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# How Doctor-Patient Mutual Trust Is Built in the Context of Irritable Bowel Syndrome: A Qualitative Study

Tudor-Stefan ROTARU<sup>1</sup>, Vasile DRUG<sup>2</sup>, Liviu OPREA<sup>3</sup>

## Abstract

Trust in the doctor-patient relationship is crucial for patients' adherence to doctors' recommendations. Despite its importance, there is little knowledge with respect to how trust builds up and is maintained in this relationship. Current literature presents disparate features of trust, not considering the dynamics of interaction and the mutual aspect of doctor-patient relationship. We carried out a qualitative study using 15 interviews of irritable bowel patients from Iasi County, Romania, focused on their trust-related experiences. The sample was recruited for maximum variation. The irritable bowel patients were considered a relevant target group for how mutual trust builds up in the context of chronic diseases because of the uncertainty perceived by these patients with respect to their medical condition. The interviews were analyzed by using the constant comparative method assisted by QSR Nvivo software. Our data analysis identified several pathways embedded in the communication process that instilled trust or distrust: medical outcomes, patient-centered communication, doctor leading patient to insight, reassurance, witnessing procedures, carelessness, and labeling patient as panicky. The novelty of this study's approach resides on reconsidering trust-related themes from an interactional and mutual point of view, as well as identifying new themes, not previously approached. Our study completes the understanding of how trust is built in doctor-patient interaction, by describing and discussing specific patterns of perception, thought and behavior.

*Keywords:* doctor-patient relationship, trust, chronic diseases, responsibility, qualitative research.

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## Introduction

Chronic diseases are pervasive globally and their prevalence is increasing worldwide (World Health Organization, 2002). Chronic diseases now represent a major health and economic burden in most societies, at an estimated 46% of global burden of disease and 59% of mortality (World Health Organization, 2002). Heart disease, stroke, diabetes, depression and cancer are the major contributors. However, Irritable Bowel Syndrome (IBS) is also a common chronic condition with a pooled prevalence of 11.2% (Lovell & Ford, 2012). Individuals with chronic diseases have a poorer quality of life and decreased life expectancy (World Health Organization, 2002). Societies are also affected directly through increasing health care costs and indirectly through a negative impact on economic development due to decreased productivity (Bao, *et al.*, 2007).

Significant scientific advances regarding the prevention, diagnosis, monitoring and treatment of chronic disease have been made (Institute of Medicine (US) Committee on Quality of Health Care in America, 2001; Schoen, *et al.*, 2006). Although these scientific advances have proven effective to improve the health outcomes of chronically-ill patients, the quality of health care still lags behind these achievements (Coleman, *et al.*, 2009). Multiple studies have shown that evidence-based health care for chronic conditions is not the norm in most health care systems and, frequently, patients do not get the care they want or need (Institute of Medicine (US) Committee on Quality of Health Care in America, 2001; Schoen, *et al.*, 2006).

This evidence-practice gap has been attributed to broad socio-economic factors as well as to individual doctor and patient factors (Fiscella, *et al.*, 2000; Fiscella & Shin, 2005). Amongst various factors that are responsible for this gap mutual trust in doctor-patient relationship plays an important role (Jin, *et al.*, 2008; Abel & Efid, 2013; Nguyen, *et al.*, 2009). This is so, because mutual trust is at the core of doctor-patient relationship, which in turn, is the vehicle, through which evidence-based recommendation are implemented. The significance of patients' trust in their doctors is well recognized and it is associated with patients' willingness to seek care, to disclose symptoms and to be compliant with therapeutic recommendations (Holman & Lorig, 2004; Oprea, *et al.*, 2010; Rogers & Braunack-Mayer, 2008). Although doctors' trust in their patients is less discussed and studied in the literature (Rogers & Braunack-Mayer, 2008; Rogers, 2002) it plays a significant role in chronic care, because in chronic care doctors must transfer significant responsibilities associated with self-care. This is so, because patients are under medical observation only once in several months and, they have to be engaged in self-care for most of the time by making health care decisions according to the changing conditions of their illnesses and their lives (Bodenheimer, *et al.*, 2002a; Bodenheimer, *et al.*, 2002b; Cojocaru, Cace, & Gavrilovici, 2013). In addition, a willingness to trust patients is a significant ethical step in recognizing the patient

as a person with control rather than merely a passive recipient of care (Rogers & Braunack-Mayer, 2008). This recognition of patients' control is part of respect for patient autonomy as well as for patients' capacity to assume responsibility for their health.

The current literature has little information with respect to how mutual trust is built and maintained. Some qualitative studies point out the importance of medical outcomes in the maintenance of trust in doctor-patient relationship. For instance, perception of good level of competence meant fulfillment of the treatment expectations that the patients had. This seemed to instill trust in the doctor and the facility and to maintain it (Gopichandran & Chetlapalli, 2013). Other qualitative studies targeting trust in primary care show that patients consider trust as maintained and reinforced if they perceived that the care they received was effective (Tarrant, *et al.*, 2010). Current literature mentions a well-built, longer form of trust, constructed during a longer relationship. These notions of long-term trust (Hillen, *et al.*, 2012) or secure trust (Tarrant, *et al.*, 2010) are found out to be in connection to medical outcomes and the length of the relationship. At least in the case of cancer patients, there seems to be a slower process which builds a deeper, trusting, relationship with the doctor that takes time and repeated interaction. Factors important to long-term trust and mentioned by patients in such studies seem to connect more to the interpersonal skills of the doctor. Caring behaviors and showing interest in the patient are considered most important for building trust (Hillen, *et al.*, 2012).

