

# Patient-Physician Trust: An Exploratory Study

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**BACKGROUND.** Patients' trust in their physicians has recently become a focus of concern, largely owing to the rise of managed care, yet the subject remains largely unstudied. We undertook a qualitative research study of patients' self-reported experiences with trust in a physician to gain further understanding of the components of trust in the context of the patient-physician relationship.

**METHODS.** Twenty-nine patient participants, aged 26 to 72, were recruited from three diverse practice sites. Four focus groups, each lasting 1.5 to 2 hours, were conducted to explore patients' experiences with trust. Focus groups were audio-recorded, transcribed, and coded by four readers, using principles of grounded theory.

**RESULTS.** The resulting consensus codes were grouped into seven categories of physician behavior, two of which related primarily to technical competence (thoroughness in evaluation and providing appropriate and effective treatment) and five of which were interpersonal (understanding patient's individual experience, expressing caring, communicating clearly and completely, building partnership/sharing power and honesty/respect for patient). Two additional categories were predisposing factors and structural/staffing factors. Each major category had multiple subcategories. Specific examples from each major category are provided.

**CONCLUSIONS.** These nine categories of physician behavior encompassed the trust experiences related by the 29 patients. These categories and the specific examples provided by patients provide insights into the process of trust formation and suggest ways in which physicians could be more effective in building and maintaining trust.

**KEY WORDS.** Communication; physician-patient relations; patient-centered care; focus groups. (*J Fam Pract* 1997; 44:169-176)

*In medicine the yearning by consumers to be seen as individuals is particularly poignant because the relationship between doctor and patient is in many ways so intimate—and, too often, so distant.*

—Anna Quindlen<sup>1</sup>

The relationship between patient and physician is at the heart of the process of good medical care, yet remains largely unmeasured and unstudied. Current changes in the delivery of medical care, most obviously those occurring under the rubric of managed care, have potentially profound effects on the patient-physician relationship. For example, a patient's choice of physician may be restricted by the health plans offered by his or her employer. Continuity with the patient's usual physician may be

lost because of changes in plans offered by the patient's employer or changes in the plans in which the physician participates. Managed care organizations place primary care physicians in the position of "gatekeepers" for specialty care and access to diagnostic tests, a role viewed with suspicion by many patients. As a result of these factors, patients may enter their relationship with a physician with a lower level of trust. In addition, pressure to increase the efficiency of outpatient medical care may result in shorter appointment times, less continuity between outpatient and inpatient care, larger provider groups, and reduced access to the patient's personal physician for urgent appointments.

Results from a large national study found that patients in health maintenance organizations had a lower proportion of health-related visits to their primary physician, and were less likely to still be with their primary physician at the end of the 2-year study, compared with patients in a fee-for-service plan.<sup>2</sup> Concurrently, physicians are facing pressures to avoid medically unnecessary tests and referrals and to choose less expensive therapeutic alternatives, practices that may put them in conflict with patient expectations.

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All these changes may reduce the quality of the patient-provider relationship, including the level of trust patients have in their provider.<sup>3,4</sup> The personal relationship between patient and physician provides the context in which caring and healing occur.<sup>5</sup> This relationship is vital to choosing and implementing treatment that is medically appropriate and acceptable to and carried out by the patient. Trust is also important in reducing anxiety and increasing a patient's sense of being cared for, which in turn may improve the patient's sense of well-being and improve functioning. Trust is highly correlated with patient satisfaction.<sup>6</sup> Potential effects of a decline in patient-provider trust include lower patient and physician satisfaction, increased disenrollment, an increased demand by patients for referrals and diagnostic tests, poorer patient adherence to treatment recommendations, increased litigation, and possibly lower health status for some patients. Patient-physician trust may be especially important for the growing number of patients with one or more chronic conditions requiring ongoing management. Thus, it is important to understand which factors are important for patient-physician trust, how patient trust is established and maintained, and what the consequences are of high and low trust or lack of trust.

