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

AUTHOR(S): Mary FitzPatrick, Carolyn Costley, Lorraine Friend

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.

"You can trust honesty – you can't trust dishonesty" (Jane).

INTRODUCTION

We 'know' intuitively that there is a strong connection between honesty and trust. And there is an interesting etymological connection from "trust" to honesty through the word "truth" (Oxford University Press, 2005). 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 empirical investigation of how we live honesty and trust in our everyday relationships, particularly in our consumer-provider relationships.

Trust currently is receiving a good deal of attention from scholars within services marketing because of its critical links through customer satisfaction and service quality to customer loyalty and retention (e.g., Crutchfield, 2001; Sirdeshmukh, Singh, & Sabol, 2002). In the context of health care services, trust is regarded as critical for healing and a key dimension of successful patient-practitioner relationships (e.g., Thom & Campbell, 1997). However, despite the acknowledged importance of trust and a burgeoning interest in other constructs like honesty and respect, we have little understanding of how consumers themselves live them in their service interactions. It is vital that consumers articulate these relational phenomena in order for service providers to make real progress toward managing relationships that their consumers will experience as satisfying.

This article reports research that explored the experiences of trust and honesty lived by consumers of primary health care services. Following the design of the research, we analyse the experiences and interaction of these constructs from the perspectives of the consumer only. Neither the article nor the research includes the perspectives of the providers of health care services. This decision was made deliberately in the interest of deepening our understanding of how the consumers themselves actually live and make sense of these constructs. The insights from their work are relevant for health care providers and consumers, as well as scholars interested in energising research and theory on service relationships.

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. Our intent here is to describe and theorise the meaning of honesty that these participants constructed in relation to trust, and to discuss the interplay of gender with these two relational constructs in primary health care contexts. When we are referring to themes constructed by the participants we use capitals to distinguish them (e.g., Honesty, Respect) from the more general sense of these words.

The two relational constructs this article focuses on, 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 both of relational constructs (e.g., honesty and trust) and of gender in the context of the health care relationships that patients are living today. It is imperative that researchers and practitioners serious about improving health care services understand how female and male patients are making sense of such key relational constructs in their relationships with health care providers

This article is organised into three broad parts. It begins with a brief overview of the patient-practitioner relationship as a specific type of consumer-provider context, and then reviews our understanding of trust, gender, and honesty in order to locate this study within the existing literature and to sketch a conceptual framework for understanding the participants' experiences. The second part of the article details the research method and then discusses the research results, using themes developed by the women and men to make sense of their trust and honesty experiences. Finally, the article presents the implications of the study for marketing and health care practitioners, and for consumers of primary health care services.

LITERATURE REVIEW

The Patient-Practitioner Relationship

The patient-practitioner relationship is a vital part of the health/illness experience for most of us. It is in the context of this relationship that our physiological symptoms are transformed into diagnoses, and we learn and practise socially appropriate illness

behaviour. The relationship itself can be very complex, due largely to the circumstances in which it is created (Budd & Sharma, 1994).

The patient enters the relationship because s/he believes that the practitioner has expert knowledge, skills, or techniques that can help achieve specific health needs. The practitioner believes that s/he can help the patient to meet health care needs because s/he possesses expert knowledge, skills, or techniques that will contribute to the patient's well-being (Agich, 1983). Facing illness and the need to be in relationship with a practitioner, patient reactions can range from vulnerability and dependence to consumerism and self-responsibility. In these circumstances, issues of power and dependency can become serious relational problems (Doney & Cannon, 1997; Kumar, Scheer, & Steenkamp, 1995). From a marketing perspective, because of the common characteristics of health care context(s) and the nature of the services themselves, health care services are regarded as characteristically high risk and high involvement purchases for the patient (Gabbott & Hogg, 1998; Mitra, Reiss, & Capella, 1999; Ostrom & Iacobucci, 1995), characteristics that considerably heighten the uncertainty perceived by patients (Crutchfield, 2001; Fox, 2000).

