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On honesty and trust, gods and mortals: Gendered experiences of honesty and trust in patient-practitioner relationships

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ABSTRACT

Honesty and trust are crucial in patient-practitioner relationships. Gender also can exert a powerful influence on how patients experience health care. This article investigates the interplay of trust and honesty with gender, as lived by patients of primary health care practitioners in New Zealand. Research found that honesty was integral to patient trust across a range of primary health care providers and that gender was key in shaping both honesty and trust within patient-practitioner relationships. The research used the qualitative methodology of Memory-work and involved two groups of participants, one comprising five women, the other four men. The groups both met for five sessions, each session lasting at least three hours. Between them participants wrote 43 individual narratives (two absences) and generated more than 30 hours of recorded group work. Honesty emerged as a major theme for both the female and the male participants. There were three important similarities in how the women and men lived and understood honesty: the importance of the practitioner telling the truth, the 'location' of honesty in the practitioner as the other significant person in the consumer-provider relationship, and honesty being interpreted as a mark of respect for the individual patient. There were also fundamental differences between the women and the men relating to the importance of genuineness of health care providers and patients' assessments of practitioner honesty. These insights provide a rich starting point for designing improvements to current health care practice that are valued by the patient, and respectful of gender differences in the needs and wants of individual consumers.

INTRODUCTION

We 'know' intuitively that there is a strong connection between honesty and trust. Indeed, both honesty and trust are fundamental to our human experience but generally taken for granted. While we readily recognise that there is a close link between honesty and trust – as Jane stated above - there has been little research into how we live honesty and trust in our everyday relationships, particularly in our consumer-provider relationships.

This article reports research that explored the experiences of trust and honesty lived by consumers of primary health care services. We analyse the experiences and interaction of these constructs from the perspectives of the patient only, in the interest of deepening our understanding of how the consumers themselves actually live and make sense of these constructs. The research found that the female and male patients taking part in the research constructed honesty as a major dimension of their trust in a range of primary health care practitioners (PHCPs). It also found both similarities and differences in how the women and men configured Honesty as a theme.

Honesty and trust are considered to be critical in positive patient-practitioner relationships, with implications for health care assessment, intervention and treatment, patient satisfaction, and health care outcomes (O'Malley & Forrest, 2002; Thakur & Perkel, 2002). Gender too is understood to exert a major impact on patients' experience of health and health care because of its power as a social force in this context (Lee & Owens, 2002; Lorber, 1997). There are rapid and profound changes taking place to traditional models for the patient-practitioner relationship and to the way we live gender. These changes heighten the importance to improving health care services of understanding how female and male patients make sense of such key relational aspects as honesty and trust in their relationships with health care providers

THE RESEARCH

Method

Using the qualitative methodology of Memory-work, the research was conducted in New Zealand and involved two groups of participants, one comprising four men, the other five women. Each participant independently wrote detailed narratives of their lived experiences of trust, using pseudonyms and writing in the third

person, on a trust topic that had been chosen by the group. The participants then came together as a group to discuss and analyse the individual narratives for the 'common' sense or the social aspects of the experiences common to the group. Then their work was extended using thematic analysis to develop the groups' themes before linking their work to the marketing, health care, and gender literatures.

Both the women's research group and the men's research group met for five sessions, each session lasting at least three hours. Between them the research participants wrote 43 individual narratives (two absences) and generated more than 30 hours of recorded group work. The participants' narratives involved a range of primary health care practitioners (those health care providers who New Zealand patients can themselves choose to consult without needing a formal referral from another health care practitioner), including general practitioners, dentists, physiotherapists, chiropractors, osteopaths, alternative healers, and midwives. The research resulted in rich written and verbal descriptions of the trust that these participants experienced, and explored the meaning that these men and women themselves ascribed to trust across various health care contexts.

