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# The acceptability of healthcare: from satisfaction to trust

T.A. Dyer[1], J. Owens[1] and P.G. Robinson[2]

[1]*Dental Public Health, University of Sheffield, Sheffield, UK;* [2]*Oral and Dental Sciences, University of Bristol, Bristol, UK*

***Abstract:*** The assessment of healthcare quality increasingly emphasises lay acceptability, as evidenced by the emergence of *patient satisfaction* and *patient-centred care* in the literature and in policy. In this paper we aim to provide a conceptual overview of acceptability and propose ways to enhance its assessment. Firstly, we map how acceptability's importance in quality assessments has increased and how the term acceptability has been used as synonymous with patient satisfaction, despite it being a broader concept. We then critique the concept of patient satisfaction and its measurement and challenge its use as an indicator of acceptability and quality. By drawing on our research and those of others, the second half of the paper describes how trust in clinicians and health services has emerged as a related concept, including a theoretical discussion of trust in healthcare outlining how it can be built, undermined and abused. We propose trust as an alternative indicator of acceptability in healthcare quality and review its measurement. Finally, we consider how healthcare policy may impact on trust and make recommendations for future research.

**Key words:** *healthcare, patient satisfaction, patient-centred care, acceptability, quality, policy*

## *The increasing importance of acceptability in quality assessment*

Generic definitions of quality can be divided into two groups (Albrecht, 1992; Hoyer and Hoyer, 2001). The first is when products or services meet pre-specified standards that are predominantly defined numerically and assessed objectively. The second is assessed subjectively as when users' expectations are met in terms of their experience, consumption and perceived value. Although there is no agreed definition of quality (Campbell and Tickle, 2013), success in healthcare is dependent on delivery of both aspects (Rattan, 2007).

Whilst healthcare quality frameworks contain many dimensions (Corrigan, 2001; Donabedian, 1966; 2003; Emanuel and Emanuel, 1996; Maxwell, 1984; Wilkinson, 1990; Wolff, 1994; World Health Organization, 1983), later models increasingly emphasise the importance of lay views on acceptability. The US Institute of Medicine (Corrigan, 2001) and the Agency for Healthcare Research and Quality (2008) identified patient-centredness as a key dimension and Donabedian (2003) included acceptability, legitimacy and lay perceptions of equity in assessment. More recently the Organisation for Economic Cooperation and Development (OECD) and the King's Fund identified patient-centredness, patient focus or responsiveness and patient experience as central to quality assessment (Arah *et al*., 2006; Raleigh and Foot, 2010).

UK reviews of healthcare quality have also identified acceptability and patient-centredness as increasingly important indicators (Leatherman and Sutherland, 2003; 2008). The Care Quality Commission (CQC), which is responsible for the assessment of healthcare quality in England, originally defined 16 essential standards of healthcare, the first of which was *respecting and involving people who use services* (CQC, 2010). Recently this has been simplified and asks five questions of services, two of which relate to their acceptability. Firstly, are services caring (do they involve and treat people with compassion, kindness, dignity and respect?) and secondly are they responsive? (i.e. organised to meet people's needs?) (CQC, 2015). This represents a continued shift away from quality as assessed via objective measures of activity volumes and waiting times to one that increasingly focuses on patient experience (Raleigh and Foot, 2010).

## *Defining acceptability*

Although the term acceptability is used commonly, it is rarely defined. Donabedian regarded user satisfaction with a service or programme as a valid assessment of its quality, as services should be patient-orientated, which only users can evaluate (Donabedian, 1980). Thus, satisfaction was as an outcome in its own right (Donabedian, 1988). Subsequently he broadened the notion of user satisfaction to *acceptability*, or "*conformity to the wishes, desires and expectations of patients and responsible members of their families*" (Donabedian, 2003). Penchansky and Thomas's (1981) conceptualisation of access also related acceptability to whether services met the expectations of service users.

Acceptability has since been considered more broadly to include a service's legitimacy or social acceptability. Donabedian (2003) saw legitimacy as conformity to social preferences, as expressed in ethical principles, values, rules and regulations. For Donabedian, individual and social acceptability did not always coincide because individuals and society often assess costs and effects of services differently. For example, individuals are concerned with personal costs whereas society considers broader aspects such as government programmes, taxation and insurance.

