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Healthcare professionals' trust in patients: A review of the empirical and theoretical literatures

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Abstract

Trust is considered as an important process in establishing positive patient–professional relationships and healthcare outcomes. While many studies denote the mutual–reciprocal nature of trust, there is a strong tendency to consider professionals merely as trustees. This article presents a review of literature addressing healthcare professionals' trust in patients, aiming to identify and compare more theoretical and more empirical contributions on the topic as a basis for developing a research agenda. We examine 31 theoretical and empirical peer-reviewed articles that address healthcare professionals' trust in patients, either as the primary or secondary focus. We found that healthcare professionals' trust in patients is still overlooked in empirical trust studies into healthcare, despite several theoretical and review articles emphasising the relevance of the topic. We propose that future empirical research considers professionals' uncertainties and vulnerabilities, and that theoretical studies reflect more on methodological approaches for researching their conceptualisations. Moreover, our findings suggest that while system-based understandings have been seen as important for considering how patients trust in their healthcare, we argue that

these same abstract systems—professional, ethical, organisational and legal—are vital to understanding how doctors become vulnerable, and therefore, how trust in their patients becomes pertinent, in their everyday work.

KEYWORDS
distrust, healthcare professional, healthcare provider perspective, patient–professional relationship, trust, uncertainty, vulnerability

1 | INTRODUCTION

Patients' trust in healthcare professionals has been the focus of an expansive body of empirical and conceptual studies, yet professionals' trust in their patients remains empirically neglected and under-theorised (Calnan & Rowe, 2008; Douglass & Calnan, 2016; Wilk & Platt, 2016). Professionals' trust in their patients has been seen as a moral duty and as the default starting point for healthcare encounters (Parsons, 1951; Skirbekk, 2009), yet patients' and professionals' perspectives challenge these considerations. Patients may feel distrusted by professionals from the outset (Rogers, 2002), while professionals may perceive potential 'risks' in trusting patients and, therefore, see good reasons to distrust them (Pilgrim, Tomasini, & Vassilev, 2011).

Distrust in patients can lead to the neglecting of symptoms and different treatment plans (Rogers, 2002), while the negotiation of trust can facilitate patients' disclosure of stigmatising issues and, in the long term, the development of good patient–professional relationships (Brown & Calnan, 2009). Yet studies rarely consider professionals' perspectives despite recurrent calls within a small number of previous studies advocating a focus on professionals' trust in patients to become a more central part of the trust in healthcare research agenda (e.g., Brennan et al., 2013; Calnan & Rowe, 2008; Douglass & Calnan, 2016; Thom et al., 2011; Wilk & Platt, 2016).

Besides being crucial for developing a more balanced and reciprocal understanding of effective healthcare relationships (Hall, Dugan, Zheng, & Mishra, 2001), investigating professionals' trust in patients can usefully inform education programmes for healthcare professionals, helping trainees think reflexively about their relationships with patients, challenging the implicit assumption that professionals always trust in their patients and reflecting on tendencies to (dis)trust some patients more than others and how this may impact on care outcomes. Existing literature reviews about the patient–professional relationship (Brennan et al., 2013) or those considering professionals' trust in patients (Douglass & Calnan, 2016; Wilk & Platt, 2016) do not address trust in patients exclusively. Accordingly, there is a disconnect between more conceptual overviews pertaining to multiple trust relations (e.g., Douglass & Calnan, 2016) and more empirical reviews (Wilk & Platt, 2016).

Amid this background, we aim in this article to assess the literatures on healthcare professionals' trust in patients, paying particular attention to assessing the state of the art in empirical research, conceptual work and the potential for these literatures to more regularly inform one another. In the next section, we present the wider context of studies of trust within healthcare and of some of the wider conceptual terrain around trust, before considering some of the existing reviews mentioned above. We then go on to describe the methodology of our narrative review, before devoting the final two main sections to the review findings and potential directions for future research.

2 | BACKGROUND: TRUST AS A MEANS OF HANDLING UNCERTAINTY AND VULNERABILITY

There is now a substantial literature on trust across a wide range of disciplines spanning the breadth of the social sciences and beyond. Möllering (2006), whose book develops a synthesis of the complex multi-disciplinarity of the field, considers trust as becoming pertinent in contexts characterised by both vulnerability and uncertainty. Elsewhere Möllering (2005, p. 286) delineates a basic problem of trust and control which, for our purposes, can be expressed as: 'how can [professionals] form positive expectations of the behaviour of [their patients] by whom they may be positively or negatively affected, that is, to whom they are vulnerable'. The nature of this vulnerability will vary in relation to the kind of care being provided and the type of patient being cared for. However, the onus on the professional to trust in order to deliver quality care, the difficulty in achieving good outcomes without trusting the patient, and the way the professional subjects herself to vulnerability amid this process of trusting (Barbalet, 2009, p. 372) are useful starting points for considering the vital yet potentially problematic nature of these trust relations.