Despite the importance of trust to the practice of medicine, there have been relatively few studies of this topic. One previous qualitative research study of 84 adults with chronic disease describes the role of patients' confidence in their physician and how such confidence changed over time.<sup>7,8</sup> A closely related concept from psychology and psychiatry, the therapeutic alliance, has also been studied and found to be an important predictor of outcome in therapy in these fields.<sup>9-14</sup> A quantitative measure of patient-physician trust has been published<sup>6</sup> but apparently not utilized in subsequent published studies. Studies of trust from business<sup>15-17</sup> and sociology<sup>18-22</sup> have not directly addressed the issue of trust in the medical setting. Recent work on the "patient-centeredness"<sup>23-27</sup> or "humaneness"<sup>28</sup> of the office visit comes closest to addressing the patient-physician relationship, but has usually focused on a single office visit. One exception was a detailed study of seven patients followed for all their visits to their family doctor over the period of 1 year.<sup>29</sup>

To investigate patient-physician trust from the perspective of patients, we conducted four patient

focus groups and used qualitative research techniques to analyze the results. The goal of the study was to gain an understanding of how patients perceive trust of a physician and how patients relate physicians' behaviors to their perceptions of trust. While these issues are also pertinent for nonphysician care providers (eg, nurses, physician assistants), we chose to restrict our investigation in the current study to patient trust of physicians.

## METHODS

### SUBJECTS

Four focus groups, with a total of 29 participants (20 women and 9 men), were conducted between November of 1993 and December of 1994 in the San Francisco Bay Area. Participants were chosen from three diverse settings to provide a broad range of experiences. The different settings, in turn, necessitated different recruitment strategies.

The first two focus groups, one with 6 participants and the other with 10, were formed with patients from a university-based family practice. Six participants were recruited from a list of 12 long-time patients generated by the two senior physicians in the practice. The remaining 10 were recruited from a list of 43 randomly sampled patients who had visited the office within the past 6 months. The 12 women and 4 men in the two groups ranged in age from 26 to 72 years; all were white college graduates.

A third focus group was composed of 4 Latino women, aged 23 to 50 years, recruited from a random sample of 54 English-speaking Hispanic patients who had recently ( $\leq 6$  months) visited a family practice residency clinic in San Jose; all had a high school education or less. The fourth focus group was recruited by flyers posted in a publicly supported medical clinic in a lower income area. Flyers were used after calling a random sample of approximately 20 patients from the clinic failed to recruit a single participant. The 7 women and 4 men in this group were all African-American, aged 29 to 50; one had graduated from college, the rest had a high school education or 1 year of college.

### FOCUS GROUPS

Focus groups were conducted at each clinic site. Basic demographic data were collected from each participant at the beginning of the session.

Participants in the third and fourth focus groups each received a payment of \$20 at the end of the group session. Focus groups lasted from 1.5 to 2 hours and were led by a sociologist (B.C.) who was experienced in focus group research using principles of qualitative research.<sup>30,31</sup> Specifically, each session was opened with an introduction, an explanation of the ground rules (eg, no interrupting), and a statement of the overall purpose of the group. Participants were then asked to describe situations they had experienced that led them to trust a physician, and situations that had caused them to lose, or not to establish, trust. The role of the moderator was to encourage comments from all participants, to guide the discussion back to the central theme of experiences related to trust, and to ask for clarification or expansion on comments: eg, "Can you say what was different about your experience with [a previous physician]?" Each group was audio-recorded and the tapes were transcribed by a professional transcriptionist. In addition, an observer was present at each session to take notes regarding the mood, nonverbal communication, and general impressions. This information was used in the group consensus sessions described below.

### DATA ANALYSIS

Our working definition of trust was "the patient's confidence that the physician will do what is best for the patient." The transcribed content of the focus group was checked for accuracy against the original audiotapes by one of the investigators (D.H.T.). Transcripts were then independently coded, using techniques of grounded theory,<sup>32</sup> which provided a systematic approach to condensing the information contained in the over 100 pages of transcript. Using grounded theory coding as a model, patient statements from the first focus group were labeled by four independent readers (a physician, a sociologist, and a research assistant, plus either a nurse researcher or a second physician). The labels were then attached to the text using a word processing software called Ethnograph.<sup>33</sup> Labeled statements ("open codes" in the lexicon of grounded theory) were then grouped into conceptual categories ("axial codes") by consensus over several meetings. The process was repeated for each subsequent focus group, and the categories (axial codes) were modified to incorporate new types of statements. Thus, the final categories included the reported experi-

ences of all participants in all four groups.