The current literature also mentions loyalty. In some qualitative studies, when patients spoke about some of the doctors that they trusted the most, they mentioned that whatever the illness may be, they would come to the doctor, leading to longer relationships (Gopichandran & Chetlapalli, 2013). There are similar findings concerning loyalty with respect to oncological patients. The patients' narratives showed that, once trust built, it prevented patients from requesting a second opinion. Almost all patients in this study believed that, in the absence of trust, they would find a second opinion or another treating oncologist (Hillen, *et al.*, 2012).

Current literature also mentions patient honesty and patients' belief they are taken seriously. One of the mechanisms is mentioned in research about primary care relationships. In such studies, both patients' and providers' narratives showed that providers wanted to trust that their patients were disclosing information important for managing their health, like non-adherence to treatment, alcohol or prescription drugs problems. Patients hoped providers would believe what they said about their health and concerns (Ratanawongsa, *et al.*, 2011).

Patient-centered communication is another distinct feature of the current literature. Listening to the patient, and addressing all doubts and questions have been identified as two determinants of trust in health care providers (Gopichandran &

Chetlapalli, 2013). The devotion of time and individual attention to patients was a specific theme of the "caring" component identified as important to building trust (Hillen, *et al.*, 2012). At the opposite, the theme of providers not taking the necessary time to explain diagnoses or answer questions is presented as illustrating lack of patient-centered communication, a distinct feature of distrust in the healthcare provider (McAlearney, *et al.*, 2012). This lack has the effect of causing resentment between patient and the healthcare team (Farahani, *et al.*, 2011). Patient-centered communication seems one of the best represented themes in studies dealing with cancer as well. A perceived relationship-building effort was illustrated by physician being attentive, taking time with the patient, and focusing on the patient (McAlearney, *et al.*, 2012). However, not providing an explanation to the patient is an important theme of distrust. These patients feel doctors are thinking only about themselves when providing scarce information about disease and treatment. In what direct reassurance is concerned, as a pathway of instilling trust, a study with respect to breast cancer patient. In it, one way in which the doctor could communicate expertise and, consequently, instill trust, is explaining ways in which patient's disease is not as bad as it might have been (Wright, *et al.*, 2004).

Another feature connected with trust in the literature, deals with laboratory tests. For doctors to make the correct diagnosis, laboratory tests are perceived by patients as a competent medical maneuver. In such studies, patients perceived doing tests as a mark of competence, which, in turn, instilled trust. In the interviews patients did not particularly know why the tests were being performed. The acts of being subject to some tests made them trust the physician and the health facility (Gopichandran & Chetlapalli, 2013). This trust-related theme was also present in studies dealing with asylum seekers' trust in general practice. Some responders found it difficult that one couldn't ask the GP for tests or procedures like they were used in their home country (O'Donnell, *et al.*, 2008). Such findings are of particular interest in the context of irritable bowel syndrome, where colonoscopy can be witnessed by patient, either live, either under sedation (Tetzlaff, 2016).

Current literature also provides apparently contradictory results concerning carelessness and perceived mistakes. Patients' narratives show that, when a trusting doctor-patient relationship has already been established, the patients are willing to overlook the pitfalls in the relationship. The relationship between pitfalls and trust seems to go in both directions: though the willingness to tolerate mistakes may be understood as a consequence of trust, it is also an indicator of the level of trust. As the willingness to accept shortcomings changes, trust can be perceived to change also (Gopichandran & Chetlapalli, 2013). Research dealing with cancer patients, mentions admitting one's mistakes as a key feature. If the doctor has misjudged a situation, and later came back to it, this also instilled trust for patients. Unexpectedly, trust does not appear easily affected by doctor's

medical mistakes like overlooking symptoms or unsatisfactory surgery results. In such studies, some patients even defended their doctor's to trust was a central theme of patient's way of building trust (Hillen, *et al.*, 2012). This is inconsistent with other results, showing that inappropriate or missed diagnoses are mentioned as a distinct theme of distrust (McAlearney, *et al.*, 2012).

Finally, literature is not clear in its conclusions on confidentiality-trust relationship. In some studies patients judged confidentiality as an unimportant consideration or determinant of trust (Hillen, *et al.*, 2012). In other studies, lack of respect for patient privacy and confidentiality is mentioned as a problematic area of patient health-care provider communication expressed by patients (Farahani, *et al.*, 2011).

As we have shown above, there is a clear research gap with respect to specific patterns of interaction between doctors and patient. Current literature analyses trust by considering disparate features like: medical outcomes, loyalty, and patient honesty, patient-centered communication, valuing laboratory tests, carelessness and perceived mistakes. However, few of these elements specifically address the mechanism of interaction between doctor and patient that participates in the build-up and maintenance of mutual trust containing these features. Virtually none of them can show how doctor's trust in the patient and patient's trust in the doctor depend on each other or influence each other. Few attempts describe how this interaction might occur in studies trying to analyze simultaneously both sides of the doctor-patient interaction (Ratanawongsa, *et al.*, 2011). Identifying specific patterns of interaction makes one able to understand how the process of building trust can be influenced in various stages of its construction. It can also help doctors and public health specialists understand and intervene in various stages where trust is strengthened, weakened, maintained or lost. This approach switches the narrower view of trust as a sum of key disparate elements into a view that conceptualizes trust as a process unfolding on several pathways simultaneously. Another advantage of filling the aforementioned gap deals with the opening of other, more dynamic methods of quantitative measurements, where such pathways can be transformed in bits of experiences where responders can identify themselves. Finally, this dynamic approach is meant to catch the cultural particularities of mutual trust between the doctor and the patient, while analyzing behavioral and attitudinal scripts that are unidentifiable in classical psychometric approaches.