Trust in healthcare contexts represents a substantial sub-field. Though considerable work has been done since, Calnan and Rowe's (2004, 2006, 2008) work usefully surveys the breadth of this sub-field which includes work from anthropology, economics, psychology and sociology, as well as various studies published within medical journals and other practice-oriented publications. Dominated by a focus on patients' trust in expert-professionals and informed more or less directly by various key social theories of trust, not least those of Luhmann (1979, 1988), Giddens (1990, 1991) and Möllering (2006), many studies in the trust in healthcare literature have conceptualised and studied the interaction between trust in systems—professional and organisational—and trust in specific individual professionals (e.g., Calnan & Sanford, 2004).

Conversely, when professionals (dis)trust a specific patient, there would seem to be less of an apparent 'system' in which the patient is embedded. Trust would, therefore, seem to be characterised more in terms of other fairly brief encounters between workers and clients (Gambetta & Hamill, 2005) or in contexts where the social norms around a longer-term relationship are implicitly understood as offering a semblance of control and predictability which facilitate trust to a greater or less degree (Möllering, 2005). Both these characterisations involve a complex interplay between vulnerability and trust, with trust opening up solutions to vulnerability (Barbalet, 2009) while simultaneously rendering the truster vulnerable to being let down by the trustee, yet where vulnerability also fosters a willingness to trust (Brown, 2009; Meyer & Ward, 2013; Möllering, 2006).

What underlies the literature pertaining to trust involving systems (e.g., Luhmann, 1979, 1988) and that which considers how trusters 'make sense' of unfamiliar others and interpret signs regarding their trustworthiness (Gambetta & Hamill, 2005; Veltkamp & Brown, 2017) is a basis in phenomenology (Schutz, 1973) in which signifiers are interpreted in relation to a wider set of assumptions and background knowledge (Brown, 2009; Gambetta & Hamill, 2005; Möllering, 2006). When applied to healthcare professionals' trust in their patients, this framework would orient researchers to explore which signs are focused upon, categorised and interpreted, based on which background assumptions (Brown, 2009), with the proviso that the taken-for-granted nature of background knowledge renders it difficult for research participants to reflect on. In this sense, professionals may implicitly interpret signifiers and employ categories in ways which they cannot describe or which they would refute (Veltkamp & Brown, 2017).

These processes of (mis)trust may also be bound up with the different ways in which professionals experience and understand their vulnerability and uncertainty (Brown & Calnan, 2012; Pilgrim et al., 2011). These theoretically oriented themes are apparent, albeit rather implicitly, within existing reviews of empirical work on professionals' trust in their patients (Brennan et al., 2013; Tofan, Bodolica, & Spraggon, 2012; Wilk & Platt, 2016). Previous literature reviews that addressed the topic of healthcare professionals' trust in patients agree that professionals are indeed vulnerable to patients and that their trust in patients should not be assumed (Brennan et al., 2013; Tofan et al., 2012; Wilk & Platt, 2016). These works also commonly note that robust investigations and precise discussions of trust are rare among the articles on healthcare professionals' trust and that some 'dimensions' of trust, such as

confidence, effective communication and cooperation, have been used for measuring and/or conceptualising trust at the expense of other relevant dimensions of trust such as fidelity, social capital and vulnerability (Wilk & Platt, 2016).

These works (Brennan et al., 2013; Tofan et al., 2012; Wilk & Platt, 2016) also highlight the transformations of healthcare settings and the impact on healthcare professionals' roles and relationship to patients. Specifically, some of the transformations cited are the adoption of a more market-oriented approach in the healthcare landscape (Tofan et al., 2012) and the introduction of new regulations. Brennan et al. (2013, p.686) describe the expansion of healthcare professionals' roles, from mere 'healers' to 'adjudicators' on eligibility for benefits, sick leave and so on. For Wilk and Platt (2016), this represents an increasingly complex relationship involving healthcare professionals and other stakeholders, exposing them to new risks, vulnerabilities and dependencies.

3 | METHODS

We carried out a narrative review (Gale, Thomas, Thwaites, Greenfield, & Brown, 2016; Greenhalgh et al., 2005) synthesising the literature on healthcare professionals' trust in patients while using the following inclusion criteria: (1) empirical or conceptual-theoretical articles published in peer-reviewed journals, (2) in English, (3) where healthcare professionals' trust in patients was the main focus or (4) healthcare professionals' trust in patients was an important finding. Searches in Portuguese, Spanish and French were also performed (using appropriate translations of key terms for each language) but did not return results related to the topic researched, which led us to restrict our review to articles in English. Book reviews, commentaries or editorials were excluded. We also excluded articles mentioning healthcare professionals' trust in patients solely in the references—for example, articles referencing works on physicians' trust to illustrate extensions of trust research in healthcare.

The choice of search terms was made based on common terms employed in the literature to refer to healthcare professionals. Two terms were commonly associated with research on healthcare professionals' trust: 'provider' (Brennan et al., 2013) and 'physician' (Wilk & Platt, 2016). Despite having our search limited to these two terms in the beginning of the search, the use of 'provider' gave us the possibility to find studies including professionals other than physicians that seemed satisfactory and in accordance to previous findings. Later on, we ran searches using specific professional terms like 'psychologists' and 'nurses', but these searches did not return new results.