Research Findings

Honesty was a major theme in their trust experiences for both the women and the men who took part in the research. It was one of five sense-making themes for trust that were common to the women and the men across a range of different primary health care encounters (encompassing, for example, different medical and alternative health care services, different providers, and different health conditions). Their themes thus represented the common patterns of experience across the diversity they detailed in their relationships with PHCPs.

There were three key sub-themes evident in both the women's and the men's Honesty theme. These common sub-themes, which cut across gender, frame the 'concept' of honesty that these patients constructed in their patient-practitioner relationships. Regardless of gender, these patients

(a) perceived the practitioner telling the truth to be central to Honesty,

(b) located Honesty in the PHCP as the 'Other' significant person in the relationship (with 'Self' being the individual patient), and

(c) interpreted PHCP honesty as a mark of respect for them as individual human beings.

However, within the frame created by these sub-themes there were important differences in the shape that Honesty took, including variations by gender. Although they held the Honesty theme in common, there were fundamental differences in how these women and men both lived it and configured it as a theme.

Honesty and Telling the Truth

PHCP truthfulness was central to Honesty for both the women and the men. However, there were subtle differences in the ways the participants made sense of PHCP truth-telling. The women in this study particularly valued PHCP honesty in the form of practitioners telling the women the truth about their ability, or more correctly, their inability, to meet the women's health needs at the time. In this sense, practitioner honesty indicated an open truthfulness in their relating with the woman as an individual human being. Truthfulness about the practitioner's own capabilities implied honest, critical self-evaluation and an honest declaration of that self-evaluation to another person, namely the woman patient. When this honesty resulted in the woman being referred on to another health care practitioner then these women tended to interpret the honesty as an indication that the practitioner was sincere in putting the woman's needs above their own.

Capability was the primary focus of this sub-theme for the women. Although these women did provide a range of lived examples of the PHCP telling the truth about diagnoses, treatment options, and prognoses, their deepest discussion on the theme of Honesty centred on encounters in which PHCPs admitted they were incapable of addressing the patient's health issues. The participants detailed situations when the PHCP had admitted not having enough knowledge about a specific condition, and not having the necessary experience or skill to treat the problem. This sense of honesty that the women developed also included admissions by practitioners that formal health care delivery protocols or systems would not meet patient needs in particular circumstances.

In the positive experiences of these women, the most trusted PHCPs followed up honesty with immediate action – they worked to identify the knowledge or the health care professional necessary to help the patient. In this sense the practitioners were still actively working in the best interests of the women's well-being; however they had assumed the role of patient's 'agent', as it were, rather than hands-on health care provider at that stage. This marriage of PHCP admission and action ensured that the women were not left

feeling abandoned, helpless, hopeless, or vulnerable to the vagaries of the public health care system.

Similarly, the men based their Honesty theme based on the practitioner telling the truth. But they developed their theme more generally on basic verbal truth-telling by practitioners across a range of situations; for instance, informing the patient fully about his health condition, admitting that they had limited knowledge or experience with a condition, and answering patient questions truthfully. No one type of truth-telling situation appeared more important than the others. So, although it was located in the practitioner, the men's construction of Honesty featured PHCP truthfulness concerning the individual man's health condition as well as the practitioner telling the truth about her/his own capabilities to deal with it, which had been at the centre of this characteristic for the women. As well as verbal truth-telling, the male participants also perceived 'honesty' in more subtle forms of relational behaviours. For instance, these men regarded practitioners who were comfortable 'researching' (going to other sources for more information) in front of the patient as honest and realistic about their own personal capabilities.

For both genders, the telling-the-truth aspect of the Honesty theme centred on the scientific/technical information about a particular condition, and the PHCP's sharing of that information with the individual as patient. From the patient's perspective, these technical details can be understood to represent part of the knowledge base that endorse the practitioner's position as an 'expert' and the patient's position of vulnerability (Lupton, 1996). Participants revealed that honest sharing of these details indicated the practitioner was choosing not to misuse this latent power. PHCP honesty at this level is linked directly to the patient's right to know the truth regarding her/his health condition. This is at the same time a patient-as-consumer right (Lupton, 1997; Samson, 1999) and a fundamental human right (Bishop & Scudder, 1985; Chauhan & Long, 2000). Both rights apply across gender.