Correspondence to: Dr T.A. Dyer, Academic Unit of Dental Public Health, School of Clinical Dentistry, University of Sheffield, Claremont Crescent, Sheffield S10 2TA, UK. Email: t.dyer@sheffield.ac.uk

To consider legitimacy/social acceptability, therefore, both service users and potential service users' views should be considered.

A similar, yet discreet literature exists in the psychology of behaviour analysis, where the term *social validity* first arises (Wolf, 1978). Wolf suggested that social validity may be applied to a variety of services, including health, and assessed the construct by posing three questions: Are the programme's (service's) goals desirable and appropriate to society? Do service users and other consumers consider the treatment processes acceptable? Are service users satisfied with all the results?

Across both literatures acceptability consistently comprises two broad elements (Figure 1): 'experiential acceptability' asks whether patients' expectations were met by their experiences of care, whereas 'social acceptability' relates to a service's legitimacy comprising ethical principles, values, rules and regulations, and which may not be based on personal experience. Despite these conceptual developments, patient satisfaction measures are still used to assess acceptability in its entirety.

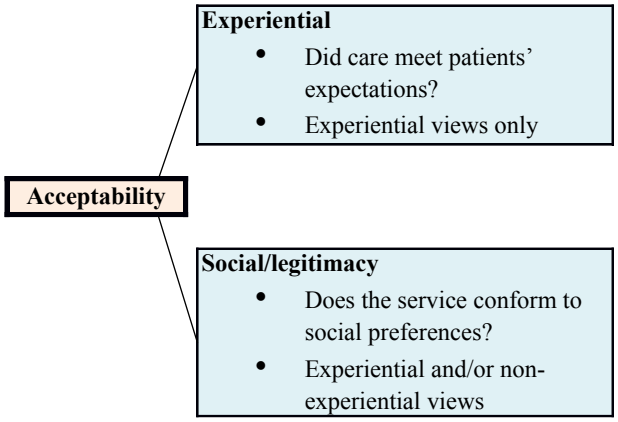


**Figure 1.** *The two aspects of lay acceptability of healthcare*

## *Problems with patient satisfaction*

Despite apparent universal interest in patient satisfaction, there has been little attention to its meaning, which has in turn undermined patient satisfaction research (Abramowitz *et al*., 1987; Calnan, 1988; Edwards and Titchen, 2003; Fitzpatrick and Hopkins, 1993; Gill and White, 2009; Hawthorne, 2006; Locker and Dunt, 1978; Newsome and Wright, 1999a; Sitzia and Wood, 1997; Turris, 2005; Williams, 1994; Williams *et al*., 1998). Conceptual clarity should precede measurement, but the opposite has been the case with patient satisfaction, with health policy rather than rational thought often driving its use.

Measures of patient satisfaction have been complicated by the concept being developed semi-independently in different disciplines including medicine, marketing, psychology, sociology and healthcare management. Consequently, 'satisfaction' is rarely defined and empirical research is often atheoretical. Most theories of patient satisfaction were published in the 1970s, 1980s and 1990s, with more recent theory being re-workings of earlier work (Aragon and Gesell, 2003; Hills and Kitchen, 2007a;b; Hudak *et al*., 2004). We will now critique patient satisfaction's theoretical and methodological difficulties.

## *Conceptual difficulties*

Theories of patient satisfaction are based, to a greater or lesser extent, on whether service users' beliefs and expectations are fulfilled (Fitzpatrick, 1984; Fox and Storms, 1981; Linder-Pelz, 1982b; Newsome and Wright, 1999a;b; Oliver and Swan, 1989; Parasuranam *et al*., 1991; Pascoe, 1983; Ware *et al*., 1983; Zeithaml and Bitner, 1996). These 'fulfilment of expectations' theories have been modified in response to new ideas and evidence that have questioned their assumptions.

Beliefs and expectations of services are not stable (Locker and Dunt, 1978), as psychosocial and other factors influence individual perceptions (Calnan, 1988; Sitzia and Wood, 1997; Williams *et al*., 1998). Therefore, expectations only predict a small proportion of variation in patient satisfaction (Linder-Pelz, 1982a). There are also logic problems with expectancy-based theories. For example, it suggests that if expectations of a service are low, then a patient would be satisfied if they are met. In fact, the opposite has been reported, where extremes of patient satisfaction and dissatisfaction occur when high or low expectations are met by services (Linder-Pelz, 1982a; Williams *et al*., 1998).

