A Study on Trust in Doctors Among the Patients Attending General Outpatient Department of Medical College, Kolkata

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ABSTRACT
Patient's trust has been defined as the patient's hopeful acceptance of a precarious circumstance where they believe the medical professional to look out for their greatest interests. Trust is crucial because it helps people manage risks and uncertainties and shapes potential behaviors in future. Objectives of this research were to find out the socio-demographic characteristics of the patients attending general outpatient department of Medical College, Kolkata, to estimate the trust in doctors among the study participants, to examine the relationship between trust in doctors and the socio-demographic characteristics and finally to explore the perspective of doctors regarding barriers to trust in doctors (if any) among study participants. A Facility-based observational descriptive type of epidemiological study having study design of a cross-sectional survey comprising both quantitative and qualitative methods. (Mixed-methods design with Convergent parallel approach: QUAN+QUAL)was conducted in the proposed study area among 101 participants. Key informant Interviews were conducted among doctors posted at GOPDs. Trust in Physician scale was used to estimate trust in doctors. Mean Trust in physicians score was 41.04 (±10.59).79.21% of the study participants did not have complete trust in doctors. Significant statistical relationship was found between trust in doctors and, age, type of family, education and occupation. Information from the KIIs revealed 4 major themes: (1) Doctor-related barriers, (2) Patient-related barriers, (3) Common cultural barriers and (4) Physical barrier. AETCOM (Attitude, Ethics and Communication) training and local language proficiency for non-native speakers is necessary to develop greater trust.

INTRODUCTION

It has been widely held that one of the most important aspects of health care is the degree of authority and autonomy that patients and physicians exhibit during healthcare interactions[1]. Several studies show how crucial it is for patients to seek knowledge and to be involved in the treatment they receive along with how much they wish to have control over their medical care[2-4]. Interpersonal trust is a vital aspect of patient-clinician relationships that may be connected to the needs of patients for control. Trust has a crucial role in medical interactions, as has long been understood[5,6]. The American Medical Association argues that the doctor-patient relationship is a moral endeavor built on a trust pact[7]. In the same way that love or friendship define the quality of an interpersonal connection, trust is the fundamental trait that provides the relationship between physicians and their patients meaning, significance and depth. Many aspects of medical ethics have as their primary purpose the preservation, enhancement and justification of trust. These goals are also significant in health care law and public policy[8-11]. Trust is widely considered an instrumental value that is necessary for therapeutic experiences to be fruitful[12]. Numerous significant behaviors and attitudes, such as patients' readiness to seek care, disclose private details, complete therapy, engage in surveys, follow treatment plans, stay with a physician and refer doctors to others, have been hypothesized or demonstrated to be influenced by it[13-16]. There are many definitions of trust that have been put forth, both specifically for the medical field[17,18] and in general[19,20]. Patient trust has been defined as the patient's hopeful acceptance of a precarious circumstance where they believe the medical professional to look out for their greatest interests[21]. This acknowledges that there is a substantial control and knowledge gap between the patient and the provider and vulnerability on the patient's end arises from their experience of disease where the patient's health and well-being are at stake[22]. Consider it further, trust is unnecessary if there is no vulnerability. The medical establishment as an entirety, hospitals, clinics, health insurance companies and medical professionals themselves can all be considered the object of trust[21]. Doctors have a key position in the provision of healthcare services, and the interaction they have with patients is vital to the engagement. Our study focusses on the trust of patients in doctors. High-trust relationships may yield specific benefits in the context of doctor-patient interactions. Patient loyalty, decreased risk perceptions and decreased medical care-shopping are just a few advantages linked to patient trust in physicians[23]. In their research Hall[21] proposed a paradigm suggesting that trust between patients and their physicians is based on patients' vulnerability and their consequent reliance on and confidence in the doctors' skill, drive, integrity and confidentiality[21,22,23]. Even with the current surge of studies on the subject, patient trust is rarely the primary aim and is typically only one of many related sub topics especially in Indian setting. No measurement tool alone, can entirely capture every nuance of this complex relationship. Thus, conceptual analysis by qualitative exploration must go hand in hand with the quantitative approach to get the perspective from both the stakeholders of interpersonal trust, i.e., doctors and patients.