Honesty is Located in the Practitioner

Both the women and the men in this research related the Honesty theme directly to the PHCP, locating their honesty experiences in the practitioner as the Other key individual of the primary health care relationship. So, both genders constructed their Honesty themes around those attitudes, responses, behaviours, and relational dynamics that participants perceived were centred in the practitioner (as opposed to those located in the individual patient or in the relationship itself). The Honesty theme, as it was constructed by participants, was focused squarely on the practitioners; thus, by

inference, these women and men regarded the PHCPs to be largely responsible for managing Honesty within the relationship.

The women and the men also characterized the practitioners' relational behaviour according to whether it related mainly to the PHCP's intellectual and technical capability to deliver 'health' to the patient (the 'cure' dimension of health care) or mainly to the PHCP's interpersonal skills (the 'care' dimension). Both the women and the men participants made sense of PHCP honesty as a 'care' dimension. This distinction between cure and care dimensions, which these women and the men made clearly and quickly themselves during the group analysis and theorising of their individual experiences, is well-supported in the health care and the services literatures.

In health care services, where the patients as customers frequently do not have the experience or knowledge to evaluate the quality of the core 'cure' component, then they use 'care' aspects as surrogate indicators both of cure and of service quality (Gabbott & Hogg, 1998). Their data indicates that these participants also used surrogate cues specifically to indicate the trustworthiness of the PHCP. Particularly in the early stages of the patient-practitioner relationship, patients often do not 'know' the PHCP personally and have not yet experienced trust in that individual. Following the theorising that accounts for the care-cure surrogacy, it is plausible that Honesty is familiar and easy-to-identify 'care' construct that health care consumers across both genders employ to help them understand the more relationally complex phenomenon of trust. Certainly for these participants, their assessments (both intuitive and conscious) of PHCP truthfulness emerged as a key aspect of PHCP honesty, which in turn indicated trustworthiness.

Honesty and Respect

The women and men interpreted and lived PHCP honesty as a demonstration of respect for them as individual patients: respect for their right to an honest response, respect for their right to make their own informed decisions, and respect for their right to the best quality health care possible.

From the perspective of the women participants, PHCP honesty established a human-to-human bond that opened up the way for mutual sharing between the woman and the practitioner. Moreover, PHCP honesty indicated that the PHCP was not willing to risk the woman's health in the interests of himSelf (or herSelf). Instead of self interest (e.g., pretending to have the knowledge or expertise, in order to preserve or promote Self), the PHCP who was honest

toward the patient was working to serve the best interests of the patient.

The men lived the particular attitude, PHCP openness, as a mark of respect. An open, up-front manner in the practitioner was evidence of personal truthfulness – no facades, no hidden agendas. Openness enabled the patient to 'meet' the real person the PHCP was and to connect with that person: "*Trust is affected by the actual person...whether or not you feel as though you get on with them as a person*" (R.). Moreover, such openness in the PHCP encouraged the patient, in turn, to respond with honesty.

Men's Emphasis on PHCP Genuineness

In addition to the sub-themes discussed above, the men developed a fourth aspect to Honesty, centred on PHCP genuineness. This sense of genuineness can be understood as an honesty about the practitioner's Self that impacts the practitioner's relating to the patient. These men inferred Honesty from their sense of a practitioner's genuineness or sincerity, evident in practitioners who were "*decent guy[s]*" (R.), "*down-to-earth*" (Brent) in their manner, and/or related as a human being to these men.

