

## **“Trust” in Healthcare Settings**

### **Annotated Bibliography**

The following document contains a number of sources related to the measurement of “trust” in healthcare settings. Often times, faith-based organizations (FBOs) state that they are trusted health care providers, but the measurement of trust is not well quantified nor understood. This annotated bibliography serves as a compilation of studies undertaken by professionals that have attempted to measure “trust” in health contexts. Sources were located across multiple platforms, and include seminal studies in the field. The studies, therefore, range in date from the 1990s, up to and including the present (2019), most up-to-date reviews. Most of the studies test the validity of scales that measure one’s trust in a healthcare professional (physician or nurse), although some scales are more comprehensive than others. The studies were located using the key words “trust”, “healthcare settings”, “psychometric scale”, “medical setting”, and “patient trust”, among others.

To date, most of the studies of the validity of trust scales have only been tested in the United States of America (although some have been shown to be useful when adapted to different cultural contexts, such as urban Shanghai). Language is an important consideration when adapting the scales, and should be considered before any are implemented. The scales themselves contain only a few items (averaging 12 items per scale, as found in one review). This is especially useful in the FBO context, as it makes the process of assessing “trust” rather efficient. The hope in the presentation of these scales is to provide resources for FBOs to measure the patient-healthcare provider trust within their own organization. By implementing such scales, an FBO can better understand their own skills and weaknesses as an organization, as well as areas that need improvement or special attention moving forward.

### **Annotated Bibliography**

Bova, C., Fennie, K. P., Watrous, E., Dieckhaus, K., & Williams, A. B. (2006, October 1).

The health care relationship (HCR) trust scale: Development and psychometric evaluation. <https://doi.org/10.1002/nur.20158>

This study details the development of a 15-item health care relationship (HCR) trust scale among HIV-positive individuals. Informational interviews and focus groups were used to create the scale. The interviews revealed that trust in this population went beyond basic trust, and was labeled by the researchers as “collaborative trust” based on 3 factors: interpersonal connection, professional

partnering, and respectful communication. This is in contrast to some other scales, such as the Wake Forest, that are single-factor scales. Similarly to other scales, the HCR scale was only tested on a United States of America population, but there was a large representation of women and minorities in the sample. It may be useful for HIV-specific programming.

Dong, E., Liang, Y., Liu, W., Du, X., Bao, Y., Du, Z., & Ma, J. (2014). Construction and validation of a preliminary Chinese version of the Wake Forest Physician Trust Scale. *Medical Science Monitor : International Medical Journal of Experimental and Clinical Research*, 20, 1142–1150. <https://doi.org/10.12659/MSM.889992>

This study details the adaptability of the Wake Forest Physician Trust Scale to a Chinese population. Hall et. al. had previously created the 10-item scale as an improvement upon existing methods for measuring trust. The items were translated by two professional translators and distributed to patients across three hospitals in Shanghai. The researchers elected to delete one item and insert two more that are specific to the Chinese population. The adapted version of the survey was reliable and findings were consistent with that of studies of the scale in English. Discrepancies were likely attributed to the non-Western culture of the population, especially among older individuals. Moreover, the study was implemented in an urban setting, so it's acceptability in a rural environment may vary. Because of this, it is important to consider the target population when implementing a revised version of the Wake Forest Scale. However, this study remains promising in that the scale has shown to be adaptable in an international context.

Garrubba M & Yap G. 2019. Trust in Health Professionals. Centre for Clinical Effectiveness, Monash Health, Melbourne, Australia.