Objectives: In consideration of the above background, we conducted our research with the objectives to find out the socio-demographic characteristics of the patients attending general outpatient department of Medical College, Kolkata, to estimate the trust in doctors among the study participants, to examine the relationship between trust in doctors and the socio-demographic characteristics and finally to explore the perspective of doctors regarding barriers to trust in doctors (if any) among study participants.

MATERIALS AND METHODS

Our study was a Facility-based observational descriptive type of epidemiological study having study design of a cross-sectional survey comprising both quantitative and qualitative methods. (Mixed-methods design with Convergent parallel approach: QUAN+QUAL). It was conducted in the general outpatient department of Medical College, Kolkata. There were two GOPD rooms-one for male patients and another for female patients. The study was conducted from the month of November to December of 2023.The quantitative strand was conducted among all the patients attending the general outpatient department of Medical College, Kolkata and the quantitative strand was conducted among all the doctors posted in the general outpatient department of Medical College, Kolkata. According to research by Banerjee *et al.,* 38.89% of study participants did not have total trust in their doctor, according to the Trust in Physician scale[24,25]. A minimal sample size of 101 was determined (after rounding off) using the standard Cochran's formula, taking into account an absolute precision of 10% and a non-response rate of 10%. Physicians attending GOPDs at Medical College, Kolkata, were identified for the qualitative investigation. Interviews with key informants continued until no new information could be obtained. Systematic random sampling was applied after proportionate stratification for the quantitative strand. According on statistics from the OPD register from the previous month, on average, 67 patients attend the Female GOPD and 22 patients attend the Male GOPD. 101 samples were split 67:22, or proportionately. That leaves 25 men and 76 women after rounding off.

Purposive sampling was used for the qualitative strand. We included in our research all patients attending the general outpatient department of Medical College, Kolkata during the study period and who granted written informed consent. Individuals with severe medical conditions or mental disorders that prevented them from responding appropriately were not enrolled. All physicians who had been assigned at Medical College, Kolkata's general outpatient department for at least six months and had given written informed consent were included in the qualitative investigation. Pre-designed, pre-tested, semi structured data collection form containing information on socio-demographic characteristics of study participants and questions from Trust in Physician Scale[24], was prepared. The 'Trust in Physician Scale' yielded a score ranging from lowest (11) to highest (55) on the Likert Scale, with the higher scores indicating more trust. Eleven components make up this instrument that gauges interpersonal trust between a doctor and patient. Its three-dimensional structure evaluates a doctor's trustworthiness, confidence in their expertise and abilities and the confidentiality and accuracy of the information they provide. A patient with highest score indicated 'having complete trust' and any score less than top score indicated 'not having complete trust'[24]. Local-language versions of the form were face- and content-validated by public health experts. This was tested for internal consistency (Reliability) through Cronbach's alpha (0.83).Interview guide and Free listing form were also prepared for Key informant interviews (KIIs).Every KII lasted roughly 20 minutes and was recorded on audio only with consent. The Institutional Ethics Committee for Human Research and Scientific Advisory Committee of the Medical College, Kolkata granted the necessary approval before the research could begin (Vide Ref No. MC/KOL/IEC/NON-SPON/1849/04/2023, dated 17.04. 2023). The participants were informed of the study's objective and the confidentiality of the findings. Anonymity was preserved throughout the whole study, and individuals were identified by their serial numbers. Collected quantitative data were entered into Microsoft excel spreadsheet 2021.According to the March 2023 update to the Modified B.G. Prasad socioeconomic classification, socioeconomic status was determined[26]. Final Information Sheet was prepared and analyzed using SPSS version 20.Suitable tests for statistical analysis were used (example-chi-square test) to examine relationship among variables at p≤0.05 level of significance. With Microsoft Word (2021), qualitative data were verbatim transcribed and relevant codes were created utilizing both deductive and inductive methods. In order to identify relevant themes and sub-themes, thematic analysis was done manually. Visual Anthropac-Freelist software was used to calculate Salience scores.