In this paper, we focus on identifying the pathways through which mutual trust in doctor-patient relationship in the context of irritable bowel syndrome is built. Our research question is: *Which are the pathways through which mutual trust between the doctor and the IBS patient is built and maintained?* We choose to carry out a qualitative study because explaining pathways and generating theory is a particular strength of qualitative research (Denzin & Lincoln, 1998; Given & Gale, 2008). Irritable bowel syndrome (IBS) has been used as a case example for mutual trust in the context of chronic diseases. It is a digestive functional disease

characterized by abdominal pain or discomfort associated with changes in bowel habits (Longstreth, *et al.*, 2006). Several etiologic pathways have been incriminated during the years for the occurrence of IBS. If alteration in the gastrointestinal motility, intestinal perception and gut-brain axis disturbances were already recognized, recently, abnormal intestinal microbiota, and the importance of genetic factors was also revealed. In addition, psychological co-morbidities are common in IBS patients (Whitehead, *et al.*, 2002). Due to a lack of an objective biological marker, the diagnosis of IBS is based on symptoms, as defined currently by the Rome III criteria (Longstreth, *et al.*, 2006).

Irritable bowel patients are often confronted with anxieties about possible diagnosis. For instance, most of irritable bowel patients have a sudden relief feeling when cancer diagnosis is excluded through colonoscopy (Jilcott Pitts, *et al.*, 2013). However, some uncertainties may persist in the presence of a functional or unclear diagnosis (Mikocka-Walus, *et al.*, 2012). On the other hand, there are indications that anxiety distorts the reception of information the patient needs before colonoscopy (Rollbusch, *et al.*, 2014).

## Method

### *Sampling and recruitment*

Fifteen irritable-bowel patients have been recruited through recommendation from hospital-based gastroenterology practices as well as general practitioners' offices from Iasi County, Romania. Irritable bowel syndrome has been used as a case example for mutual trust in the context of chronic diseases thanks to the particulars of uncertainty and anxiety feelings these patients have. All patients met the Roma III criteria for IBS (Longstreth, *et al.*, 2006). Maximum variability of the sample has been targeted. The average age was 50 years and 6 months. The youngest participant was 21 and the oldest participant was 74 years old. Six of the participants were males and nine were females. Six participants had graduate studies, one had postgraduate studies and eight had undergraduate studies. We have stopped the recruitment process when the saturation has been reached.

### *Data collection*

Data were collected between 22<sup>nd</sup> of January 2015 and 5<sup>th</sup> of August 2015 via semi-structured interviews, which were audio-recorded and transcribed verbatim. An interview guide developed by the research team was used and gradually adjusted to maintain a degree of consistency between interviews but also help reaching the saturation point. Interviews were conducted face-to-face, after informed consent explained and signed.

## **Data analysis**

Data analysis began following the first three interviews. Constant comparative method has been used, in order to find out repetitive patterns (Glaser, 1965). These patterns attempted conceptual comparisons while at least one feature was constant (e.g. same patient in interaction with different doctors, same specialty approached by different patient with irritable bowel, different patient with same type of long-lasting relationship with their GP etc.). Written versions were imported in QSR NVIVO 9. After an initial analysis that considered smaller units, a code structure was created. It contained nodes grouped to discover patterns of how mutual trust is built and maintained. One of these three larger nodes was context which has been considered either temporally (e.g. long-lasting relationship with the doctor), emotionally (e.g. fearful uncertainty about a potential disease), informationally (e.g. well-informed patient).

## **Results**

In this qualitative study we tried to identify the pathways through which mutual trust in doctor-patient relationship in the context of irritable bowel syndrome is built and maintained. Several themes emerged from our analysis, which dealt with interactions leading to one-side or mutual trust.

### ***Outcomes: the continuous success in the context of a longer relationship makes both patient and doctors trust each other***

One of the most frequent patterns we have identified emphasized the importance of results in the medical care, for both patient and doctor. Results meant for patient the proof of the medical care being effective and doctor being competent. On the other hand, for the doctor, good results in medical care meant a patient who complied with recommendations and followed treatments. It also dealt with patient's honesty as a component of doctor-patient relationship: patients did tell the truth about how they complied with their own treatment. These contexts also lead to loyalty, to getting back to the same doctor for different health problems.

*Investigator: Something else? What is important for the patient to trust his doctor?*

*Patient: To look for results... If one had good results with one doctor, you keep going to the same one. One doesn't go to see someone else because one has heard that the other doctor might be better than the current one [...] when you had results, it's good to keep seeing the same doctor. [...] the doctor sees if you follow your treatment, if you come when called [...]. I mean, patient's behavior makes the doctor trust him/her. I mean, if the doctor sees that there is no feedback from the patient, what can he do? She has her hands tied. And then, it's logic she won't trust the patient. (male, 48 years old, graduate studies)*



*Investigator: How did you realize Miss X is competent... that she knows what she is doing?*

*Patient: I was well after the treatment she gave me. (male, 72 years old, undergraduate studies)*