Our goal was to access the largest number of publications possible and, for this, we used general terms found in literature that emerged from the first searches: 'trust', 'physician', 'patient', 'physician–patient relationship' and 'healthcare provider'. Although some of the English language literature employs other terms (e.g., confidence, following Luhmann, 1988) alongside trust, our assessment of the literature found that trust was a reliable term to focus upon. We then proceeded to search in the following databases and journals—they were chosen because of their likeliness to include a broad range of results on the topic: MEDLINE, PubMed, Google Scholar, *Sociology of Health and Illness*, *Health*, *Risk & Society* and *Journal of Trust Research*. However, this initial search uncovered very few relevant results ($n = 8$, while most articles focused on the patients' perspective), and so we ended up pursuing a snowball search approach (Wohlin, 2014).

From the initial search, we identified the article 'Trust matters for doctors: towards an agenda for research' (Douglass & Calnan, 2016) as a starting point. Then, by examining its references (backwards snowballing) and articles that refer to it (forward snowballing), an initial set of articles emerged. We ran additional searches on Google Scholar to avoid risk of 'publisher bias' caused by searches in specific publishers' databases (Wohlin, 2014, p. 5). In this additional search, we used the terms 'trust', 'doctors', 'healthcare practitioners', 'healthcare providers' and 'patients' in different combinations. On this step of the procedure, we identified eight articles, including Douglass and Calnan (2016). Another search on the same electronic database using the quoted phrases 'trust by doctors' and 'physicians' trust in patients', quoted in articles found in the initial searches, resulted in eight more articles.

The next step consisted of forward snowballing from the initial set of 16 articles. Through this process, 15 more papers were identified, and all the consequent processes of forward snowballing were run on Google Scholar. We proceeded to examine all references cited by the articles found so far (backwards snowballing) and reading these abstracts resulted in six more articles. One further round of forward and backwards snowballing followed, but no new articles were found. We set out to read the full texts of these 37 articles. When the inclusion and exclusion criteria were applied, 31 studies were ultimately included in this review. Previous reviews including healthcare professionals' trust in patients (Brennan et al., 2013; Tofan & Bodolica, 2012; Wilk & Platt, 2016) covered nine articles included in this study.

We carried out data extraction from the full text of the 31 articles regarding information such as authors, year of publication, title, keywords, academic discipline, type of study, theoretical framework about trust, context, type of professionals and type of patients, methods and key findings. Additionally, for each article, we classified (following Brennan et al., 2013) whether trust was the main focus (trust in patients as a primary) or emerged as a relevant outcome (secondary). We use this classification to summarise the literature and distinguish the articles according to their different ways of approaching and portraying the topic. An important finding which we discuss below was the common theme of distrust. While mistrust was used in some articles, we report these findings as distrust, following Marsh and Dibben's (2005) terminological specifications.

4 | OVERVIEW OF THE LITERATURE

The literature predominantly emerged from the United States ($n = 12$ articles) and the United Kingdom ($n = 4$). Other countries studied included France ($n = 3$), Canada ($n = 2$), Brazil ($n = 2$), Australia ($n = 1$), China ($n = 1$), India ($n = 1$), Netherlands ($n = 1$), Moldova ($n = 1$), Norway ($n = 1$), South Africa ($n = 1$) and Sweden ($n = 1$). The articles were published between 2002 and 2018 and consisted of empirical ($n = 20$) and theoretical studies ($n = 8$) and literature reviews ($n = 3$), that either investigated trust in patients ($n = 19$) or included this as a secondary outcome ($n = 12$). The frequency of publication in the period mentioned was irregular, and the years 2013 and 2016 saw the largest number of publications ($n = 5$ in each).

The first authors of the 31 publications worked in the following academic disciplines: Medicine ($n = 15$), Health studies ($n = 6$), Ethics as sub areas of Philosophy or Law ($n = 4$), Psychology ($n = 2$), other Social Sciences ($n = 3$) and Nursing ($n = 1$). The keywords (or variations of these) used more than once were: trust ($n = 15$), provider–patient relationship ($n = 9$), pain ($n = 8$), opioids ($n = 7$), clinical judgement ($n = 4$), distrust ($n = 4$), qualitative research ($n = 4$), addiction ($n = 3$), patient–provider communication ($n = 3$), attitude of health personnel ($n = 2$), ethics ($n = 2$), healthcare ($n = 2$), health disparities ($n = 2$) and substance related disorders ($n = 2$).

The most studied healthcare professionals were physicians ($n = 19$). If we also consider studies of diverse healthcare professionals ($n = 8$) or primary care professionals without specifications ($n = 2$), the number of studies with physicians would increase. In two articles, it was not clear which type of healthcare professionals were involved. It was not always possible to classify which patients' professionals were engaging with. Six studies specified neither patients' profiles nor context of care. Care contexts were, however, seemingly important in motivating and informing research about the topic of trust. Common features of these contexts included uncertainty —related to diagnosis or management of the condition—and associated forms of patient stigmatisation and distrust.