This mismatch between expectations and satisfaction led to discrepancy-based theories. Disconfirmation Theory (Oliver, 1980) from consumer and marketing research, argues that expectations vary with the perceived importance of factors being considered. Satisfaction then depends on the extent to which these 'revised' expectations are met (Newsome and Wright, 1999a; Parasuranam *et al*., 1991; Pascoe, 1983; Zeithaml and Bitner, 1996). Again, data do not fully support discrepancy-based theories. Positive and negative experiences do not always translate into positive or negative evaluations. Instead the duty and culpability of the service provider in those experiences are important (Williams *et al*., 1998). For example, a dissatisfied patient might not perceive any problems encountered to be the clinician's responsibility, particularly when interpersonal interaction has been good, and so may report being satisfied overall. Indeed, the importance of duty and culpability in patient evaluations has been confirmed in qualitative research (Dougall *et al*., 2000; Edwards *et al*., 2004; Nystrom *et al*., 2003).

Williams regarded patient satisfaction as based on three consumerist assumptions: patients have opinions; they believe their opinions to be legitimate; and they are willing to express them (Williams, 1994). However, patients and consumers differ, in that 'consumer' implies a service is paid for and that the service in question has been chosen, neither of which is always true in healthcare (Dougall *et al*., 2000; Williams, 1994). Thus, the notion of a 'healthcare consumer' may be inappropriate (Annandale, 2001; Blaxter, 1995; Scambler, 2002) and it is questionable if it is possible to measure satisfaction when some patients may not believe the legitimacy of their own opinions (Dougall *et al*., 2000; Williams, 1994).

This conceptual elusiveness of patient satisfaction has led to post-modernist theorising. In her feminist critique, Turris (2005) saw patient satisfaction as a perceptual, relativistic and dynamic concept, relating more to the process rather than the outcome of care. She concluded that its dynamic nature posed methodological difficulties.

## *Methodological difficulties*

### *Multidimensional nature*

Questionnaires often divide patient satisfaction into dimensions (Sitzia and Wood, 1997) such as clinicians' affective behaviour (communication, listening skills, care and empathy etc.), technical competence and outcomes of care. Comparisons of the relative importance of these dimensions reveal professional competence and the interpersonal relationship as the most important (Williams and Calnan, 1991b). Yet, questions on such factors are less frequently included, resulting in many measures emphasising management issues rather than patients' concerns (Calnan, 1988; Edwards *et al*., 2004; Schneider and Palmer, 2002).

An additional problem is that when asked about professional competence and technical aspects of care, patients often assume basic competence and focus on clinicians' affective behaviour instead (Ben-Sira, 1976; Chaffin *et al*., 2007; Corah *et al*., 1984; Fitzpatrick and Hopkins, 1993; Schouten *et al*., 2003; Sitzia and Wood, 1997).

### *Selection bias*

Satisfaction is usually measured at the end of treatment. Dissatisfied patients are more likely to discontinue treatment, especially if it is prolonged (Blais, 1990; Pascoe and Attkisson, 1983), and consequently satisfaction is likely to be over-estimated.

### *High undifferentiated levels of patient satisfaction*

Few patients express dissatisfaction or are critical of care in surveys (Abramowitz *et al*., 1987; Edwards *et al*., 2004; Hopton *et al*., 1993 ; Saila *et al*., 2008; Schneider and Palmer, 2002). For example, 80-90% of UK patients have been consistently satisfied with care over the past 40 years (Cartwright, 1964; Edwards *et al*., 2004; Khayat and Salter, 1994; Sitzia and Wood, 1997; Williams and Calnan, 1991b). Consequently, it is difficult to distinguish between levels of satisfaction or identify temporal changes.

Other factors may lead to bias (Dougall *et al*., 2000) including social desirability, ingratiating response (Bruster *et al*., 1994; Ley, 1972; Raphael, 1967) and self-interest biases (LeVois *et al*., 1981; Owens and Batchelor, 1996). Some patients report satisfaction, despite misgivings, due to worse healthcare experiences in the past (Meredith *et al*., 1993). Others may evaluate an experience positively to justify their choice of provider and time and effort in attending (Festinger, 1957). Finally, there may be Hawthorne effects (Landsberger, 1958) where services/clinicians under observation change their behaviour.