Ways of being in relation to a primary health care practitioner have changed rapidly over the past few decades. While the traditional, biomedical model is still the dominant framework for patient-practitioner relationships in Western societies (Cant & Sharma, 2000; Lupton, 2002; Nettleton & Gustafsson, 2002), patients and practitioners today are negotiating alternative forms for these health care relationships. The biomedical model, from a social-political perspective, prescribes subjugation and silence as part of the traditional role of 'patient', and supports a health care culture founded on a patriarchal positivism and emphasising control through rationality and separation, practitioner-centredness, and a focus on short-term results (Miller & Crabtree, 2000; Waitzkin, 1991). In contrast, alternative patient-practitioner relationships are characteristically more mutual and shared, and centred on the patient (Robinson, 2003; Thakur & Perkel, 2002). Central to these new models are notions of relationality and the quality of interaction (Frank, 2002; Walker, Arnold, Miller-Day, & Webb, 2001).

Trust

High levels of uncertainty and perceived risk generate high levels of vulnerability and dependency in patients, and can also evoke intense feelings of ambivalence, dependence, and anxiety (Lupton, 1996). In such conditions patients choose to trust – or not - their primary health care practitioners, because trust offers them a

solution to “the paralysis of unbearable uncertainty” (Cassell, 1991, p. 76). In the face of uncertainty and anxiety, trust enables a confidence in the expertise and control that patients perceive in the practitioner and so, reduces their perceived risk. In this sense, trust is a means of simplifying complexity and moving on, despite the insecurity caused by uncertainty in risky health circumstances.

Trust increases the individual's willingness to seek care from a health care practitioner, disclose personal information, undergo treatment, and follow the practitioner's advice (O'Malley & Forrest, 2002; Thakur & Perkel, 2002). In health care contexts, trust facilitates cooperation and healing, and fosters empowerment for those patients keen to take more responsibility for their health care (Daniel, 1998; Johns, 1996). At the relational level, health care authors recognize patient trust to be a key component of the patient-practitioner interaction, impacting through the ‘health' of that relationship on the patient's health (Balint & Shelton, 1996; Leopold, Cooper, & Clancy, 1996; Mechanic & Schlesinger, 1996; Thom & Campbell, 1997).

From a marketing perspective, trust is linked to patient satisfaction and continuity with the practitioner (Derose, Hays, McCaffrey, & Baker, 2001; O'Malley & Forrest, 2002), it fosters patient retention and positive word of mouth, and thus increases earnings (Leisen & Hyman, 2001). Research also suggests that patient trust lowers those transaction costs involved in “reassuring the patient or reducing uncertainty, including additional tests and referrals, and costs associated with incomplete disclosure of information by the patient” (Thom, 2000, p. 246).

Honesty

The health care literature tends to conceptualise, theorise, and prescribe honesty as another relational aspect that health care practitioners should aspire to in their relationships with patients (e.g., Chauhan & Long, 2000; Thakur & Perkel, 2002). Again, like trust, honesty is mentioned frequently in the literature but there are few studies yet that have undertaken specific empirical investigation of the construct. Nursing academics, dedicated to developing a caring ideology to balance the over-emphasis on cure fostered by the biomedical approach (e.g., Hartrick, 2001; Parker, 1991; Watson, 1988), embed honesty in discussions of ‘therapeutic' relationships where the patient is respected and cared for with compassion, empathy, and authenticity (Chauhan & Long, 2000). Honesty, in these articles, is regarded as an integral element of ‘care' within the relationship.

Honesty is often linked with trust within the health care literature (e.g., Chauhan & Long, 2000; Montgomery, 1993; Potter, 1996). While the link between honesty and trust is implied in the majority of work, there is a small but growing group of research that (a) includes the construct of honesty on their empirical agendas, and (b) explicitly addresses the links between honesty and trust (e.g., Hall, Zheng, Dugan, Camacho, Kidd, Mishra, Balkrishnan, 2002; Leisen & Hyman, 2001; Safran, Kosinski, Tarlov, Rogers, Taira, Leiberman, & Ware, 1998). This group of research, mainly concerned with developing scales to measure patient trust (predominantly in medical physicians), posits honesty as a component of trust and thus helps to establish empirically the centrality of honesty in relation to trust in health care services.