Pain management ($n = 9$), often relating to opioid prescribing, was the most common research context where professionals' trust was investigated. Care for service-users diagnosed with substance use or abuse-related conditions was the second most common identified context ($n = 5$). Care differences related to ethnicity or race and stigmatisation were also considered in some of the articles ($n = 3$) as well as in relation to healthcare system changes or particularities ($n = 3$). Some of the other contexts of care were borderline personality disorder ($n = 1$), inflammatory bowel disease ($n = 1$), emergency medicine ($n = 1$), patient safety problems ($n = 1$) and abortion provision ($n = 1$).

4.1 | Theoretical and methodological approaches

The articles covered in the review, whether empirical or more theoretical, all emphasised the importance of researching professionals' trust in patients, yet there was much less consensus on how to conceptualise 'trust'. Eleven articles offered no definition of trust (Burgess et al., 2008; Chibnall, Tait, & Gammack, 2018; Dineen & Dubois, 2016; Diniz, Madeiro, & Rosas, 2014; Kennedy et al., 2017; Langley & Klopper, 2005; Lindberg, Bjoorn, Karlen, & Oxelmark, 2013; Losin, Anderson, & Wager, 2017; Matthias et al., 2013; Merrill, Rhodes, Deyo, Marlatt, & Bradley, 2002; Sun et al., 2018). These articles addressed trust secondarily, except for Sun et al.'s (2018) study of relations between resilience and physicians' trust. The majority of these articles were empirical and investigated different topics: decision-making involving opioid prescription or medical care of drug users (Burgess et al., 2008; Chibnall, Tait, & Gammack, 2018; Matthias et al., 2013; Merrill et al., 2002; Kennedy et al., 2017), patient–clinician relationships (Langley & Klopper, 2005; Losin et al., 2017), conscientious objection in case of abortion (Diniz et al., 2014) and professionals' attitudes towards complementary and alternative medicine when treating patients with inflammatory bowel disease (Lindberg et al., 2013). The lack of explicit conceptualisations was surprising given several theoretical articles emphasising the importance of developing understandings of the phenomenon (e.g., Douglass & Calnan, 2016).

Where conceptualisations were evident, we were able to identify three main orientations. All articles, whether trust was conceptualised explicitly or not, included one of these three orientations—albeit sometimes implicitly: (1) approaching trust as a complex or nebulous phenomenon understood from a philosophical perspective in light of ethical arguments (Entwistle & Quick, 2006; Francis, 2010; Lago, Peter, & Bogus, 2017; Miller, 2007; Reyre et al., 2017, 2014; Rogers, 2002; Skirbekk, 2009; Thom, 2011; Tofan, Bodolica, & Spraggon, 2012); (2) considering trust as an individual assessment of anothers' trustworthiness (Buchnam & Ho, 2013; Buchnam, Ho, & Illes, 2016; Burgess et al., 2008; Chibnall et al., 2018; Dineen & Dubois, 2016; Diniz et al., 2014; Francis, 2010; Kennedy et al., 2017; Lago et al., 2017; Langley & Klopper, 2005; Lindberg et al., 2013; Losin et al., 2017; Matthias et al., 2013; Merrill et al., 2002; Moskowitz et al., 2011; Pellaccia et al., 2016; Sun et al., 2018; Thom et al., 2011; Treloar & Rance, 2014); and (3) considering trust as a complex process involving contextual and communicative dynamics (Brennan et al., 2013; Douglass & Calnan, 2016; Groenewegen, Hansen, & Jong, 2018; Kane, Calnan, & Radkar, 2015; Reyre et al., 2014; Skirbekk et al., 2011).

Some of the articles, more theoretical or more empirical, straddled boundaries across the three orientations. Articles that addressed trust as a complex or nebulous phenomenon, as understood from a philosophical perspective in light of various ethical arguments, broadly referred to the doctor–patient relationship (Francis, 2010; Rogers, 2002; Thom et al., 2011; Tofan et al., 2012) and care for specific conditions such as drug addiction (Lago et al., 2017; Reyre et al., 2014, 2017; Skirbekk, 2009) or chronic pain (Miller, 2007). Patient safety (Entwistle & Quick, 2006) and confidentiality (Francis, 2010) were also discussed by framing trust from an ethical perspective. Generally speaking, these articles aimed to address the uncertainties and vulnerabilities raised in medical encounters characterised by conflicting motivations, with most focused on clinical decision-making. This focus was also a common feature of the individualised perspective of trust represented by the second orientation—evaluating another's trustworthiness.