The tendency to agree with statements in questionnaires is another potential source of bias (Ware, 1978). Agreement with favourably and negatively worded items leads to higher and lower levels of satisfaction (Ross *et al*., 1995; Ware, 1978) and there is no accepted method of estimating this acquiescence bias.

Two further factors may influence satisfaction surveys. Gratitude is often confused with satisfaction, particularly in older populations and patients who feel problems are too large to remedy may omit to mention them (Williams *et al.*, 1998).

However, responses to questions about specific aspects of healthcare vary widely thus the problem may not be entirely methodological. For example, dissatisfaction with waiting times, communication in primary care, rigid routines in secondary care is common (Jones *et al.*, 1987; Ley, 1972; Williams and Calnan, 1991a). Consequently, dissatisfaction might be the starting point rather than satisfaction (Becker and Newsom, 2003; Goldwag *et al.*, 2002).

### *Characteristics of patient satisfaction measures*

There is marked heterogeneity in the 3,000 or so published empirical studies on patient satisfaction (Hawthorne, 2006). Many use *ad hoc,* un-validated measures which lack theoretical and conceptual underpinnings (van Campen *et al.*, 1995). Other measures of patients' experiences do not use the term 'satisfaction'. The characteristics of measures can be challenged in two themes: content and method.

### *Content*

Measures can use global and/or multidimensional items. Although easy to use, the validity, reliability and precision of global items are questionable, as the dimensions of healthcare that patients consider in their assessment are unclear (Feinstein, 1987). Global items may mask specific areas of dissatisfaction and elicit highly skewed findings (Blais, 1990; Ferris, 1992; Locker and Dunt, 1978). Multidimensional measures enquire about aspects of care assumed to be important (Ware *et al*., 1983), but may still omit those important to patients (Edwards *et al.*, 2004; Schneider and Palmer, 2002; Wensing *et al.*, 1994).

Most measures focus on satisfaction with the process of care; only 4% of studies inquire about outcomes (Hall and Dornan, 1988; Hudak and Wright, 2000). Yet many patients evaluate outcomes separately from process and place importance on both (Fitzpatrick and Hopkins, 1993; Turris, 2005). Consequently, some argue that process and outcomes should be assessed separately (Hudak and Wright, 2000). Furthermore, measures can be generic or discipline or disease-specific. Generic measures assess satisfaction in any population but may omit important factors for specific disciplines (Hudak and Wright, 2000). Although specific measures are more sensitive, their data are not comparable across conditions/disciplines.

Finally, questionnaires using direct and indirect questions can elicit varying patient satisfaction. Direct questions inquire about patients' own experiences whereas indirect ask about attitudes toward healthcare in general (Ferris, 1992). Direct questions tend to elicit higher levels of satisfaction (Hall and Dornan, 1988) and are more effective in assessing services experienced (Guyatt *et al.*, 1995; Pascoe and Attkisson, 1983), but the reasons for this remain inadequately explored.

### *Methodological factors*

Questionnaire format can influence apparent satisfaction. Most use closed questions (Hudak and Wright, 2000). Yet open questions allow participants to comment on matters omitted from the measure to elicit areas of dissatisfaction (Carr-Hill, 1992; Locker and Dunt, 1978; Turris, 2005).

In general, interviewer administered measures yield higher scores (Ferris, 1992; LeVois *et al.*, 1981). Yet interviews can identify dissatisfaction when open-ended questions are used (Hudak and Wright, 2000), befitting a qualitative method (Turris, 2005; Williams *et al.*, 1998). Questionnaires distributed by hand, rather than mailed, to participants yield higher scores and response rates. Handout surveys have more missing data, lower variation in response and fewer written comments (Gribble and Haupt, 2005).

Overall, Hawthorne (2006) concluded that none of the instruments used in healthcare was satisfactory. Consequently, it is difficult to interpret findings or compare studies.