Gender

Gender also is a social phenomenon in that, like trust and honesty, it is co-created in our interactions. We negotiate gender in relation to others (Annandale & Hunt, 2000; Lorber, 1997; Tavris, 1999). Gender is considered to be one of the most significant factors in the social construction of health and illness (Lorber, 1997). It impacts on illness through our economic circumstances, our work and family responsibilities, lifestyle choices such as diet and exercise patterns, and our patterns of interaction with health care practitioners (Annandale, 1998; Lorber, 1997; Popay & Groves, 2000).

Gender effects that have been noted in various health care contexts indicate that men tend to be less concerned about a variety of health risks than women (Andaleeb & Basu, 1995; Kahn et al., 1997); women are more likely to seek medical treatment for a given set of symptoms than are men (Kahn et al., 1997); men tend to keep quiet about their health problems, even with partners or close families (Cameron & Bernardes, 1998), and women report higher overall satisfaction (specifically with their physicians) than male patients (Mummalaneni & Gopalakrishna, 1995).

Conventional wisdom and research on gender emphasises gender as difference and the male or female occupancy of distinct social roles. However, over the past three decades this has given way under rapid social change to new conceptualisations of gender (Annandale & Hunt, 2000). Again, while the traditional gender models continue to be dominant, today there is a much wider range of masculinities and femininities available and practised. Evidenced in the move away from male-only and female-only samples to gender comparative samples, contemporary knowledge on gender is focussed on the complex dynamics of interacting roles and statuses, and people's gendered experience of roles as they are actively

constructed in real lives (Cameron & Bernardes, 1998; Mac an Ghaill, 1996). This article reflects that focus.

To conclude, given the acknowledged importance of trust, honesty, and gender, and their potentially profound effects (as separate influences) on patients' experience of health care, it is reasonable to expect that together they could create an important dynamic in patient-practitioner relationships. A review of the literature finds very little empirical research in any health care context that explores specifically the interactions of trust and honesty with gender. Therefore, this article extends the literature by qualitatively analysing new data that (1) focus on honesty in relation to trust across a range of primary health care practitioners, and (2) are grounded in the experiences of patients themselves.

THE RESEARCH

Method

Using the qualitative methodology of Memory-work (Haug and Others, 1987), the research was conducted in New Zealand and involved two groups of participants, one comprising four men, the other five women (FitzPatrick, 2004). Some of these people had responded to print advertisements about the research, others were accessed by 'snowballing'; final participants were selected using purposeful sampling techniques. All participants were able and eager to detail their experiences (positive or negative) of trust in primary health care practitioners. Participants' trust experiences covered 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). Examples of PHCPs provided by participants included general practitioners, dentists, physiotherapists, chiropractors, osteopaths, alternative healers, and midwives.

Each participant independently wrote detailed narratives of their lived experiences of trust. Participants used pseudonyms and wrote in the third person in order to disengage from the remembered experience and write fully about it from the point of view of an observer. The trust experiences chosen by the groups were evoked by agreed 'trigger' topics that each group felt explored and represented trust within the patient-practitioner relationship. 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, and the processes used to make sense of them. Their collective work was extended by the first author, 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 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 in various health care service contexts. This article focuses on the participants' construction of the theme of Honesty within those trust experiences.

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 stub-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. In the sections below we discuss in full the three sub-themes to Honesty that the participants held in common. We then go on to highlight

gender differences in their Honesty themes and in how these women and men related Honesty overall to trust .

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. The subject of this relational honesty generally concerned 'cure'-related aspects; notably the practitioner's ability to assess, diagnose, or treat a specific condition. However, even though the subject was 'cure', PHCP honesty was experienced by these women at a deeper level as a 'care' dimension in their trust experiences; 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.

