Public trust in health care

Trustworthy doctors in confidence building systems

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Public trust in healthcare systems requires a balance to be struck between the macro concerns of ''public'' confidence and the microdynamics of ''private'' interpersonal trust between patients and health professionals

The role of trust in public services has received increasing attention over the past decade.[1] In the UK, for the most part, attention has only been focused on public trust in the wake of serious service failings—failings that have had such impacts on the national psyche that they are often recalled by a single name of place, perpetrator or victim (see box)—for example, in the police service (Stephen Lawrence, Soham), rail transport (the Paddington, Hatfield, and Potters Bar disasters), and farming/food policy (foot and mouth disease and BSE). British public health care (the NHS) has, in particular, come under intense scrutiny following widespread public dismay over numerous scandals (Alder Hey, Bristol, various malpractice cases at the General Medical Council and, most notorious of all, Harold Shipman). In each of these cases ''public trust betrayed'' has emerged as a common theme.

But what is ''public trust''? Too often the term appears to be a convenient ''catch all'' expression used for making rather general statements about the relationships between groups (patients, service users, the public) and their service providers (doctors, hospitals, the NHS). Yet ''trust''—the set of expectations that one party holds about another's likely behaviour in a situation entailing risk to that first party—is more usually something that resides within individuals than in groups. How, then, can we move from this *individualised* understanding of trust to notions of *collective* public trust in institutions and organisations?

Two papers in this issue of *QSHC*[2 3] go some way towards bridging this important gap. In the first paper Calnan and Stanford[2] use survey data to show that reporting by individuals of the extent of their trust in health services depends on the specific aspects of service enquired about. On average, respondents had a much lower level of belief that *systems* can deliver (that is, high quality, accessible, and timely care at reasonable cost) than confidence in the more immediate aspects of the doctor-patient encounter (for example, getting sufficient and considered attention from well trained doctors). In further analyses Calnan and Stanford suggest that overall assessments of public trust are driven more by patient perceptions of these micro aspects of patient care than the systems aspects of service delivery.

The second paper by Checkland *et al*[3] sheds considerable light on these empirical relationships by differentiating between trust and confidence. Public confidence is seen as being related to perceptions about the ability of extant systems to manage and deal with potential risks—for example, through regulation, measurement and governance. In contrast, public trust relates more to individuals' experiences of care delivery, being concerned with the interpersonal aspects of care and moral choices in the face of uncertainty.[4] This very useful distinction enables some important linkages to be

Tragedies and scandals in the UK with implications for ''public trust''

Stephen Lawrence
In April 1993, black teenager Stephen Lawrence was murdered by racist thugs at a bus stop in Eltham, south-east London. A bungled police investigation meant that no one has been convicted for his murder. A subsequent enquiry (the Macpherson report) blamed ''institutional racism'' for some of these failings.

Soham
In August 2002, two young girls were murdered in the village of Soham by a local school caretaker. The caretaker had been employed despite a history of allegations of sexual assault and rape, often involving under age girls. Police checks designed to prevent the employment of such people in sensitive positions failed to uncover this history.

Paddington, Hatfield and Potters Bar
These three significant rail accidents, causing death and injury, seriously undermined public confidence in the safety of rail systems and the associated regulatory frameworks.

Foot and mouth disease
The rapid spread of this highly infectious disease in the spring of 2001, and the ensuing attempts to control it, raised many questions about the intensive nature of food production and related animal welfare in the UK.

BSE
Bovine spongiform encephalopathy (BSE), more popularly known as ''mad cow disease'', is a disease of cattle first identified in 1986. Despite many government assurances to the contrary, it is now accepted that this animal disease has potential implications for human health.

Alder Hay
This scandal takes its name from a children's hospital in Liverpool where hundreds of organs were ''harvested'' from dead children and stored for medical experimentation without the approval of the grieving parents. Subsequent investigations showed the practice to have taken place elsewhere across the UK and have led to legislation tightening up on the retention of human tissue for research.