### *Epistemological critique and recent methodological recommendations*

Typically, inquiry into patient satisfaction is designed, explicitly or implicitly, with an objectivist epistemology and uses quantitative methods. This stance assumes it is stable and easily measured (Edwards *et al.*, 2004; Edwards and Titchen, 2003; Gilbert and Veloutsou, 2006; Shneider and Palmer, 2002; Turris, 2005). However, difficulties arise from the lack of a consistent definition of 'satisfaction', its dynamic nature and because it is a social rather than a technical phenomenon. Consequently, quantitative approaches may be too rigid to identify dissatisfaction (Edwards *et al.*, 2004; Edwards and Titchen, 2003; Schneider and Palmer, 2002; Turris, 2005; Williams, 1994; Williams *et al.*, 1998). Nonetheless, positive qualitative comments correlate with quantitative ratings of satisfaction (Santuzzi *et al.*, 2009). At best, satisfaction questionnaires may provide a troubleshooting function but lack precision for detailed evaluation (Williams, 1994).

Qualitative approaches can identify dissatisfaction (Edwards *et al.*, 2004; Nystrom *et al.*, 2003; McIver and Meredith, 1998; Schneider and Palmer, 2002; Williams *et al.*, 1998) and may capture patients' experiences and perceptions of services (Dougall *et al.*, 2000; Hannemann-Weber *et al.*, 2011; McIver and Meredith, 1998; Schneider and Palmer, 2002; Turris, 2005; Williams *et al.*, 1998). However, interpretation requires caution. For example, a negative experience identified in qualitative research could be misinterpreted as a negative evaluation of a service as a whole; the patient's view of the service may be positive once duty and culpability have been considered (Williams *et al.*, 1998). Such an interpretation would be a misuse of qualitative data, which should avoid using the person as the unit of analysis. Consequently, the use of patient satisfaction data as an outcome or as an indicator of service quality has been questioned (Gill and White, 2009).

## The emergence of trust in acceptability

Our mixed-methods research into the acceptability of the use of dental therapists (Dyer and Robinson, 2008; 2009; Dyer *et al.*, 2010; 2013; 2014) acknowledged its conceptual and methodological complexity and used mixed-methods to incorporate the views of those who had and had not been treated by a therapist (Figure 1). Trust emerged as a key factor in the social and experiential acceptability of dental therapists. For those who had not experienced care, familiarity and trust in the dentist delegating care was critical, as were trust in the health service and profession to adequately train and regulate the dental team. Interestingly, those seeing the health service as based on collectivist principles tended to be more trusting than those with more consumerist perspectives.

Similarly, the acceptability of dental therapists to those who had experienced care was also dependent on trust in the therapist and the dentist overseeing care and secondly in the profession and health system to adequately train and regulate them. Trust in individual clinicians was influenced by interpersonal interaction, clinicians' affective behaviour (i.e. communication skills, caring and empathic nature), past experiences and the continuity of care.

Trust has also emerged from studies of patients' experience of care from doctors (Calnan and Rowe, 2008) and of pharmacist-led medical services where they had substituted for doctors (Gidman *et al.*, 2012). Trust may be conceptually discrete from patient satisfaction as it reflects attitudes to new or on-going relationships; conversely satisfaction is experiential and includes assessment of clinician performance (Calnan and Rowe, 2008; Thom *et al.*, 2004). This implies that a patient who trusts a clinician may not necessarily be satisfied with an episode of care, and *vice versa*. Like satisfaction, trust in clinicians may impact on the effectiveness of care (Mechanic, 1996; 1998) and may be a better indicator of quality than satisfaction (Thom *et al.*, 2004).

### *Theories of trust*

The conceptual development of trust builds on or challenges the theories of Giddens and Luhmann (Giddens 1990; 1994b; Gilson, 2003; Hardin, 1991; 2006; Luhmann, 1979; 2000; Misztal, 1996; Sztompka, 1999).

Giddens and Luhmann distinguish between trust operating at a system level (which Luhmann describes as 'institutional' and Giddens as 'faceless') from that at an interpersonal level or what Giddens describes as 'facework'. Both regard interpersonal trust as negotiated between individuals. It can be built, sustained or damaged in face-to-face encounters and is likely to increase with longer relationships. Giddens sees 'access points' to the system where facework commitments arise when the affective behaviour of the agent (e.g. dentist) influences trust in that system (health service). Both theorists see trust as necessary to overcome shortfalls in information and knowledge. Although their conceptualisations of the 'system' are similar, Luhmann incorporates social, political and judicial systems as well as healthcare.