A story Amy recounted during one group session about the treatment of her baby Katie illustrates well the construct of PHCP Honesty. In this case Honesty was displayed slightly differently by the Plunket nurse [a specialist child and community health nurse], by the locum GP, and finally by the midwife:

Katie was diagnosed as having a haemangeoma inside of her lip. The Plunket nurse said, "I don't know what to do about this." Our GP was on holiday and so we had a fill-in GP and she said, "I think I

know what she has but it's beyond me. She has to go a paediatric specialist because we don't know what to do about this. But I'm new. I've only been here a year." And I said "I'll call our midwife and I'll ask her [which paediatric specialist to take Katie to]." So I rang Constance [the midwife] and said "What about this particular one [paediatric specialist]?" and she said, "Yes, I like him very much. Yes, I would highly recommend that you go to him. But we have a problem. You have a gatekeeper." (She didn't say that but in a different word - "The receptionist is going to be a real you-know-what.") She said, "We'll get through this. I'm going to tell you exactly what to say." And she didn't mind me taking notes. She said, "I know you're a smart woman. Well, I know you are not going to have any problem, and if you do you get Peter [Amy's husband]." And so sure enough I said, "Okay I'm too scared. You deal with it." So he did. And he rang her up and said, "This is the situation and our daughter's been referred. She needs to see him." He said "Constance could have written the script," because the receptionist acted exactly like she predicted, I mean, step by step by step, and he just pushed on through and he said, "No. We were told she has to see him. You look in your book and you tell me when the next available appointment is." He just kept on and in time she came back and said, "Well, next week."

In the positive experiences of these women, such as Amy's telephone 'encounter' with her midwife, 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. In the men's experiences the dialogic direction of truthfulness about the patient's health condition is from the practitioner outwards to the patient, and thus it has the patient at its centre. In contrast, the specific PHCP truthfulness about clinical capabilities that was so valued by the women, is directed inwards toward the practitioner Self, and concerns the practitioner's own cure-related capabilities.

As well as verbal truth-telling, the male participants also perceived 'honesty' in more subtle forms of relational behaviours. Practitioners who were comfortable 'researching' (going to other sources for more information) in front of the patient were regarded as honest and realistic about their own personal capabilities:

"He [PHCP] declared his difficulties as a GP trying to make sense of all the medical issues and the many sources to access for new information" (Brent).
"Not trying to be God but just trying to be a real person and saying…'This is what I think it is, I'll just back it up with…'" (Jimmy).

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 endorses 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 men made clearly and quickly themselves during the collective analysis and theorising of their individual experiences, is well-supported in the health care and the services literatures.

Health care researchers theorise that the 'cure' or scientific-technical dimension to the practitioner's delivery of health care service relates to the 'medical'/'science' content of the health care delivery and how proficiently specialist health expertise and knowledge are applied to the assessment, diagnosis, and treatment of a health concern: specifically, what health care is delivered . The 'care' or psychosocial elements of the service delivery constitute the subjective dimension describing how the health care is delivered (Carmel & Glick, 1996; Gabbott & Hogg, 1998).

Parallel distinctions are found in the services literature, based on the classic service model proposed by Gronroos (1984) in which he divides service performance into the 'technical' or 'instrumental' dimension, and the 'functional' or 'expressive' dimension.

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:

Louise: How do you feel about a doctor or a health care practitioner admitting that they don't know all the answers?
Jane: Mine does it all the time.
Amy: It makes me feel like they're a real person and they really care…Because they're a human being I expect them not to know everything and if they come across like they know everything, warning bells start going off in my head, thinking something is wrong.
Jane: My GP he says "No I'm sorry I can't do this. Bye I'm ringing the hospital now – they'll see you there."
Melissa: I think somebody who admits they don't know what they're dealing with is going to find out how they are going to deal with you - somebody that sits there and makes believe they know what they're dealing with is going to fuddle on and probably treat you wrong because they don't know what they are dealing with, they're not willing to admit it and they won't look up and read up about it.
Amy: I think there is an element of fear in there because if they're coming across like this then maybe they really don't know and they're putting on an act and they could actually make it worse.
Jane: You can trust honesty - you can't trust dishonesty. And that's one of the big things with my GP.
Louise: And so what are we risking when our practitioner is being dishonest?
Jane: Your life.
Melissa: Yeah.
Amy: Mmm.
Melissa: Or at least your health.