This final "model" was reviewed by the readers. Analysis using the full grounded theory model, which requires iteration of the above procedures until additional focus groups provide no new information ("saturation"), was not performed because of the limited resources. Experiences are assumed to be true as related by the patients. No attempt was made to validate events using medical records, as the purpose of the study was to explore patients' perceptions of their experiences.

## RESULTS

Summarizing the complexity and richness of over 100 pages of transcribed results is challenging. We have chosen to illustrate the broader categories developed through coding and consensus with selected specific verbatim examples. Participants' reported experiences were grouped by study coders into nine general categories, each with several subcategories based on similar types of experiences (Table). Seven of these categories related to the physician-patient interaction: (1) thoroughness in evaluation, (2) understanding the patient's individual experience, (3) caring, (4) providing appropriate and effective treatment, (5) communicating clearly and completely, (6) partnership building, and (7) honesty/respect for the patient. Two additional categories not related to the interaction were predisposing factors and structural/staffing factors. Each of these general categories is discussed below, using both positive and negative examples.

1. *Thoroughly evaluating problems.* Participants related numerous positive experiences in which they felt that the thoroughness of treatment generated trust. A total of 29 statements from 18 participants fell under this category. The specific experiences included the physician taking a complete history and doing a physical examination; the physician seeking additional information on new treatments; and the physician ordering tests or making referrals.

*Example 1a (+)* "...I am really pleased with her thoroughness, friendliness, following through on something that, you know, might have been just questionable.... [1 minute later:] That gave me a greater feeling of trust that nothing's going to be overlooked." [78-year-old white woman]

Negative examples included instances where the physician was not as careful or as thorough as expected:

*Example 1b (-)* "He didn't pick up on the cough at all and didn't, you know, listen to my lungs....And I would complain about little things here or there and they were always kind of well, that wasn't very important." [66-year-old white woman]

**2. Understanding the patient's individual experience** For some participants, trust was closely related to feeling personally understood:

*Example 2a (+)* "I don't know, somehow it increases my trust in the doctor that they are interested enough in you as a person to want to know how I feel about the treatment." [35-year-old white man]

*Example 2b (+)* "My husband was a patient with very serious things for a long time, and Dr \_\_\_ and Dr \_\_\_ saw us all through it with great understanding of our desires." [85-year-old white

woman]

*Example 2c (+)* "Our relationship through the years has really been good. We understand each other." [50-year-old Latino woman]

Participants also provided examples where they felt a lack of trust because the physician treated their disease without sufficient attention to their individual experience with the disease:

*Example 2d (-)* "But I've run across [physicians] who are trying to tell me how I feel. First of all, you can't do that. You can say anything you want, but you can't tell me how I feel." [African-American man]

**3. Expressing caring.** This category had the most poignant positive and negative examples. Some of the most common positive examples were expressions of empathy and behaviors designed to relieve patients' pain or distress:

*Example 3a (+)* "He touches my hand and says everything is going to be okay....He kept saying, how are you doing, are you okay?" [34-year-old Latino woman]

*Example 3b (+)* "...she showed me a lot of caring. That she's interested in her patients, their health, their well-being, as a person and a patient. And that to me is a very caring thing that I feel." [African-American man]

Negative examples included ignoring pain or distress:

*Example 3c (-)* "So then I kept asking him to please give her something for the pain. And they did give her something after but not during the time that she was having it [a surgical procedure] done. So that was a bad experience." [50-year-old Latino woman]