Giddens and Luhmann differ in that the former sees the need to trust in society arising from perceived increased risk, self-reflection and willingness to challenge experts in late modernity. Trust is necessary because choices are made with partial knowledge; if there is full knowledge, there is no need to trust. The decision to trust is made after rational deliberation, but requires a leap of faith, which Giddens likens to a religious belief. Giddens' 'faceless' commitment reflects the perceived legitimacy, technical competence and ability of a system and he argues that trust in a system is sustained through 'facework' commitment, i.e. trust in clinicians is required to trust the health system as a whole (Giddens, 1990; 1994b).

Luhmann regards trust as 'glue' holding society together, reducing complexity and the need to constantly to make decisions for ourselves. He argues that as system complexity increases, systems develop to allow an increase in trust. For example, the culture and ethos of a health service can shape the clinicians that work within it (Gilson, 2003). Luhmann's theory rests on relationships, with trust acting as a medium of interaction between social systems and individuals. Trust in one system may influence other social systems and individuals. The corollary is also the case, where trust in an individual (e.g. a dentist) is contingent on trust in social systems, so Luhmann sees trust as both an outcome and response to increasing complexity in late modern society. For Luhmann, the decision to trust is based on an extrapolation of evidence from past experiences, rather than a religious belief-like leap. However, when past experiences indicate there is no risk, confidence rather than trust is held in the individual or system (Luhmann, 1979; 2000).

Like Giddens, Mistzal (1996) emphasised the importance of ontological security in an individual's ability to trust others in interpersonal interactions. She agrees that trust reduces social complexity, but also proposes that it helps social cohesion and collaboration and builds social capital. Sztompka (1999) challenges the notion of trust in abstract systems or objects, such as a health service or machinery, asserting that only people can be trusted. He accepts that it can be held with different levels and aspects of society, ranging from interpersonal trust, trust in categories of people (e.g. clinicians), trust in institutions (e.g. hospitals) and trust in the social systems as a whole (e.g. a health service). However, for him it is trust in individuals working within these different levels and aspects of society that matter.

Hardin (2006) warns against conflating trust, trusting and trustworthiness as this might over-emphasise how to trust, rather than why we trust and how to be trustworthy. His 'encapsulated interests' account of trust relates to interpersonal relationships involving a truster (e.g. a patient) and a matter at stake (Hardin, 1987; 1991). This assumes that a clinician has an interest in maintaining a relationship with a patient and has an incentive to be trustworthy. In addition, the clinician will have variable moral commitment to be trustworthy and psychological predisposition to behaviour that indicates trustworthiness. The patient, on the other hand, assumes that the clinician will take their interests into account, and their ability to trust will also depend on their psychological predisposition to do so.

Hardin differentiated between trust in individuals and systems. The encapsulated interest account is a cognitive process based on knowledge that cannot be applied to institutions (e.g. a health service), as we can never know enough about them to trust. Consequently, he sees 'trust' in institutions and systems as a different phenomenon, for which he prefers the term confidence. He also disputes Luhmann's notion that trust or confidence in one institution or system can spill over into another.

Although implied by many authors (Giddens, 1990; 1994b; Gilson, 2003; Hardin, 2006; Luhmann, 1979; 2000; Misztal, 1996), few emphasise the importance of power in trust in professional relationships or systems. Greener described three categories of trust in healthcare (Greener, 2003). *Voluntary Trust* is built over time through ongoing clinician/patient relationships and shared decision-making. *Involuntary Trust* involves power and information asymmetry, where the patient has no option but to trust. *Hegemonic Trust* requires unquestioning acceptance. These categories can apply at either clinician/patient or health system levels. The sociology of professions literature concurs that power is critical in trust in interactions, but tends to focus on the potential for the exploitation of trust as a consequence of power asymmetries (Freidson, 1988; 1994a;b). For example, as a patient is relatively powerless and vulnerable, they may mistakenly regard a clinician as trustworthy if they are ill-equipped to assess competence, whereas the clinician can deceive the patient by conveying honesty and integrity, whilst working for their own ends (Gilson, 2003; Pilgrim *et al*., 2011).

