the behaviour of the patient concerned.

Non-economic importance

This is here defined as an individual’s perception of the potential non-economic value of a situation. It is therefore necessary to consider the subjective opinion of the trusting individual regarding the importance of the situation concerned. One might expect that the greater the perception of non-economic importance, the greater the possibility of co-operative behaviour. This is because high perceptions of non-economic importance would be

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**Figure 3.** A model of trust development in the patient-physician relationship. ‘On-Trust’, trust informed on the basis of the recommendation of a third party, conferred ex ante of knowledge of the other individual in the relationship, lasting the length of the first interaction; Calculus-Based Trust, trust formed between individuals in the early stages of a relationship, on the basis of what each sees s/he can get out of the relationship in terms of whether or not the outcomes of creating and sustaining the relationship are greater than the costs of severing it; Knowledge-Based Trust, trust formed over a period of time between individuals on the basis of shared knowledge, allowing each to make predictions about the other’s behaviour; Identification-Based Trust, trust with a high degree of indentification with wishes/intentions of the other individual, such that each can act and substitute for the other in the particular situational setting.
expected to contribute to a low co-operation threshold.

Risk

The link between risk and trust is long established but difficult to clarify.\(^\text{14}\) Some writers argue that trust cannot be present in a situation unless risk is also present,\(^\text{41,42}\) while others (notably reference 33) do not. Nevertheless, there is wide acceptance of perceptions of risk in determining behaviour, and this is especially so in the doctor-physician relationship.\(^\text{1}\) One might expect that the greater the perception of risk, the lesser the possibility of trusting, co-operative behaviour in the immediate situation, although learned trust would be expected to increase from rewarded experience where risk had been perceived to be high.

Competence

The impact of perceived competence on a professional relationship is important in considering whether to trust an individual, and it has been noted as a key trust determinant in a number of studies.\(^\text{1,2,43–48}\) One might expect that the greater the perception of competence, the greater the possibility of, co-operative behaviour for fundamentally the same reason as that discussed under ‘Non-economic importance’ above, (i.e.) a lowered co-operation threshold which the situational trust present is then sufficient to overcome.

Self competence

Increased self awareness of one’s abilities compared with the other parties, affects behaviour in intimate relationships.\(^\text{1,2,49,50}\) Thus, patient empowerment is usually perceived as a goal, but some patients may actively avoid this involvement, perhaps where the patient has a very high perception of physician’s competence. In other cases, patient empowerment may be the source of tension between the physician and the patient where, for example, ‘alternative therapies’ not supported by the physician are adopted that go against conventional scientific evidence. This behaviour, on the other hand, may be indicative of a situation where the patient has a comparatively low perception of the physician’s competence.

Co-ordinator judgement

This is defined in our model as an individual’s perception of the co-ordinating party’s (i.e. the GP’s) ability to select the appropriate physician according to the particular requirements of the patient and the illness.

Implications

This paper offers a model by which to analyse trust, an antecedent of co-operation and partnership, in the context of clinical patient-physician relationships by integrating interdisciplinary approaches. Using this model it is possible to identify and map trust levels and thresholds of co-operative behaviour, and then modify physician behaviour to enhance co-operation between patient-physician interaction forming a partnership. Understanding the process and levels of development for physician-patient partnerships, and their impact on efficacy of treatments, will allow better characterization of partnerships, and better prediction of compliance or co-operative behaviour.

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References