Articles that approached trust as an individual assessment of others' trustworthiness explored decision-making and medical judgement in dealing with opioid prescription, pain management and addiction treatment (Buchnam et al., 2016; Buchnam & Ho, 2013; Moskowitz et al., 2011; Pellaccia et al., 2016; Treloar & Rance, 2014), focussing on the interpersonal nature of trust and its behavioural and cognitive manifestations, such as expectations. These articles included medical encounters for the care of conditions marked by medical uncertainties, highlighting professionals' vulnerabilities amid such care giving and stressing the police-like or 'investigator' role that physicians (most commonly) were expected to perform in the clinical setting (Diniz et al., 2014; Merrill et al., 2002; Pellaccia et al., 2016). Some authors suggested formal contracts signed by patients (e.g., opioid contracts, see Fishman, Bandman, Edwards, & Borsook, 1999) are inefficient governance mechanisms and problematic for the physician–

patient relationship in such treatment contexts (Buchnam et al., 2016; Buchnam & Ho, 2013), noting the importance of legal and regulatory mechanisms for understanding the professional–patient relationship. Some of these authors also argued that 'negative societal attitudes' may be important in shaping professional–patient relationships (Merrill et al., 2002).

Some of these latter studies merged the interpersonal approach of trust with ethical arguments about the encounter between patients and healthcare professionals. In this light, medical encounters were interpersonal interactions and could represent dilemma situations, being interpreted as a possible source of conflicting interests between patients and doctors (Buchnam et al., 2016; Buchnam & Ho, 2013; Burgess et al., 2008; Chibnall et al., 2018; Dineen & Dubois, 2016; Kennedy et al., 2017; Matthias et al., 2013), such as when prescribing opioids in situations with 'potential for abuse' (Miller, 2007) or performing abortions in Brazil (Diniz et al., 2014). These ethical-interactive considerations of trust also included studies investigating relations between categories of identity (e.g., race, stigmatised conditions), trust and the delivery of care (Burgess et al., 2008; Losin et al., 2017; Moskowitz et al., 2011; Thom et al., 2011).

Articles that tended to portray trust as a complex process involving contextual and communicative dynamics discussed the negotiating of trust, while emphasising that important features of this trust are taken-for-granted (Skirbekk, 2009) as they pertain to individuals and institutions (Reyre et al., 2014, 2017). Such studies also framed healthcare professionals' trust in patients amidst complex and changing healthcare systems (Groenewegen et al., 2018; Kane, Calnan, & Radkar, 2015) and reflected on interrelations between different types of trust among diverse actors (e.g., doctors, patients, organisations, systems) in offering a model of doctors' trust (Douglass & Calnan, 2016). In contrast to articles from the other two orientations, most of these articles did not focus on the individual management of stigmatised conditions. Instead, these authors illustrated implicit and explicit interpretations of trust (Skirbekk, 2009) or used encounters involving addiction treatment to advocate for institutional and individual efforts to restore trust (Reyre et al., 2014, 2017).

While qualitative studies were more common, and tended to include different healthcare professionals, patients and other actors, quantitative studies usually only included physicians in primary care. Focussing on the physician–patient relationship, medical judgement and decision-making, these quantitative studies often framed trust as an individual assessment of others' trustworthiness, focussing on the psychological or psychosocial aspects of trust.

5 | FEATURES OF HEALTHCARE PROFESSIONALS' TRUST IN PATIENTS

Taking a step back to consider the broader picture emerging from the body of literature we reviewed, three temporal stages of healthcare professionals' (dis)trust in patients become especially apparent: (1) 'pre-trust': the contextual-related uncertainties and vulnerabilities, (2) the communicative and conflictual dynamics of '(dis)trust' itself and (3) 'post-hoc trust dynamics': the unfolding relational dynamics shaping vulnerabilities and uncertainties following specific actions or utterances from which (dis)trust is inferred.

Below we offer a critical analysis of these temporal stages, discussing them in light of the broader literature on trust in healthcare. Figure 1 displays the interrelations between the features: uncertainties and vulnerabilities can be contextual or emerge in the relational dynamics between professionals and patients. We locate (dis)trust as central to this model, as shaped by and impacting upon various forms of vulnerability and uncertainty. Trust is possible when vulnerabilities and uncertainties are 'accepted', that is where the professional acts 'as if' vulnerabilities and uncertainties are unproblematic due to expectations about a positive future (Lewis & Weigert, 1985). Distrust emerges, however, when vulnerabilities and uncertainties are unable to be 'assumed away' (Brown, 2009, p. 401) or where trust is later breached.