### *Developing and maintaining trust and trustworthiness*

Despite these conceptual differences, there is broad agreement on the factors involved in trust and trustworthiness. For clinicians, trustworthiness is based on perceived competence, honesty and integrity (Fugelli, 2001; Pilgrim *et al*., 2011). At an interpersonal level, the ability to assess these aspects and to trust combines a cognitive element; grounded in rational judgment and an affective element; grounded in relationships (Gilson, 2003; Hardin, 2006; Luhmann, 2000; Misztal, 1996; Sztompka, 1999). The cognitive element comprises expectations, perceived risk and past experience, whereas the affective element will include an assessment of openness, empathy and mutuality in decision-making (Pilgrim *et al.*, 2011). Given its complex multi-layered nature, trust is often linked to familiarity and perpetuation of relationships (Hardin, 2006; Pilgrim *et al.*, 2011; Sztompka, 1999) and therefore continuity of care is critical in trust. The only negative experiences reported by our participants were from practices where staff turnover was perceived to be high and communication poor (Dyer *et al.*, 2013; 2014).

Our data also revealed that the health system was widely trusted (Dyer and Robinson, 2008; Dyer *et al.*, 2013; 2014). Despite bad experiences, participants remained willing to trust dentistry as a whole, seemingly supporting Luhmann's, rather than Giddens', less linear theory. Moreover, and consistent with theory, subsequent positive experiences could alter perceptions to build interpersonal trust and in dentistry overall (Calnan and Rowe, 2008; Giddens, 1990; 1994b; Luhmann, 1979; 2000; Pilgrim *et al.*, 2011).

Interpersonal trust facilitated by good clinician-patient interactions is a key factor in the acceptability of care. Our data identified patients' perceptions of clinicians' competence, honesty and integrity as indicators of trustworthiness (Fugelli, 2001; Pilgrim *et al.*, 2011) and the judgment of whether clinicians have these qualities is largely based on their affective behaviour. Participants implied the importance of mutuality in decision-making and the dental worker's capacity for respect and empathy. Clinicians' competence was also important, alongside continuity of care. All of these factors are regarded as fundamental in building trust (Fugelli, 2001; Pilgrim *et al.*, 2011).

One way to improve affective behaviour and ultimately build trust is for clinicians to take a holistic, patient-centred approach, working toward mutual understanding and avoidance of coercion (Balint, 1957; Mishler, 1984; Scambler and Britten, 2001). These factors' importance is unsurprising given they also determine patient satisfaction in general healthcare (Sitzia and Wood, 1997), dentistry (Newsome and Wright, 1999a;b) and patients' perceptions of the ideal dentist (Lahti *et al.*, 1992; 1995; 1996) and are fundamental in shared-decision making (Elwyn *et al.*, 2012; Frosch and Kaplan, 1999; Kaplan and Frosch, 2005). Overall, our data support continued emphasis of communication skills in undergraduate and postgraduate education and the importance of a patient-centred approach in practice.

Given its salience, patients' trust in clinicians should not be underestimated or abused. As we have seen, the need to trust partially arises from information asymmetries. This has implications for ethical practice (Pilgrim *et al.*, 2011), particularly the imperative of valid (informed) consent (GDC 2005; 2008; GMC, 2006; 2008). The extent to which patients can be fully informed is questionable and so involuntary trust may always be needed, even within shared decision-making (Elwyn *et al.*, 2012). Power and information asymmetries are inevitable (Greener, 2003) and are not necessarily the cause of dissatisfaction or poor quality care (Charles *et al.*, 1999a;b). Indeed, it is argued, public perception of the legitimacy and quality of services is dependent on the existence of trust (Donabedian, 2003; Gilson, 2003).

### *Marketisation, healthcare consumerism and trust*

Recent policies establishing a healthcare market appear to have increased the number of service providers, which may undermine continuity of care, encourage industrialisation and deprofessionalisation; resulting in the weakening of trust (Calnan and Rowe, 2008; Fugelli, 2001) and the legitimacy of services (Gilson, 2003). Indeed, there is evidence that the quality of the NHS has reduced and patients' perceptions of the service have been harmed, whereas satisfaction with individual experiences of care remains high (Kings Fund, 2012). Our data suggest that the perception of the nature of dental services is important in their acceptability. Collectivist, public service views tended to be more trusting of the system to regulate and train dental team members than more consumerist perspectives consistent with a healthcare market. A similar finding was reported when pharmacists were substituted for GPs (Gidman *et al*., 2012).