Bristol
Higher than expected mortality rates of paediatric cardiothoracic surgery patients in the Bristol Royal Infirmary led to professional misconduct proceedings against three doctors and a subsequent public inquiry.

Harold Shipman
A single handed GP from Hyde, Greater Manchester, Harold Shipman was found guilty in the criminal courts of the murders of 15 of his patients. Subsequent enquiries suggest that the number actually murdered could have exceeded 200.

made between micro and macro perceptions of public services.

Repeated interactions between individual patients and the healthcare professionals who care for them provide those individuals with a series of specific experiences on which to draw.[5] As a result, whatever public confidence they bring with them to the clinic is soon superseded by a far more direct and concrete set of experiences that inform their level of trust.[6] Calnan and Stanford's work suggests that it is these experiences—rather than abstract knowledge of systems—that most closely informs subsequent overall assessments of what they term ''trust''. However, public alarm over periodic scandals and crises may be articulated as a loss of trust and lead to calls for more systems of scrutiny and control to be put in place.[7] These systems in turn may modulate the nature of subsequent care giving episodes, impacting on trust. Thus, two distinct but interacting processes may be being conflated and muddled because of the non-specific use of terms such as ''public trust''. As a result, concerns and remedies may be badly mismatched.

These papers therefore pose two very important challenges for policy makers and service managers. Firstly, they emphasise the primacy of interpersonal contacts in maintaining and moulding public perceptions. Notwithstanding the need for confidence building systems, greater attention may need to be paid to the microdynamics of the professional/user interface. Secondly, these papers highlight the potential interactions between these macro and micro issues and further suggest that such interactions may work in both directions. ''Public'' confidence building systems may hamper the development of interpersonal (that is, ''private'') trust building consultations between patients and professionals. We suggest that this is because explicit and systemic measurement of accountability can serve to lessen the value placed in the implicit and personal trust relationships (with, for example, patients, clients, relatives or even co-workers) that ultimately enable professional work.[8] At the same time, however, excellent interpersonal skills and the development of high levels of ''private trust'' may serve to shield the incompetent (Dr Shipman, of course, was very well regarded by many of his patients).

Effective and safe healthcare systems that command public respect thus need serious attention to be paid to both the macro concerns of ''public'' confidence building systems and the microdynamics of ''private'' interpersonal trust between all the individuals concerned with health delivery (patients, nurses, clinicians, managers). In both these areas there is potential for dysfunctional consequences as well as desirable outcomes. Getting the balance right will be difficult, but neither approach on its own will suffice.

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Change management

Are we suffering from change fatigue?

P Garside

Clinicians must be motivated to accept the changes necessary to achieve improvements in quality and performance

Quality improvements require change. Performance improvements require change. When a health system aspires to both over a sustained period there is a serious risk of ''change fatigue''—key players getting tired of new initiatives and the way they are implemented—invariably the key players needed to make the changes work and bring in the improvements.

The National Health Service (NHS) in England has pursued improvements in performance and quality for almost 10 years, but particularly since the Labour government came to power in 1997.[1 2] Significant extra funding has been made available by central government, and structures and systems have been established to ensure that the NHS ''modernises'' its practices. These programmes have achieved results: waiting times are down for elective procedures, access to care has improved, and more resources for staff and treatment are available to managers and clinicians. The improvements in performance have been achieved through the relentless application of targets via a managerial regime working ''top down'' in the NHS. Quality and service improvements are encouraged through a wide range of initiatives embraced principally through the Modernisation Agency, an agency of government focused on changing processes and systems to improve both quality and performance.

In this month's *QSHC* Gollop *et al*[3] address the issue of scepticism and resistance to changes in working practices. The authors rightly point out that this resistance is principally among medical staff, and that the reasons include personal reluctance to change, misunderstanding of the aims of improvement programmes, and a dislike of the methods by which the programmes have been promoted.

Managers cope with change in a different way from clinicians (accepting that many clinicians have significant managerial responsibility). It has become almost customary practice for