Studies in our review stressed uncertainties and vulnerabilities as antecedents and/or consequences of (dis)trust. As these uncertainties and vulnerabilities become explicit as '*pre-trust*' or '*post-hoc trust dynamics*' conditions, some authors describe a 'crisis' of professionals' trust in patients (Sun et al., 2018), suggesting

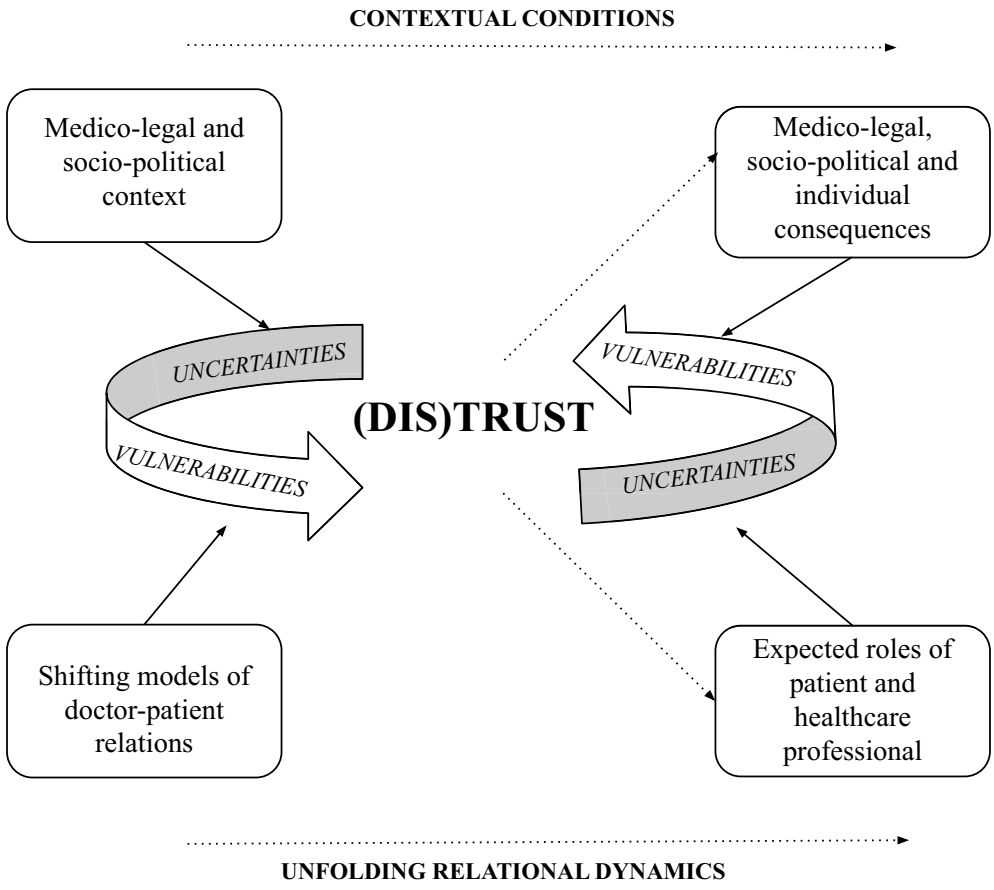

FIGURE 1 Healthcare professionals' trust in patients' diagram

decreasing levels of professionals' trust in patients following regulatory changes (Groenewegen et al., 2018). Several studies focused on investigating distrust at the interpersonal level—most commonly that of doctors. Distrust was described as a way for professionals to deal with uncertainty and vulnerability, whereby they refused to make themselves vulnerable to particular futures characterised by uncertainty. Some authors argued, though, that it is possible to negotiate trust and build a trusting relationship with patients with the collaborative efforts of patients and professionals, thus emphasising the reciprocal character of trust. Several studies which considered trust in reciprocal–relational terms also highlighted longer-term shifts in power dynamics in healthcare relationships.

5.1 | (Dis)trust

As a way to understand trust, the reviewed studies broadly focused on distrust in three different senses—echoing distinctions pointed to by Hall et al. (2001): as a result of past breaches of trust, as the absence of trust building or as a pathway to trust. These three ways of considering processes involving distrust represent a further challenge to notions of professionals' trust in patients as a default starting position. Referring to past breaches of trust, professionals justified a distrusting stance. For these professionals, distrust served as a form of quasi-certainty, used to

avoid vulnerabilities they had experienced following past encounters and resulted in barriers to treatment (Chibnall et al., 2018; Diniz et al., 2014; Moskowitz et al., 2011; Rogers, 2002). Some of the professionals shared generalising narratives in describing their avoidance of treating specific categories of patients (Chibnall et al., 2018), pursuing extra information through an interrogation-type approach (Dineen & Dubois, 2016; Pellaccia et al., 2016), and/or emphasised contractualised relations in healthcare (Buchnam & Ho, 2013).

Such forms of professional distrust could, however, pave the way towards trust by coordinating their efforts together with those of patients amid wider institutional structures. These efforts could be communicative—for example, in discussing distrust with the patient (Skirbekk, 2009; Skirbekk et al., 2011) and others involved (Reyre et al., 2014, 2017)—and recognising patient and professional fallibility as inherent to medical practice, thus adopting a position of 'epistemic humility' (Buchnam & Ho, 2013). The expression of empathy was also seen as a way to overcome distrust and assume a trusting stance (Buchnam et al., 2016; Kennedy et al., 2017).