The men lived 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:

Jimmy: They're not playing God.
Brent: No.
Jimmy: And they're basically making it comfortable enough for us to open up and say whatever you may want to say…Just not [relating] in that patronising manner. Not condescending or patronising…
R.: And being generally focused on you.
Dave: Yeah. Able to say 'Look, I need to check a reference on this', or, you know, 'I need to get a book to go and find something out…'.
Jimmy: Yeah. Not by saying 'I'm God. I know all'. And 'Look at the certificate on the wall'…[but] getting comfortable before you start talking about…what's happening for you.
Brent: Guys aren't used to sharing those sorts of things, are they?
R.: No.
Brent: They maybe share them with their wife, but actually sharing them with another male is a challenge to the old comfort zone.

During a collective analysis of the links between Honesty and patient trust, Dave explained that he felt safe with a practitioner who related to him in an open manner; in contrast with

...*being made to feel small or ignorant or just not really explaining things thoroughly, like 'It's nothing you really need to know about'. And you feel vulnerable in that situation. You want to be in a situation where you can be respected.*

This comment indicated that PHCP honesty was experienced as a sign of respect for him as an individual, a signal to the patient that his vulnerability would not be exploited, his self-esteem which is central to the traditional concept of masculinity (Cameron & Bernardes, 2000), was safe in this patient-practitioner relationship.

Finally, to extend the participants' work, we see that it is possible that the Honesty theme is common to the women and the men by virtue of their shared humanity and position as 'patient' in these primary health care relationships, and therefore it transcends gender at this more abstract level of theme. At this level Respect becomes a vital aspect of honesty and trust when we understand that it restores and maintains the humanness of the individual in a relational context that under the biomedical model dehumanises patients in general (Miller & Crabtree, 2000), awarding power to the practitioner and prescribing obeisance and compliance for the patient, regardless of gender. The nursing literature provides theoretical support for this notion that Respect and Honesty are

PHCP care responses common to these participants because of their shared humanness and their shared position as ‘patient'.

Contemporary nursing theory on caring rests on the assumption that caring is a natural human condition, a relational involvement and responsiveness that is triggered by the inherent vulnerability of health care patients (Montgomery, 1993; Noddings, 1984). According to participants, PHCP honesty affirmed the individual as a person. In this sense, PHCP honesty distinguishes patients from objects and thus signals a way of relating in which the practitioner is treating the person as a valued human being (Buber's ‘I-Thou' relation) rather than as an object (‘I-it') (Gadow, 1985; Chauhan & Long, 2000). PHCP honesty at this level thus involves the basic rights of patients as human beings, and therefore challenges us to address the wider issues of human ethics implicit in the patient-practitioner relationship.

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 (King, 2003; Peter & Morgan, 2001).

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' "*:

A momentary pause, which seems a little longer than just a moment. Dave notices that there seems a slight narrowing of the eyes, a stiffening of the back. The smile is gone to be replaced by a more neutral expression. He replies: "Me? Oh, I've still got poison in my mouth." No smile accompanies this quip. There is instead a curt politeness which indicates that the conversation is over…Dave senses he'd overstepped the mark and he figures the last thing you really want to do is piss off your dentist.

Dave committed to the treatment but the dentist's perceived dishonesty had the effect of limiting the trust that Dave had in him. Dave trusted the dentist's technical ability "to do the job" and was prepared to undergo treatment (extremely competitive quote for service, high tech equipment, two-hour treatment) even though he did not trust the dentist personally. Dave's trust was based on his predominantly cognitive appraisals of the dentist's efficiency and competency, similar to Andaleeb's 'unstable trust' (1992) in that Dave questioned the dentist's motives but trusted his competence. Dave's experience did not include the subjective, emotional dimensions that distinguish the deep relational trust that theorists contend is intrinsically preferable (Barney & Hansen, 1994; Murphy & Gundlach, 1997).