Patient-centered communication: both doctor and patient ask pertinent questions, which, in turn, are interpreted as competence from both sides, instilling trust. Another pattern of building mutual trust is by exchanging questions and answers from either doctor or patient. In patients' narratives, doctors' attitude seems relevant for trust. Patient interpreted the quantity of questions the doctors asked as a sign the doctor cares and is really interested to find the correct diagnosis and treatment. The doctor seems to interpret the questions asked by the patient and his answers as a constructive involvement in the therapeutic process and a competence to supply valid information:

*Investigator: [...] how did trust appear, in your case with this doctor?*

*Patient: I would say during the consultation [...] the fact that she asked me many questions... (27, female, graduate studies)*

*Patient: There is a certain aura of a person whom you trust. She was smiling, calm, and immediately asked me: what happened? Please, tell me! She waited; she was patient and asked me, indeed, a lot of questions. She put no diagnosis before asking me a lot of questions.*

*Investigator: What does it mean she asks you a lot of questions?*

*Patient: It means she is interested and what she will make a precise diagnosis. It won't be something general or vague. (24, female, graduate studies)*

### ***Insight: patient gets an understanding about his/her anxieties which, in turn, instills trust***

Another pattern of communication we identified among the patients we interviewed is related to anxiety and overreacting with respect to medical check-ups. Patient is worried about possible unidentified diagnosis or courses of treatment. The doctor supports the patient, by showing him/her that the reactions might be over exaggerated. Subsequently, patient becomes aware of his/her psychological processes, and this, in turn, makes him/her trust doctor even more. This happens especially in the context of a long-lasting relationship.

*Patient: She knows how to temperate me, if you want to see yet another doctor she says: "Let's see, let's think about it a bit more..." [...]*

*Patient: ... I kept doing investigations with many doctors. But my GP told me, in the end: "Mrs. X, let's stop. You went to see enough doctors, and I am sticking with my initial opinion that it's about anxiety. It leads you to an end which is not necessarily beneficial to you: to keep asking for opinions and it's not the case. These are useless*

*expenses and efforts. Let's stop a little and see..." She probably realized the state I was in, and this was normal. (57, female, graduate studies)*

*Investigator: How was it in your case?*

*Patient: When going to my GP.... If you go to her too often, she says: "stay calm, don't approach the problem like that, and be a little more relaxed or..."*

*Investigator: Does this happen with your doctor?*

*Patient: Yes, yes, yes...*

*Investigator: And what effect does this have on trust? Does it make you gain more trust when you realize it?*

*Patient: Yes, exactly. (39, female, undergraduate studies)*

### ***Reassurance: Anxieties are soothed once investigations are carried out and reasons for fear are excluded***

Another pattern of interaction we identified, deals with how uncertainty and anxiety is soothed once investigations are carried out and reasons for fears are excluded. In the context of uncertainty about health problems, patient is worried he/she might have something worse. The investigations have the power to exclude a possible bad diagnosis (like cancer). Therefore, patient becomes suddenly soothed and reinforced in his/her feeling of trust towards the doctor.

*Patient: I'm the type of person that doesn't connect much with doctors. But afterwards, when something happens that might get out of control [...] and I feel it's something that might be serious....*

*Investigator: What?*

*Patient: Incurable diseases, especially. I am honestly thinking about cancer. This could hit me unexpectedly [...].*

*Patient: It meant he somehow gained my trust [...]. It appeared like a serious investigation... They did, how do they call that? ...an echography. [...] Following the echography, he said there is nothing to be seen, and I should just need to run some blood tests to confirm everything is OK. (41, male, postgraduate studies)*

### ***Witnessing: patient gets to be a witness to the imaging diagnosis procedure and this instills trust, despite lack of medical information***

A way of building trust that we could identify from what our patients told us came from the fact that they could be a witness of the colonoscopy. This soothed their anxieties, on one hand, but also instilled trust through "seeing with my own eyes" idea. Apparently, for some patients, it was important that they had this visual" proof" of the exclusion of a worse possible diagnosis.

*Investigator : What made you consider her nice ?*

*Patient : The way she talked... I mean... she spoke to me nicely, consulted me, seated me nicely in there... «Look for yourself on the monitor »*

*Investigator: And what did this mean to you? ...the fact that she said: «Look for yourself on the monitor » [...] What did you think about it?*

*Patient: Well, a satisfaction because... Anyway... I had no idea if there was something wrong but... I could see the interior of the big bowel, how they call it... (62, male, undergraduate studies)*

*Patient: [...] I think I lean towards colonoscopy. Because without something concrete... without me seeing if there is something or not*

*Investigator: I see. Some people told me about colonoscopy, and about the fact that the doctor allowed them to see for themselves on the monitor. [...] What did it mean to you, the fact that you could look on the monitor?*

*Patient: It gave me more trust. (21, female, undergraduate student)*

***Carelessness: A patient with uncertainties and anxieties about his/her condition notices mistakes the doctor makes due to lack of attention; this, in turn, makes the patient question if the doctor can be relied upon***

Another pathway that leads to distrust is to be found in the case of patients who notice what they perceive to be attention-related mistakes in the doctor-patient interactions. These can include transcription mistakes, errors in prescribing or differences between what they know from other sources and what is presented to them by the doctor. An already anxious patient becomes more uncertain about the disease and the course of treatment by noticing the aforementioned mistakes. This, in turn, makes the patient question if the doctor can be relied upon.