Trust, on the other hand, was mostly referred to as a reciprocal–interpersonal phenomenon where professionals expected patients to act in specific ways: being honest about their motives and symptoms, being competent in terms of assessing relevant symptoms (Rogers, 2002) and in following medical recommendations and respecting professionals' boundaries by attending appointments on time (Thom et al., 2011). Some studies following a more philosophical–ethical orientation argued that trust in patients is a moral duty for healthcare professionals because they are less vulnerable. Trusting patients, and the risks associated with this, was therefore argued by some as a necessary basis of clinical practice (Rogers, 2002). These arguments may underestimate the vulnerabilities experienced by professionals, disregarding healthcare professionals' fears—for example, when dealing with opioid prescription in the United States or less legitimated medical conditions commonly associated with negative stereotypes. The fears and vulnerabilities of professionals become more explicit when we also consider the pre and post conditions of trust and distrust described in the articles included in this review.

5.2 | 'Pre-trust': Contextual-related uncertainties and vulnerabilities

The shifting medico-legal and socio-political conditions of late-modern healthcare were seen to shape new forms of physician–patient relationship (Brown & Calnan, 2015; Douglass & Calnan, 2016). Uncertainty was typically seen to have increased amid myriad changes, including shifting regulatory structures, the complexity of contemporary healthcare systems, market-oriented approaches to healthcare, the biomedical orientation of Western medicine, lack of specific medical education for conditions such as chronic pain or addiction which are increasingly common, stigmatisation of certain medical conditions, negative social attitudes and negative past experiences. Many of these contextual conditions were similar to those described as challenging trust in medicine and doctors (Mechanic, 1996) and tend to generate more formal decision-making forms of uncertainty (Buchnam et al., 2016; Buchnam & Ho, 2013; Miller, 2007; Rogers, 2002). Meanwhile, we consider changing interaction norms (Brown, Elston, & Gabe, 2015) and evolving social attitudes towards some conditions, such as abortion (Diniz et al., 2014) or drug use (Merrill et al., 2002), as leading to more informal-interactional uncertainties. Both forms of contextual uncertainties were commonly considered to shape doctors' roles.

New regulations for professional practice heighten vulnerabilities in the doctor–patient relationship, whereby professionals are held more responsible for the veracity of patients' descriptions of their conditions (Buchnam et al., 2016; Dineen & Dubois, 2016; Diniz et al., 2014; Kennedy et al., 2017; Reyre et al., 2014). This regulatory shift has taken place alongside an emphasis, both formal and informal, upon patient-centred communication where patients are considered more as clients, and satisfaction has become an increasingly important measure of healthcare quality (Scambler & Britten, 2001).

Such tensions amid conflicting interests and obligations have become important emerging sources of vulnerability impacting importantly on professionals' trust in their patients. The subjective aspects of specific conditions like chronic pain can represent a further threat to medical certainty and expose doctors' vulnerabilities: can the

patient be trusted in terms of their motives and competence to seek care appropriately and to describe their symptoms accurately (Rogers, 2002)? Trusting or (dis)trusting patients, meanwhile, then gives rise to further uncertainties such as those emerging alongside various vulnerabilities as the relationship develops over time. We now turn to these 'post-hoc' conditions.

5.3 | 'Post-hoc trust dynamics': Unfolding relational dynamics shaping uncertainties and vulnerabilities

Even when healthcare professionals and patients establish a trusting relationship, uncertainty over the honesty of the patient may become a problem because of the current norms of 'patient care' which may oblige professionals to prescribe, amid worries that the doctor would be seen as exercising 'medical dominance' (Broom & Woodward, 1996) were they not to do so (Moloney, 2017). Under these apparent pressures to prescribe, conditions such as chronic pain raise the spectre of iatrogenic harm which then becomes a further source of uncertainty and vulnerability (Buchnam et al., 2016; Buchnam & Ho, 2013; Entwistle & Quick, 2006). Further fears and related vulnerabilities that unfold in these changing professional-patient relationship dynamics include fear of deceit (Dineen & Dubois, 2016; Diniz et al., 2014; Merrill et al., 2002), fear of being manipulated (Merrill et al., 2002), fear of contravening wider public norms (Diniz et al., 2014) and fear of litigation (Kane, Calnan, & Radkar, 2015).

These fears involve vulnerabilities related to professional practice, identity, image and reputation in contexts where professionals, especially doctors, can be legally and morally held accountable and where social and system norms are shifting. Fear of being deceived relates to the possibility of causing harm to the patient and others, which can result in legal sanctions that impede professional practice. Fear of being manipulated can be related to the changes in power dynamics in medical encounters. Fear of being judged by the public opinion relates to the possibility of professionals' having their competence questioned by the broader public based on moral arguments. An example of this is that of conscientious objection of Brazilian doctors in cases of abortion following rape (Diniz et al., 2014). Although the regulations allow for the practice, doctors are prone to create barriers towards performing the procedure because of wider negative public opinion about abortion in Brazil. So while vulnerabilities regarding deceit and litigation are linked to developments in legal-regulatory systems, vulnerabilities pertaining to being manipulated and judged amid wider public values and moral frameworks can be linked to socio-moral lifeworlds. It is the combination of shifting systems and lifeworlds which is particularly important to grasping tensions and breakdowns in care (Brown, Flores, & Alaszewski, 2019).