The human qualities that constituted PHCP genuineness for these men, and the phrases used to express them, heighten the distinction lived by these men between "I am God" PHCPs (Jimmy) and those with their feet on terra firma. (The question begging to be asked at this point is: Do men find it difficult to trust God?) This sub-theme relates to the importance of a personal connection between patient and practitioner, and also points to issues for these men around relational power within the patient-practitioner relationship. Lack of knowledge and the traditional patient role both position the patient at a power disadvantage, a relational position that these men found decidedly uncomfortable at times. A practitioner who was honest with them, providing knowledge and respecting them as individuals, was signalling a relationship context in which these men could maintain their autonomy, which theorists hold is integral to the predominant contemporary male identity.

Another fascinating difference between these women and men in how they lived Honesty in relation to trust is revealed in the men's work dealing with assessing practitioner honesty. The men used various strategies to evaluate practitioner honesty including deliberate 'testing' of the practitioner and an innate sensory device that they called a "*built-in bullshit radar*" (R. & Jimmy). For example, at the end of the initial consultation and after agreeing to a quote to replace his amalgam fillings Dave decided to ask the

dentist to declare his position on dental mercury – to "*see if the dentist 'puts his money where his mouth is' "*".

Dave's testing of the dentist points to a suspicion that underlay the encounter. This suspicion, usually focused on the PHCP, emerged as a common characteristic across the health care experiences of these men. They revealed an undercurrent of suspicion that ran, at times very strongly, through their experiences, which could result in profound feelings of isolation and anxiety.

These men believed that trust was to be earned - they had been brought up to regard trust in this way (R.). From this perspective, trust was a transaction between the patient and the PHCP, calculated by the patient on the demonstrations by the practitioner of perceived trustworthiness or untrustworthiness. On this basis these men frequently started their relationships with PHCPs from a position of either suspicion or, at best, of neutrality. The men used the analogies of a water jug and bank account to explain that, from 'empty', their trust in the PHCP was increased or decreased according to whether they perceived their suspicions were allayed or confirmed. 'Testing' the practitioner's honesty was a straightforward means for the individual to decide what shape trust would take.

CONCLUDING COMMENTS AND IMPLICATIONS

Honesty was found to be an important indicator of PHCP trustworthiness for several reasons. First, simply it appeared to be a relatively easy indicator for the patients to use, evidenced in their focus on PHCPs telling the truth. Participants used honesty to indicate PHCP trustworthiness often, naturally, and with significant consequences for their trust in practitioners. Second, honesty gave these participants an indication of the practitioner-as-a-human-being rather than as a technician and thus has the potential, evidenced in the men's experience, to mark the difference between deeper relational trust, which R. called a "higher order of trust", and trust based on competence alone.

The intersubjective dimensions discussed in this paper underscore the relationality of trust and honesty, and the part played by both patient and practitioner in their creation. That both these women and men located their Honesty themes in the PHCP points to the need for practitioners to be mindful of the pivotal part they play in the construction of patient experiences of health care. Both the women and the men also drew attention to the connection between honesty and respect for them as persons. For the men, the genuineness of the practitioner was a particularly important aspect of PHCP honesty at this subjective level. These experiences all add

weight to the mandate for health care practitioners to attend to their relational skills - the 'care' skills of the health care service - and to understand the impact that their behaviour has on the overall quality of the health care encounter. It also reminds us of the complex interplay between relational constructs in our real-life encounters with others; we do not live any one of these relational constructs in isolation.

For consumers of primary health care services (medical and alternative) the work of these women and men underlines the importance of PHCP honesty as an indicator of the respect the practitioner has for the patient. From this, the research reinforces the ways in which consumers can 'use' PHCP honesty to indicate the trustworthiness of the practitioner. Finally, the dynamic relational dimension to the constructs of honesty and trust implies that the consumer, as well as the practitioner, has a mutual responsibility in negotiating more satisfying, effective health care relationships. In particular, being aware of how gender affects relational behaviour in this service context means that health care consumers can make more informed choices around the development – or not - of their relationships with primary health care practitioners.

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