*Patient: I am embarrassed to tell you but it's one thing on my results sheet and some other he writes in the discharge sheet [...] I think he doesn't pay attention. He's very busy and pays no attention.*

*Investigator: This is what make you lose trust? The fact that it's one thing written in the bloodwork and another on your discharge sheet?*

*Patient: Yes (64, female, undergraduate studies)*

***Panic label: a scared patient is perceived and verbally labeled by the doctor as panicky; consequently, patient starts doubting that the doctor really takes him/her seriously.***

A very illustrative example of interaction that builds distrust is the doctor-patient communication sequence dealing with labels like *scared* or *panicky*. This pattern is different from the one dealing with simple patient reassurance. It's an example of interaction where patients feel the "panicky" label as stigma. After

this label is applied by the doctor, the patient starts questioning if he/she is taken seriously and loses trust. It makes patient doubt that the doctor will do all the things necessary to arrive at a correct diagnosis. It is an interaction where both actors seem to lose trust simultaneously.

*Investigator: What did you think about when you were consulted?*

*Patient: I thought I might have appendicitis [...]*

*Investigator: And what did he say when you said it might be appendicitis?*

*Patient: He asked me if I was a panicky nature... And yes, I am panicky. I am very scared of appendicitis, since childhood when a schoolmate of mine had peritonitis. And it was tougher to solve out. And since then, I have this constant fear... what if I will have one, what then?*

*Investigator: I know I am being very detailed, but what did you think when he asked you: « Are you a panicky nature? ».*

*Patient: That he would easily exclude the appendicitis diagnosis.*

*Investigator: And what would this mean?*

*Patient: This would mean I can come worse off if and when I would get to surgery.*

*Investigator: And what about the trust in him, or how you perceived the relationship with his competency?*

*Patient: I had less trust*

*[...]*

*Investigator: Did the first doctor trust you?*

*Patient: No, I don't think so.*

*Investigator: How did you come to this conclusion?*

*Patient: After I told him I was panicky... I guess I felt he didn't treat me with the same attention as other doctors did. (27, female, university studies)*

In this qualitative study we tried to identify the pathways through which mutual trust in doctor-patient relationship in the context of irritable bowel syndrome is built and maintained. Several themes, related to the specific interactions between doctor and patient emerged. One of these themes deals with outcomes, the continuous success in the context of a longer relationship that makes both patient and doctors trust each other. Another theme deals with patient-centered communication, specifically when both doctor and patient ask pertinent questions, which, in turn, are interpreted as competence and honesty from both sides, instilling trust. A third particular theme is insight when patient gets an understanding about his/her anxieties which, in turn, instills trust in the doctor that occasioned the insight. Reassurance is another theme that emerged, with respect to anxieties that are soothed once investigations are carried out and reasons for fear are excluded. Witnessing the diagnosis investigations is another theme. Apparently, if patient gets to be a witness to the imaging diagnosis procedure, this instills trust, despite lack of medical information. With respect to pathways dealing with distrust, patients spoke of carelessness. The script they describe deals with a patient with uncertainties and anxieties that notices mistakes the doctor makes due to lack of attention; this, in turn, makes the patient question if the doctor can be relied upon.

Finally, another theme is the panic label. Patients told about when a scared patient is perceived and verbally labeled by the doctor as panicky, this, consequently, makes patient doubting that the doctor really takes him/her seriously. In the discussion section, we compare our findings with several disparate features identified in the literature.

## Discussion

In this qualitative study we focused on identifying the pathways through which trust in doctor-patient relationship in the context of irritable bowel syndrome is built. We identified several themes which bear resemblance to themes taken out from narratives in other studies dealing with trust. Therefore, we are going to present similarities and differences between our findings and the current literature on the subject.

### *Outcomes in doctor-patient relationship*

One of the themes we identified relates to the importance of results in the medical care, for both patient and doctor. We illustrated that, for some of our patients, results meant for patient the proof of being worthy of trust. Patients' perception of good level of competence meant fulfillment of the treatment expectations that the patients had. This seemed to instill trust in the doctor and the facility and also to maintain it, as shown by previous studies (Gopichandran & Chetlapalli, 2013). Equally, we understood the theme we identified as an interaction in which the successive positive results in the context of a longer relationship made both patient and doctors trust each other and maintain the trust-based relationship. This result bears some resemblance to what is mentioned in the current literature concerning loyalty with respect to returning to the same doctor, whatever the illness (Gopichandran & Chetlapalli, 2013) or asking for the second opinion (Hillen, *et al.*, 2012).

We identified a theme concerning the results in the context of a longer relationship. This theme has similarities and differences with what is mentioned in literature long-term trust (Hillen, *et al.*, 2012) or secure trust (Tarrant, *et al.*, 2010). Our finding is similar with previous conclusions that trust is maintained if patients perceive that the care they received has been effective (Tarrant, *et al.*, 2010). With respect with dissimilarities with these previous studies, it's worth mentioning what some of them deal with cancer patients. In them, caring behaviors and showing interest in the patient are considered most important for building trust, not the theme of repeated positive treatment results that we extracted from our data. Cancer patients also build trust due to perceived threat of cancer, which is different from that IBS patients experience (Hillen, *et al.*, 2012).

Our findings bear also resemblance to the mechanism previously identified with respect to patient honesty and being believed by the doctor. In previous studies, providers want to trust that their patients are disclosing information important for managing their health. On the other hand, patients hope providers will believe what they say about their health and concerns (Ratanawongsa, *et al.*, 2011). In short, our findings seem to confirm the idea that both honesty and competence are key features that contribute to the maintenance of trust in long-term relationships.