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.

The “built-in bullshit detector” explained by the participants referred to a “gut feeling” that alerted the patient to practitioners who were perceived to be “quacks” - those who were “pretending to be…doctor[s]” (Jimmy) or who “talked a load of rubbish” (Brent), for instance. Perceived practitioner dishonesty set off the detector and signaled an untrustworthiness in the practitioner. The participants developed the detector metaphor quickly and naturally during their group work. It appeared to be a shared way of understanding and communicating some of the more intuitive processes these men used in their trust experiences, and provided colourful insights to one of the links between honesty and trust as they lived it.

CONCLUDING COMMENTS AND IMPLICATIONS

This article has discussed the experience of Honesty lived by patients in their primary health care relationships. Research participants revealed that Honesty was integral to their construction of trust in their health care service providers. The women and the men developed Honesty into a distinct theme in their understanding of patient trust, and thus underscored its intrinsic importance as a separate facet in their construction of patient trust. They lived both as complex multi-dimensional relational constructs, that were embedded in the immediate context of the patient-practitioner relationship and also, through gender, in the wider socio-cultural context.

Honesty has strong connections through basic human needs and values to notions of shared humanness, which implies the need for primary health care practitioners to relate with patients as one human being to another. The contemporary Western health care context has strong roots in a science of health that alienates the practitioner from the patient, and distances the two from each other as living, feeling human beings. The implication here is that practitioners incorporate in the individualisation of their service conscious efforts to ‘re-humanise' their interactions to meet patient trust needs that are founded on the notion of shared humanity. This suggests that the PHCP consider stepping out over any line drawn to separate practitioner from patient and instead relate one human being to another, regardless of prescribed social roles (e.g., patient, gender) and expectations.

Their data revealed that both the women and the men participants used PHCP honesty as an indicator of the trustworthiness of the

PHCP. Honesty was an important indicator 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:

R.: Trust is affected by the actual person. There's a sort of ‘personality' to it, which is to do with just whether or not you feel as though you get on with them as a person, and whether or not you think they're a decent guy or not…
Jimmy: It's ability but it's also…yeah…
R.: It's a sort of gut feeling about what sort of person they are.

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. This adds 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.

Both the women and the men also drew attention to the connection between honesty and respect for them as persons. Marketing scholars theorise links between honesty, respect, and trust (e.g., Friman, Garling, Millett, & Mattsson, 2002; Ganesan, 1994; Kumar, Scheer, & Steenkamp, 1995) but do not illuminate the subjective aspects of these trust facets. For the men, the genuineness of the practitioner was a particularly important aspect of PHCP honesty at this subjective level, a focus well-supported in the nursing literature (e.g., Chauhan & Long, 2000; Montgomery, 1993).

The gendered differences in their Honesty themes represent those aspects that the participants lived quite differently. PHCPs who respect these differences can be sensitive and responsive to gendered needs and relational patterns in their interactions with patients. For example, this article clearly highlighted PHCP suspicion as an issue that was critical in the men's constructions of honesty

and trust. Primary health care practitioners who are reflexive about their own place and responsibilities in constructing patient trust, and aware of gendered needs and relational patterns in their interactions with patients can take steps to actively generate, sustain or disrupt patterns in the interest of fostering better quality patient-practitioner relationships.

The Honesty sub-themes pinpoint specific aspects of the patient-practitioner interaction that are vital to trust according to these participants and therefore act as signposts for any primary health care practice aiming to improve patients' health care experiences.

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.

For marketing practitioners, this article demands that we broaden our research focus from the individual consumer as an isolated unit to take in the relational sphere in which individuals are interdependent. It is in the context of their relationships that an individual's behaviour becomes meaningful.

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