The notion of the *patient consumer* has arisen where policy adopts a free market model, with patients regarded as customers. Our findings are consistent with Gidden's concept of the individual reflecting entrepreneurially for self-benefit and where the unquestioning acceptance of medicine as the sole source of expertise is challenged (Giddens, 1994a; 1999b). Ironically, this increases the need to trust if patients recognise their lack of knowledge. However, our data also identified the tension for patients who wish to exercise informed choice on the one hand, yet wish to take a more passive role as a 'receiver' of services in which they trust clinicians in the absence of full knowledge, on the other (Lupton, 1997).

### *Measurement of trust*

There have been relatively few attempts to measure trust in healthcare (Calnan and Rowe, 2004). Some researchers have tried to measure trust in clinicians (Hall, 2002; Tarrant *et al.*, 2003; Thom *et al.*, 2002; Lord *et al.*, 2012) and healthcare systems (Balkrishnan *et al.*, 2003; Egede and Ellis, 2008; Lord *et al.*, 2012). Most recently, a measure of trust in dentists has been developed (Armfield *et al.,* 2014).

The history of measuring trust in healthcare parallels that of patient satisfaction. Trust is multidimensional, with interpersonal communication, familiarity and continuity of care being important factors. Technical competence is relevant but patients feel unable to assess it directly and use clinicians' affective behaviour as a proxy (Anderson and Dedrick, 1990; Croker *et al.*, 2013; Egede and Ellis, 2008; Kao *et al.*, 1998; Krupat *et al.*, 2001; Tarrant *et al.*, 2003; 2008; Thom *et al.*, 1999). Like satisfaction, attempts to quantify trust have been questioned epistemologically and methodologically (Calnan and Rowe, 2004; Pearson and Raeke, 2000). Our data suggest that trust in clinicians is based on their perceived trustworthiness, honesty and integrity, which are in turn influenced by their affective behaviour, particularly patients' perceptions of their communication and listening skills, and their caring and empathic nature. A sense of shared-decision making was also important for some patients. Although technical competence was referred to by participants, it was of less importance and was often presumed. Consequently, positive affective behaviour appears essential for clinicians to be perceived trustworthy. Our data also confirm the importance of continuity of care in engendering trust in individuals and teams. Such factors were also pertinent in a quantitative preliminary study (Armfield *et al.*, 2014). Conversely, mistrust was related to untreated dental pain, adverse experiences, enforced change of dentists, reduced and delayed dental visiting and dental anxiety (Armfield *et al.*, 2014), although as a quantitative study, a deeper understanding of these remain unexplored.

Studies testing interventions to increase trust yield inconsistent findings perhaps due to its multidimensional nature and the heterogeneous contexts and measures used (Rolfe *et al.*, 2014). Nonetheless, our findings (Dyer and Robinson, 2008; Dyer *et al.*, 2010; 2013; 2014) and those of Armfield and co-workers (2014), emphasise positive affective behaviour in the training of dentists and dental therapists. However, this should go beyond communication skills to include the importance of empathy, honesty and integrity. These factors are strongly linked with professional duty and ethics (Zijlstra-Shaw *et al.*, 2012; 2013)

### *Concluding remarks and recommendations for research*

Our research suggests that trust in clinicians and services is likely to be a better indicator of acceptability and quality that the illusive and transitory concept of patient satisfaction. In addition, given its importance to patients and regulatory bodies, it is surprising that trust has not been emphasised more in the quality of healthcare. "Trust" is ubiquitous in standards documents published by the GDC, GMC and other regulatory bodies, and its role is a key factor in perceptions of professionalism. Perhaps the *Friends and Family Test*

(NHS England, 2015) is unwittingly assessing trust in the NHS in England. By asking patients whether they would recommend a service to others reflects a broader assessment that goes beyond mere satisfaction with a single encounter. For example, one encounter may not have met a patient's expectations, but positive experiences over a longer period of time might still make them recommend the service to others. Yet, there is little research in how to engender trust or how to be trustworthy and we are only just starting develop ways of measuring trust in dentists. More research in all of these areas is needed.

Despite extensive multidisciplinary, theoretical and conceptual debate, further work is also required to refine a model of trust in healthcare that can inform future empirical research. Without conceptual clarity, the same mistakes made with patient satisfaction will be repeated that will undermine evaluations of healthcare. With greater marketisation of dentistry and healthcare in general, including more private providers contracted to deliver services still funded through taxation, public and patient trust in such services will become increasingly important as an indicator of their acceptability and quality.

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