### ***Patient-centered communication***

In our interviews, we identified a pathway of trust building by the rich exchange of questions and answers from either doctor or patient. This pathway deals with an interaction between the two parties. It was made apparent that patients interpret the quantity of questions the doctor asks as a sign the doctor is really interested to find the correct diagnosis and treatment. The caring attitude the doctor has, together with the perceived competence in information gathering, seemed crucial in patients' narratives of trust. On the other hand, the doctor seems to understand the questions asked by the patient and his answers as a constructive involvement in the therapeutic process and a competence to supply valid information. Patient's competence is relevant for doctor's trust in them. Elements of this interaction are apparent in previous research, although they are not presented together, as an interaction per se, but separately. Some studies indeed mentioned listening to the patient, and addressing all questions as determinants of trust in health care providers (Gopichandran & Chetlapalli, 2013). Our results are also similar to what has been found in research regarding cervical cancer screening with, patient-centered communication as one of the best represented themes. The physician being attentive, taking time with the patient, and focusing on the patient was perceived as important (McAlearney, *et al.*, 2012) while not taking the necessary time to explain answer questions is presented as illustrating lack of patient-centered communication (McAlearney, *et al.*, 2012).

Previous literature showed that not providing an explanation to the patient was an important theme of distrust (Hillen, *et al.*, 2012). This can be somehow connected to our results, although the quality and quantity of questions asked by both doctors and patients is a different theme than the repeated question-asking and being answered. Our study puts an emphasis on interaction as a key finding in understanding the pathway through which trust is built and maintained.

### ***Witnessing diagnostic procedure***

In our study, we found a theme related to witnessing the diagnosis procedure. Apparently, this soothed patient's anxieties, on one hand, but also instilled trust through "seeing with one's own eyes" certitude. Even if it doesn't superpose completely, the theme we found might be similar to how patients valued laboratory tests as a competent medical maneuver despite not knowing particularly what tests are performed (Gopichandran & Chetlapalli, 2013; O'Donnell, *et al.*, 2008). Our findings also showed that even if patients didn't have medical knowledge to interpret the colonoscopy, witnessing the procedure instilled trust. Apparently, it's possible that both pathways are true: on one hand, colonoscopy is regarded as a competent diagnosis maneuver. On the other hand, patient gets to see by himself/herself that there is nothing dangerous inside his/her body. This result is interesting in the context of actual trends concerning sedation use in colonoscopy (Tetzlaff, 2016). Even though witnessing the procedure itself might soon be considered unfeasible, presenting the recorded procedure to the patient might prove important with respect to the preservation of the trust-related benefit.

### ***Reassurance as reinforcement***

One theme that emerged in our study is how uncertainty and anxiety is soothed once investigations are carried out and reasons for fears are excluded. In the context of uncertainty about health problems, patient is worried about receiving bad news. The investigations have the power to exclude a possible bad diagnosis or prognosis. Therefore, patient becomes suddenly soothed and reinforced in his/her feeling of trust towards the doctor. Our finding is somehow connected with other ways of reassuring the patient. By explaining ways in which patient's disease is not as bad as it might have been, patients gets reassured and a feeling of trust (Wright, *et al.*, 2004).

### ***Carelessness***

Concerning distrust, the narratives of our patients mentioned carelessness as a pathway of building distrust in the relationship. In our study, this theme is illustrated by a patient with uncertainties and anxieties about her condition who notices minor and attention-related mistakes the doctor makes. This fact casts doubt if the doctor can be relied upon. This can complete the apparently contradictory findings of previous studies about trust in health care where patients are found, on one hand, as willing to overlook the pitfalls in a well-established relationship. The willingness to tolerate mistakes may be understood as a consequence of trust; it is also an indicator of the level of trust (Gopichandran & Chetlapalli, 2013). On the other hand, previous studies showed that inappropriate or missed diagnoses are a distinct theme of distrust (McAlearney, *et al.*, 2012). There is a big resemblance

between the theme of perceived mistakes we identified in our study, and what patients understood as mistakes in the aforementioned research, even if the stake is different in the case of IBS and in the case of cancer. As a corollary, in our own study, doctor's unrecognized mistake is understood by the patient in the context of a relationship which is not, yet, built on trust. Therefore, the pitfall participates in the building of distrust towards the doctor.

### ***The panic label***

In our study we showed examples where the “panicky” or “scared” label is applied by the doctor. The patient starts questioning if he/she is taken seriously and loses trust. It makes patient doubt that the doctor will do all the things necessary to arrive at a correct diagnosis. We found no examples in literature dealing with this specific interaction. However, studies showed that missed diagnoses are mentioned as a distinct theme of distrust, and this illustrates the direction. The theme of doctors not taking the time to explain or answer questions is presented as a distinct feature of distrust in the healthcare provider (McAlearney, *et al.*, 2012). This might come in contrast with how patients seem to perceive medical thorough investigations: doing laboratory tests to make the correct diagnosis is perceived as a competent medical maneuver (Gopichandran & Chetlapalli, 2013).

### ***Insight***

An original finding of our study deals with another pattern of communication we identified among the patients we interviewed. This script of doctor-patient interaction is related to anxiety and overreacting with respect to medical check-ups. In this scenario, the patient is worried about possible unidentified diagnosis or courses of treatment. The doctor supports the patient, by showing him/her that the reactions might be over exaggerated. Subsequently, patient becomes aware of his/her psychological processes, and this, in turn, makes him/her trust doctor even more. This happens especially in the context of a long-lasting relationship. We consider this theme to be a distinct theme compared with the reassurance theme. It does not deal with the simple reinforcement the patient gets when, finally, his worries are soothed by the exclusion of serious illnesses. This theme pertains with how patient perceives that the doctor helped him/her become aware of his/her own emotional processes when coping with anxiety through extensive check-ups and verifications. We consider this theme to be the psychotherapeutic equivalent of insight (Richfield, 1954), when patient becomes aware and considers valid an interpretation of his own emotional processes, and, subsequently, is empowered in relationship with them.