TABLE

**Categories of Patient Experiences Positively or Negatively Affecting Trust**

1. <i>Thoroughly evaluating problems</i> Carefully reviewing history Demonstrating up-to-date knowledge Willingness to refer Searching for additional information Ordering tests Giving best effort	5. <i>Communicating clearly and completely</i> Active listening Acknowledging patient's concerns Explaining completely and honestly Answering questions Direct communication Being sensitive Being relaxed and calm
2. <i>Understanding patient's individual experience</i> Responding to patient's needs Knowing patient and family Taking into account patient/family preferences Avoiding assumptions Tailoring treatment to patient Treating patient as unique Considering "whole person"	6. <i>Building partnership/sharing power</i> Providing options Treating patient as an equal Trusting patient Open to new ideas, flexible
3. <i>Expressing caring</i> Concern for patient's comfort Expressions of concern/empathy Offering to help Reassuring and comforting Being hopeful Putting patient's interests first	7. <i>Demonstrating honesty/respect for patient</i> Admitting mistakes Honoring commitments Respectful, nonjudgmental
4. <i>Providing appropriate and effective treatment</i> Recognizing seriousness of condition Making correct diagnosis Achieving desired outcome Use of preventive services	8. <i>Predisposing factors</i> Training Age, sex Recommendations of other patients Professional appearance
	9. <i>Structural/staffing</i> Courtesy of office staff Messages to physician Obtaining laboratory results Access to physician On-call arrangements

4. *Providing appropriate and effective treatment.* Positive examples in this category were instances where participants perceived that physicians acted appropriately or that a good or bad outcome was due to the actions of the physician.

*Example 4a (+)* "[My husband] started having chest pains....I insisted an appointment be made the next day. It was made immediately. We went in, and within 15 minutes they were on the phone to get a heart specialist from \_\_\_\_\_ over here, who came and said it was very serious, there might eventually be open heart surgery, which there was some months later." [78-year-old white woman]

Conversely, participants related experiences of treatment they considered inappropriate that caused them to lose trust in their physician:

*Example 4b (-)* "When [my son] was about 4 months he all of a sudden got an incredible fever. He was very sick....I kept insisting there was something wrong with my son and basically begged the physician to take a blood test. Basically what she told me was, this is your first child, right?...She finally took a blood test. I got a call 3 days later from someone in the lab, who said, your child is very, very ill. He ended up having septicemia. We switched because I felt like, in that position, we couldn't trust our physician." [38-year-old white woman]

5. *Communicating clearly and completely.*

Communication was seen as integral to the quality of the care provided, and therefore an important contributor to trust. Good communication, both attentive listening and careful explanations, built trust:

*Example 5a (+)* "...if they spend a couple minutes listening to your particular situation...to me that has always generated a lot of trust." [38-year-old white woman]

*Example 5b (+)* "Trust seems to be more something you develop having the doctor give some feedback, having the doctor convey to you that they have a good feel for what's wrong with you...." [46-year-old white man]

*Example 5c (+)* "I can tell him anything and he really understands. And he explains things so that I understand it. Because he has been explaining things to me I have lost weight. I was a borderline diabetic." [50-year-old Latino woman]

Negative examples reflected a frustration and vulnerability at not being able to understand what the

doctor was doing or why and not being able to ask questions:

*Example 5d (-)* "So I was in the hospital 2 days and...the doctor walked in and said, 'Well, I want to tell you have lymphoma, but you're lucky.' And I said, 'Lucky about what?' 'Well, 80 percent cure from lymphoma, don't have to worry, 80 percent.' ...He walked out of the room." [66-year-old white woman]

*Example 5e (-)* "And if he asks if I have any questions, I feel like I am bothering him." [34-year-old Latino woman]

6. *Building a partnership.* Sharing power and working with the patient as a partner was seen as helping to ensure that patients had their preferences considered and their needs met:

*Example 6a (+)* "I like it when the doctor talks to me about what's wrong and what the options are." [35-year-old white man]

*Example 6b (+)* "She tells you and says, 'What do you think of this and what do you think we should do?' Then she talks it over with you." [50-year-old Latino woman]