The vulnerabilities of healthcare professionals thus differ importantly from those of patients, but in ways which render problematic various arguments asserting that professionals are, by nature, less vulnerable (Merrill et al., 2002; Miller, 2007; Rogers, 2002). In trusting particular patients, professionals put their future career, their sense of professional vocation, their personal identity and their public reputation at stake. Bureaucratic systems of legal regulation, tort liability and organisational (new public) management pressures, alongside lifeworlds of professional values, norms and public esteem may, therefore, combine to render trusting patients a very precarious process.

6 | FUTURE DIRECTIONS

Future theoretical research on trust will hopefully build upon these emerging concepts, frameworks and empirical findings and foster dialogue between theoretical and empirical perspectives. Articles in this review, with a few exceptions, examined trust with an interpersonal focus, emphasising the relationship between physicians and patients in stigmatised conditions (e.g., HIV, Hepatitis C, drug abuse, drug addiction, chronic pain) and tending to focus on individual aspects of trust. Addressing trust in such a manner did not mean though that these studies ignored context as significant to grasping (dis)trust of patients. Authors considered vulnerabilities, uncertainties

and (dis)trust to different extents in discussing healthcare professionals' trust in patients. Specialised medical knowledge, medical evidence, the nature of medicine and regulatory aspects of professional practice were all pointed out as unfolding aspects of the new healthcare relationship dynamics in late-modernity that shape (dis)trust. Moreover, patients were seemingly viewed by professionals as embedded in particular socio-cultural systems and categorised—and in some cases stigmatised—accordingly amid narratives which served to justify casting doubts on the trustworthiness of some. Thus, the professional–patient interaction should not be depicted as between two individuals, but between two 'representatives' of various larger groups, each with a given history of social actions and (mis)representations which shape how others make meaning of them (Scambler & Britten, 2001, p. 63). Patients' symptoms or conditions—chronic pain, drug addiction—could be considered by professionals as cautionary markers that justified a distrusting stance from professionals.

Given that empirical research into professionals' trust in their patients remains relatively rare and that half of the empirical articles in our review did little to conceptualise trust, a fairly obvious path forward is the development of more empirical studies which are more thoroughly informed by, and then 'speaking back' to, the emerging conceptual literature. In this sense, the existing sub-field remains pre-paradigmatic in the Kuhnian sense. Common reference points and usage of concepts will enable a critical engagement and discussion between researchers, with emerging empirical findings then being more thoroughly examined, and potentially replicated (or contradicted), across different settings. While, over time, this would form a useful basis for larger-scale comparative research—comparing different healthcare domains and national system settings—in the shorter-term, the field is most likely to be moved forward by in-depth, conceptually and theoretically aware studies using qualitative methods and smaller case-study designs.

As has been established above, while professionals' trust in patients is not ostensibly oriented by systems—given that patients are not themselves embedded in 'systems' as such (as is the case with patients' trust in professionals)—abstract systems of expert knowledge, legal regulation and organisational management, alongside lifeworlds (social institutions) of norms, values and moral codes, are fundamental to grasping the dynamics of uncertainty and vulnerability which characterise professionals' (dis)trust. Empirical research, which uses such systems, and the vulnerabilities and uncertainties they give rise to, as sensitising concepts (Blumer, 1954), will be well placed to do justice to the complexity, multidimensionality and nuanced nature of professionals' (dis)trust in patients.

Given that US-based pain management and opioid prescribing contexts are over-represented in the empirical studies reviewed above, a more 'transactional' culture in healthcare and the unusually dysfunctional history of opioid prescribing in the United States (see Fishman et al., 1999; Hall, 2006) distorts the wider findings and explains the preponderance of distrust in this review. A wider range of country and treatment contexts, alongside comparative studies, will be important in further characterising the influence of different systems.

In exploring trust dynamics, it is important, however, that professionals' trust is not reducing to systems and that researchers remain attentive to interactive dynamics and how strangers are (re)interpreted as they come to be 'known'. Attentiveness to the categories professionals use, alongside the core signifiers used when implicitly locating patients in particular categories (see Veltkamp & Brown, 2017; Warner & Gabe, 2004), would be one important analytical focus.

7 | CONCLUSION

In summary, we have identified key features of healthcare professionals' trust in patients reported in the literature (summarised in Figure 1). We have argued that both system and lifeworld understandings are vital to comprehending healthcare professionals' trust in patients, as these illuminate how multiple structures of accountability and related forms of vulnerability and uncertainties shape healthcare professionals' (dis)trust in patients, as well as the taken-for-granted assumptions drawn upon in categorising unfamiliar patients. We have suggested that the emerging conceptual literature be used to inform future empirical studies—initially more in-depth and smaller in

scale. Finally, we have argued that gradually developing empirical research across an array of different contexts is needed in order to compare different configurations of political-economic factors (systems) and socio-cultural lifeworlds, in order to better address and grasp the complex nature of professionals' trust in patients.

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