## *Confidentiality*

Another important result of our study is the lack of emphasis on confidentiality. Almost all our patients did not emphasize confidentiality as an important feature of their trust in the doctor. They didn't mention situations where confidentiality is kept or transgressed, despite specific question targeting this topic. This totally supports the findings of previous studies, where patients judged confidentiality as an unimportant consideration or determinant of trust (Hillen, *et al.*, 2012) but is inconsistent with studies that mentioned lack of respect for patient privacy and confidentiality as a key point of patient health-care provider communication expressed by patients (Farahani, *et al.*, 2011).

In this study, we focused on identifying the pathways through which trust in doctor-patient relationship in the context of irritable bowel syndrome is built. The empirical literature dealt so far with disparate features of trust, not considering interactions and the mutual influence between the patient's trust in the doctor and the doctor's trust in the patient. The originality of our endeavor resides in the focus we had on interactions, identifying sequences of interactions or scripts in which there are revealed the mechanisms of how mutual trust is built and maintained in the context of the relationship between the doctor and the IBS patient. Among themes that are reconsidered from an interaction point of view, we identified other themes which were not previously approached, like insight or the labeling of patient as panicky.

The present study has limits that derive from the particulars of its methodology and research question. Building up and adapting interview guides proved a difficult task when trying to catch-up the particulars of doctor-patient interaction. Sometimes, this was not possible without additional questions that might be considered leading when taken out of the context. In what the number of participants is concerned, the fifteen patients we interviewed didn't allow the exploration of all particular or smaller themes that emerged. Despite looking for maximum variability, some patients provided more illustrative examples than others, possibly related with their degree of language mastery and expression. It is also worth mentioning that the objective of the study proved difficult to connect with present literature, as previous studies focused on disparate features of trust and not mechanisms or scripts. This further complicated the process of data gathering. Among the limits of the study, we can also point out that the qualitative endeavor doesn't allow for generalizations usual in quantitative studies.

Other studies can further explore the dynamics of mutual trust by targeting specific interactional scripts or sequences (e.g.: *What did you think? And how did he react?*). In parallel, quantitative studies can use the data presented here in order to build quantitative questionnaires with items derived from the specific patterns

we described. This will allow for new factors to be identified by Exploratory Factor Analysis, together with the discovery of culturally-appropriated psychometrical constructs.

## **Conclusion**

In this qualitative study we investigated the pathways through which mutual trust in doctor-patient relationship in the context of irritable bowel syndrome is built. Irritable bowel syndrome has been used as an example for mutual trust in the context of chronic diseases thanks to the particulars of uncertainty and anxiety feelings these patients have. Several themes emerged from our analysis, which dealt with interactions leading to one-side or mutual trust. Patients talked about the successive medical outcomes in the context of long-lasting relationships, patient-centered communication, the insight obtained by the patient with the help of his/her doctor, the value of witnessing the diagnostic procedure and the function of reassurance of doctor-patient interaction. Pitfalls in doctor-patient mutual trust dealt with perceived mistakes and the “panicky” label the doctors used. Most of our results connect with similar outcomes mentioned in the empirical literature, but bring an extra approach based on interaction and mutual influence. Our study brings information on mechanisms for how mutual trust is built and maintained: particular interactions of perception, thought and behavior. These interactions are described and discussed. Our study completes the understanding of how mutual trust is built in doctor-patient interaction, bringing more input into future qualitative and quantitative investigations.

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## References

- Abel, W. & Eford, J. (2013). The Association between Trust in Health Care Providers and Medication Adherence among Black Women with Hypertension. *Front Public Health, 1*, 1-6.
- Bao, Y., Fox, S. & Escarce, J. (2007). Socioeconomic and racial/ethnic differences in the discussion of cancer screening: “between-” versus “within-” physician differences. *Health Serv Res., 42*(3) 950-970.
- Bodenheimer, T., Wagner, E. & Grumbach, K. (2002). Improving primary care for patients with chronic illness.. *JAMA, 288*(14), 1775-1779.
- Bodenheimer, T., Wagner, E. & Grumbach, K. (2002). Improving primary care for patients with chronic illness: the chronic care model, Part 2. *JAMA, 288*(15), 1909-1914.
- Cojocar, D., Cace, S., Gavrilovici, C. (2013). Christian and secular dimensions of the doctor-patient relationship. *Journal for the Study of Religions and Ideologies, 12*(34), 37-56.
- Coleman, K., Austin, B., Brach, C. & Wagner, E. (2009). Evidence on the Chronic Care Model in the new millennium. *Health Aff (Millwood), 28*(1), 75-85.
- Denzin, N. & Lincoln, Y., 1998. *The landscape of qualitative research: theories and issues*. Thousand Oaks: Sage Publications.
- Farahani, M., Sahragard, R., Carroll, J. & Mohammadi, E. (2011). Communication barriers to patient education in cardiac inpatient care: a qualitative study of multiple perspectives. *Int J Nurs Pract, 17*(3), 322-328.
- Fiscella, K. & Shin, P. (2005). The inverse care law: implications for healthcare of vulnerable populations. *J Ambul Care Manage, 28*(4), 304-312.
- Fiscella, K., Franks, P., Gold, M. & Clancy, C. (2000). Inequality in quality: addressing socioeconomic, racial, and ethnic disparities in health care. *JAMA, 283*(19), 2579-2584.
- Given, L. & Gale, G. (2008). *The Sage encyclopedia of qualitative research methods*. Los Angeles: Sage Publications.
- Glaser, B. (1965). The Constant Comparative Method of Qualitative Analysis. *Social Problems, 12*(4), 436-445.
- Gopichandran, V. & Chetlapalli, S. (2013). Dimensions and determinants of trust in health care in resource poor settings—a qualitative exploration. *PLoS One, 8*(7), 1-8.
- Hillen, M., Onderwater, A.T., van Zwieten, M.C., de Haes, H.C., & Smets, E.M. (2012). Disentangling cancer patients’ trust in their oncologist: a qualitative study. *Psycho-oncology, 21*(4), 392-399.
- Holman, H. & Lorig, K. (2004). Patient self-management: a key to effectiveness and efficiency in care of chronic disease. *Public Health Rep, 119*(3), 239-243.
- Institute of Medicine (US) Committee on Quality of Health Care in America, 2001. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington DC: National Academies Press (US).
- Jilcott Pitts, S., Lea, C.Z., May, C.L., Stowe, C., Hamill, D.J., Walker, K.T., Fitzgerald, T.L. (2013). “Fault-line of an earthquake”: a qualitative examination of barriers and facilitators to colorectal cancer screening in rural, Eastern North Carolina. *J Rural Health, 29*(1), 78-87.