[https://monashhealth.org/wp-content/uploads/2019/06/TrustinHealthProfess\\_ReviewFINAL.pdf](https://monashhealth.org/wp-content/uploads/2019/06/TrustinHealthProfess_ReviewFINAL.pdf)

A 2019 review briefly summarizes information on the topic of trust in health care settings. The review includes tools to measure trust, the role of trust in the quality of healthcare, and interventions to improve trust. Some of the highlighted tools to measure trust include the Wake Forest Physician Trust Scale, Abbreviated Wake Forest Physician Trust Scale, Health Care Relationship Trust Scale, the Health Care Relationship Trust Scale Revised, and the Trust in Physician Scale. The review does not name any one of these scales as preferable, but does mention that the Trust in Physician Scale remains to be the most widely used. Little evidence currently exists to bolster that any intervention was able to improve trust, although previously identified factors such as improved communication skills and continuity of care are still considered essential in trust building. While this article is short, it gives a brief overview of the current knowledge of trust in healthcare settings, including not only scales to measure it, but also possible implications of improving trust in the healthcare relationship.

Hall, M. A., Dugan, E., Zheng, B., & Mishra, A. K. (2001). Trust in Physicians and Medical Institutions: What Is It, Can It Be Measured, and Does It Matter? *The Milbank Quarterly*, 79(4), 613–639. <https://doi.org/10.1111/1468-0009.00223>

This article from 2001 summarizes the current studies and measures of trust to date by a team of researchers involved in the creation of the Wake Forest Physician Trust Scale. The article focuses on many dimensions of trust in healthcare settings, including measures, predictors, dimensions and consequences. Hall et. al. also present the items of the Wake Forest scale in greater detail, focusing more on the explanation of the items rather than the statistical validation of the scale itself. The article serves as an in-depth justification for the creation and development of a new scale to measure patient-physician trust.

Hall, M. A., Zheng, B., Dugan, E., Camacho, F., Kidd, K. E., Mishra, A., & Balkrishnan, R. (2002). Measuring Patients' Trust in their Primary Care Providers. *Medical Care Research and Review*, 59(3), 293–318. <https://doi.org/10.1177/1077558702059003004>

This 2002 study aimed to create a scale to measure trust, building upon existing trust scales and refining them to include a more accurate conceptualization of patient-physician relationships. Hall et. al. set out to compare their scale to the existing Anderson/Dedrick, Safran, and Kao scales (all developed from 1990-1998). While the existing scales were reliable, the sample populations remained small and specialized and focused solely on the physician rather than other health care providers. The Wake Forest scale was created from a conceptual model that captures the interpersonal trust between a healthcare provider and patient. 26 items that cover the four dimensions of physician trust (fidelity, competence, confidentiality, and honesty) were then validated against a national sample. The finalized Wake Forest Trust Scale presented is 10 items,

and applies more broadly than the trust scales generated before it. It is important to note that this scale includes more global items than its predecessors, but was only tested on an American population for validation.

LoCurto, J., & Berg, G. M. (2016a). Trust in healthcare settings: Scale development, methods, and preliminary determinants. *SAGE Open Medicine*, 4.

<https://doi.org/10.1177/2050312116664224>

This systematic review served to identify the determinants of trust as cited by others in the field. 12 studies were identified that specifically focused on the development of a trust scale in these settings, as well as the determinants for trust itself. The determinants identified most frequently included honesty, confidentiality, dependability, communication, competency, fiduciary responsibility, fidelity, agency, respect, caring, privacy, and global. The review continues by summarizing the important steps needed to create a trust scale for a specific community; the steps followed by most researchers in the field require engagement in the community in the form of interviews, in order to properly identify the determinants of health that are most applicable to the culture and region. This study is useful in the sense that it outlines the most frequent themes of trust in healthcare settings, as well as emphasizes the need for members of the community to be involved in the creation of a scale that measures psychosocial variables. Although it offers no new research on the topic, the review also highlights a current gap in the literature on how to establish trust in emergency situations-- an important consideration for any organizations working in unstable areas.

Müller, E., Zill, J. M., Dirmaier, J., Härter, M., & Scholl, I. (2014). Assessment of trust in physician: a systematic review of measures. *PloS one*, 9(9), e106844.