Maintaining a hierarchical relationship, on the other hand, was perceived as blocking trust:

*Example 6c (-)* "...if I think that doctor feels that he's better than I am or that he's much more superior than I am, there's no way I can see him. I wouldn't trust him to do anything." [African-American man]

7. *Demonstrating honesty and respect for the patient.* There were no examples where honesty was cited as a factor that increased trust, perhaps because physician honesty is assumed. Examples of perceived dishonesty were few, but were particularly detrimental to trust when they did occur:

*Example 7a (-)* "But the only thing that really upset me...is...they made the agreement that [my physician] will deliver my baby, and she was here [at the clinic] and I kept calling when I had my baby. She never delivered my baby." [37-year-old Latino woman]

Like honesty, respect was most noticeable in its absence. Examples were predominately from first-time encounters in the emergency department or hospital:

*Example 7b (-)* "I was having these hot flashes and I went to talk with her. When I first met her,

she was really cross with me. She said, 'If you would dress a little better, not with the sweater in this heat....' She said it in an awful way." [50-year-old Latino woman]

In addition to the above examples of situations where participants experienced, or failed to experience, trust in their interactions with physicians, the focus groups identified several factors outside the physician-patient encounter that influenced trust.

8. *Predisposing factors.* Examples of predisposing factors were whether a physician was recommended by another patient and the physician's training, age, or sex:

*Example 8a (+)* "So I'm going in there [to see the recommended physician] with a certain amount of trust that this person is professional and this person is trained..." [35-year-old white man]

*Example 8b (+)* "It seems to me the older ones are smarter, I guess. They know exactly what is wrong all the time and what medicine to give us." [37-year-old Latino woman]

9. *Structural/staffing factors.* Examples were provided of how staffing factors, particularly in the areas of being able to communicate with the physician and to obtain information such as the results of laboratory tests, affected trust in the quality of care separately from trust in the physician:

*Example 9a (-)* "One of the hardest things I had is getting past the front desk. It has been a nightmare for me....It worries you when you don't have competent staff at the front desk." [38-year-old white woman]

*Example 9b (-)* "If you don't know if your messages are getting through, or if you don't know if your physician has the chart, how can they make competent medical decisions?" [41-year-old white woman]

Participants seemed to have little trouble distinguishing trust from satisfaction. The former they saw as relationship-specific, developing over time, while the latter was a result of the more mechanical aspects of each visit. As one 41-year-old woman participant stated, "You only come in five times a year, or your child does, and you see five different people, then...even if every interaction is okay and positive,

you don't get to build trust."

Participants noted that trusting a physician would make them more likely to listen to the physician's advice and to follow a recommended treatment. "This individual understands me and it is that trust. When you have that feeling about someone, you are going to take their advice and you will feel good and think this is right." [38-year-old white woman] "If you trust your physician, you are going to be listening more, you will be a little more attentive, a little more at ease." [37-year-old white man]

Because Latinos and African-Americans were from lower socioeconomic backgrounds than the white groups, it was impossible to separate differences by ethnic status from socioeconomic differences. Also, with only one group of Latinos and one of African-Americans, it is not possible to generalize the results with any certainty. Nevertheless, it is worth noting that the negative experiences cited by the African-American and Latino groups included several examples of lack of respect, lack of privacy, and deaths of friends or relatives due to what was perceived to be poor medical care; such dramatic experiences were not cited by the white group.

## DISCUSSION

The results of the current study are consistent with prior quantitative studies of patient satisfaction and communication in finding that both technical competency and interpersonal characteristics are important to patient satisfaction.<sup>34-37</sup> The current study suggests that while patients can and do distinguish factors that are primarily technical, eg, making the correct diagnosis, from those that are interpersonal, eg, explaining a treatment, they perceive both as being important in determining the quality of the care, and hence both are important for developing trust. This view is more in line with the view that interpersonal characteristics are another aspect of professional competence. Indeed, a striking impression from listening to the participants was that a good "bedside manner" is not just a desirable amenity, it is essential to providing competent care. Because the study was conducted on primary care patients, the results may not be generalizable to other settings. For example, patients undergoing major surgery may make clearer distinctions between technical competency and interpersonal attributes.