- Jin, J., Sklar, G., Min Sen Oh, V. & Chuen Li, S. (2008). Factors affecting therapeutic compliance: A review from the patient's perspective. *Ther Clin Risk Manag*, 4(1), 269-286.
- Longstreth, G., Thompson, W.G., Chey, W.D., Houghton, L.A., Mearin, F., Spiller, R.C. (2006). Functional bowel disorders. *Gastroenterology*, 130(5), 1480-1491.
- Lovell, R. & Ford, A. (2012). Global prevalence of and risk factors for irritable bowel syndrome: a meta-analysis. *Clin Gastroenterol Hepatol*, 10(7), 712-721.
- McAlearney, A., Oliveri, J.M., Post, D.M., Song, P.H., Jacobs, E., Waibel, J., Harrop, J.P., Steinman, K., Paskett, E.D. (2012). Trust and distrust among Appalachian women regarding cervical cancer screening: a qualitative study. *Patient Educ Couns*, 86(1), 120-126.
- Mikocka-Walus, A., Moulds, L., Rollbusch, N. & Andrews, J. (2012). "It's a tube up your bottom; it makes people nervous": the experience of anxiety in initial colonoscopy patients. *Gastroenterol Nurs*, 35(6), 392-401.
- Nguyen, G., LaVeist, T.A., Harris, M.L., Datta, L.W., Bayless, T.M., Brant, S.R. (2009). Patient trust-in-physician and race are predictors of adherence to medical management in inflammatory bowel disease. *Inflamm Bowel Dis*, 15(8), 1233-1239.
- O'Donnell, C., Higgins, M., Chauhan, R. & Mullen, K. (2008). Asylum seekers' expectations of and trust in general practice: a qualitative study. *Br J Gen Pract*, 58(557), e1-11.
- Oprea, L., Braunack-Mayer, A., Rogers, W. & Stocks, N. (2010). An ethical justification for the Chronic Care Model (CCM). *Health Expect*, 13(1), 55-64.
- Ratanawongsa, N., Wright, S., Vargo, E. & Carrese, J. (2011). Challenges in primary care relationships: seeing it from both sides. *Patient Educ Couns*, 85(1), 40-45.
- Richfield, J. (1954). An analysis of the concept of insight. *The Psychoanalytic Quarterly*, 23, 390-408.
- Rogers, W. & Braunack-Mayer, A. (2008). *Practical Ethics for General Practice*. 2nd ed. Oxford: Oxford University Press.
- Rogers, W. (2002). Is there a moral duty for doctors to trust patients?. *J Med Ethics*, 28(2), 77-80.
- Rollbusch, N., Mikocka-Walus, A. & Andrews, J. (2014). The experience of anxiety in colonoscopy outpatients: a mixed-method study. *Gastroenterol Nurs*, 37(2), 166-175.
- Schoen, C. Schoen, C., Osborn, R., Huynh, P.T. *et al.* (2006). On the front lines of care: primary care doctors' office systems, experiences, and views in seven countries. *Health Aff (Millwood)*, 25(6), 555-571.
- Tarrant, C., Dixon-Woods, M., Colman, A. & Stokes, T. (2010). Continuity and trust in primary care: a qualitative study informed by game theory. *Ann Fam Med*, 8(5), 440-446.
- Tetzlaff, J. (2016). Practical considerations in the management of sedation for colonoscopy. *Curr Opin Anaesthesiol*, 29(4), 512-518.
- Whitehead, W., Palsson, O. & Jones, K. (2002). Systematic review of the comorbidity of irritable bowel syndrome with other disorders: what are the causes and implications?. *Gastroenterology*, 122(4), 1140-1156.
- World Health Organization (2002). Innovative care for chronic conditions: building blocks for action: global report. Geneva: World Health Organization.
- Wright, E., Holcombe, C. & Salmon, P. (2004). Doctors' communication of trust, care, and respect in breast cancer: qualitative study. *BMJ*, 328, 864.