<https://doi.org/10.1371/journal.pone.0106844>

Since there are many scales with which to measure trust, a systematic review was done to analyze and compare the quality of the existing scales. Quality was systematically determined based on the COnsensus-based Standards for the selection of health Measurement INstruments (COSMIN) checklist. 5 scales were selected for review, and most performed rather poorly in terms of cross-cultural validity. The authors stressed the need to develop scales for different populations and in different languages in order to account for this. Overall, when existing studies were evaluated for internal consistency, the Wake Forest Scale performed better than that of the Trust in Physician Scale, despite the Trust in Physician Scale being more well-studied. No scale tested well in terms of psychometric properties, signaling that the scales should be further refined and improved upon.

Ozawa, S., Paina, L., & Qiu, M. (2016). Exploring pathways for building trust in vaccination and strengthening health system resilience. *BMC Health Services Research*, 16(7),

639. <https://doi.org/10.1186/s12913-016-1867-7>

This article is of particular interest as it focuses on trust from the health systems strengthening point of view, unlike many other measures and conceptualizations of trust. The researchers utilize a literature review, model identification & iterative model development and scenario identification to develop a causal loop diagram (CLD). The CLD demonstrates the role of

trust and communication in utilization of health services and, more specifically, vaccination. Through different scenarios, trust is either lost or gained in a health system as depicted by the authors. This article is particularly useful in visualizing and exploring the multifaceted nature of trust within a larger health system. It also serves as a kind of conceptual “map” for trust in the community, and factors that can affect it.

Ozawa, S., & Sripad, P. (2013). How do you measure trust in the health system? A systematic review of the literature. *Social Science & Medicine*, 91, 10–14.

<https://doi.org/10.1016/j.socscimed.2013.05.005>

Another systematic review of current literature identified a total of 45 scales used to measure trust in the health system. The scales measured trust in a number of ways; most were patient-physician relationships, but patient relationships to nurses, health systems, insurers, and researchers were also captured. Most scales were only tested in English, and in the USA. The measures generally tried to capture 5-6 content areas, and contained an average of 12 items. The report emphasizes areas where current measures of trust are excelling (such as scales developed with the use of qualitative data) and areas where they fall short (such as lack of multilingual scales). This review serves as a guide to current tools used to measure trust, as well as a recommendation for ways in which to improve them.

Smith, J. W., Leahy, J. E., Anderson, D. H., & Davenport, M. A. (2013). Community/Agency Trust: A Measurement Instrument. *Society & Natural Resources*, 26(4), 472–477.

<https://doi.org/10.1080/08941920.2012.742606>

Although this scale does not focus specifically on the role of trust in the health field, it does have an emphasis on understanding the role of trust in a community in which an agency is operating. This scale was developed from interviews with community members living near a managed resource area in order to measure the trust of the community in the agency. The test was proven both reliable and valid. It is a multifactorial scale with a total of 22 items in 5 domains; Dispositional Trust, Trust in Federal Government, Shared Values, Moral Competency, Technical Competency. This scale may not be specific to the healthcare setting, but it demonstrates a method with which to determine the level to which a community trusts an agency in a more value-based sense than other scales might. Since several of the domain questions include a focus on morals and values, as well as utilize the input provided by community members themselves, the scale has the potential to be adapted to the FBO setting.

Thom, D. H., Ribisl, K. M., Stewart, A. L., Luke, D. A., & Physicians, T. S. T. S. (1999).

Further Validation and Reliability Testing of the Trust in Physician Scale. *Medical Care*, 37(5), 510–517. <http://www.jstor.org/stable/3767237?origin=JSTOR-pdf>

The Trust in Physician Scale is an 11-item method used to measure patient-physician trust and developed in 1990. This study focuses on further validating the scale in private practices, and is one of the few to do so by



quantitative measures over the span of a 6 month period. Some of the main revisions of the scale include changing wording from “strongly (dis)agree” to “totally (dis)agree” to prevent skew in the positive direction. The study also highlighted that trust, as measured by this scale, was a predictor of patient satisfaction, self-reported adherence, and continuity of care. This scale is limited by its age and the fact that it is used primarily in Western settings, but demonstrates the scale’s ability to predict the adherence and satisfaction of patients.

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