The distinction made between trust and satisfac-

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tion by participants in the current study has potential implications for quantitative health services measures. The correlation between trust, as measured by the Trust in Physician Scale, and patient satisfaction, as measured by the Medical Interview Satisfaction Scale, was .62,<sup>6</sup> implying that trust contributes substantially to a patient's satisfaction with her or his physician. Trust, however, unlike satisfaction, is a concept specific to a relationship; this specificity gives it more potential explanatory power. For example, finding that greater physician communication or a more patient-centered approach increases patient satisfaction<sup>38,39</sup> may make even more sense if thought of as increasing patient trust. Likewise, the finding that greater satisfaction is associated with increased adherence to treatment<sup>40,41</sup> seems to make more sense if *trust* can be substituted for *satisfaction*. The relationship between trust, satisfaction, and the above variables remains to be worked out. Until then, one should be cautious that changes designed to increase patient satisfaction, especially those that focus on efficiency and cost reduction, do not adversely affect patient trust.

In the one published quantitative measure of trust, the authors assessed three dimensions of trust: "dependability of the physician ('looks out' for the patient's best interests), confidence in the physician's knowledge and skills, and confidentiality and reliability of information between the physician and patient."<sup>6</sup> The findings from our study included reported experiences corresponding to physician dependability, knowledge and skills, and reliability. Interestingly, while privacy was an identified issue, confidentiality (not sharing information inappropriately with others) was not reported, perhaps because recognized violations of confidentiality are perceived as unlikely in the urbanized settings in which this study took place. Our study also identified several other potential dimensions to be considered in a quantitative measure of trust: mutual understanding, caring, communication ("interpersonal competency"), and respect for patient autonomy.

Our focus group results are consistent with several psychological studies of trust, defined as cooperative behavior that depends on one person's expectation that the other person will voluntarily act to the first person's benefit. Such studies have shown trust to be more likely in situations where communication is greater<sup>21</sup> and where there is an explicitly shared

goal, eg, an agreed upon goal for treatment.<sup>42</sup> Trust is also more likely when a person's autonomy is respected<sup>22</sup> and when the relationship is viewed as long-term.<sup>22</sup> Conversely, in situations where there is a discrepancy between the importance of the outcome to the person and the power of the person to affect the outcome, trust is less likely to occur.<sup>42</sup> This type of relationship exists when the patient cares most about the medical outcome but has little power to affect it, which is the situation if the physician is unwilling to share information and decision-making. By sharing information and decision-making, the physician can reduce this power differential and increase the likelihood of trust. Thus, the findings that better communication, mutual goals, and shared power are perceived as trust-enhancing by patients is consistent with this experimental evidence in non-medical settings.

This study had several limitations that should be noted. It is an exploratory study of a broad topic using a small number of focus groups composed of diverse participants. As in most qualitative studies, the participants were not statistically representative of any population, and the format did not allow for quantification of the frequency of the experiences reported. On the other hand, the qualitative research technique used in this study seems well suited to investigate patient-physician trust because it allows for identification of types of experiences that might not have been anticipated, and therefore not assessed in a quantitative survey study. Moreover, this approach encouraged participants to identify and explain the relationships between their experience and the development of trust, a dimension difficult to explore in quantitative research. Finally, while there was considerable agreement and easy consensus on the labeling of specific statements, defining the nine conceptual categories was less straightforward. There is overlap between some categories, and the choice of labels undoubtedly was influenced by preexisting concepts. These categories do, however, summarize the reported experiences of the participants in a way that is succinct, makes intuitive sense, and suggests relationships to be further explored.

Additional questions for further research include: (1) which physician behaviors are most important for establishing and maintaining trust, and whether these behaviors differ among ethnic groups; (2) how changes in the organizational structure of medical

care affect trust; and (3) what impact trust has on health outcomes, particularly for patients with chronic disease. Understanding the patient's experience of trust is an important first step in this research.

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