RESULTS AND DISCUSSIONS

Socio-Demographic Characteristics: Mean age (±2SD) of the participants was 37.14 (±29.04) years and median age was 38 with IQR of 16.50 years.The patients were aged from 15 years to 86 years rendering the range to be 71. As per sampling 74.26% (75) and 25.74%(26) female and male patients were selected respectively. Amongst them 53.47% (54) followed Islam and the rest were Hindu by faith. 69.31% (70) of the study participants were from general category of caste.67.33% (68) of the patientscame from joint families. Considering their residence, 68.32% (69) were rural residents.33.66% (34) of the study participants were from lower middle (IV) socio-economic status as per Modified B.G. Prasad socio-economic classification updated on March 2023. 19.80% (20)of the participants were illiterate. Regarding their occupation, 56.44% (57) were homemakers. 68.32% (69) were currently married.

Trust in Physicians Score: Mean Trust in physicians score (±2SD) was 41.04 (±21.18) and median Trust in physicians score was 39 with the IQR of 21.The Trust in physicians score ranged from 21-55 (Range=34). 79.21%(80) of the patients did not have complete trust in doctors.

Relationship Between Trust in Doctors and Socio-Demographic Characteristics: Significant statistical relationship was found between trust in doctors and age, type of family, education and occupation of the participants.

Qualitative Exploratory Findings: Through the Key Informant Interviews, 10 doctors: all who attended patients at GOPDs for at least 6 months (4 men: K3, K4, K6, K10 and 6 women: K1, K2, K5, K7, K8, K9) shared their perspectives on perceived barriers to building trust in doctors among patients. Information from the KIIs revealed 4 major themes: (1) Doctor-related barriers, (2) Patient-related barriers, (3) Common cultural barriers and (4) Physical barrier. Under the first theme, the major sub-themes were "Hasty consultation", "Impolite behaviour" and "Intimidating attitude". In case of "Hasty consultation"-related barriers, lack of individual counselling emerged as a vital aspect that is commonplace due to huge footfall of patients. In this context K1 commented:
"Sometimes we have to just prescribe and call for the next patient without verbal instructions because we have to clear the overcrowding as soon as possible."
Under the "Impolite behaviors" sub-theme, Lack of cordial and polite behavior with patients posed a major concern. K2 reiterated in this regard:
"If you are polite and humble then the patients will keep coming back to you. Unless are polite they will seek other doctors naturally."

Table 1: Distribution of Study Subjects According to Trust in Physicians-Score and Selected Socio-Demographic Variables (n=101)

Variables	Trust in doctors		Trust in Physicians score (mean±2SD)	Statistical test
	Do not have Complete trust,n (%)	Have complete trust,n (%)		
Age (in years)				χ²(df)=5.755 (1)
38 years and below	50 (87.72)	7 (12.28)	40.42±18.578	**P=0.016***
Above 38 years	30 (68.18)	14 (31.82)	41.84±24.278	t=-0.666
Gender				χ²(df)=3.648 (1)
Male	24 (92.31)	2 (7.69)	35.31±16.176	P=0.056
Female	56 (74.67)	19 (25.33)	43.03±21.35	t=-3.363
Religion				χ²(df)=1.857 (1)
Hinduism	40 (85.11)	7 (14.89)	38.51±21.718	P=0.173
Islam	40 (74.07)	14 (25.93)	43.24±19.872	t=-2.286
Caste				χ²(df)=0.591 (1)
General	54 (77.14)	16 (22.86)	39.43±22.234	P=0.591
Reserved	26 (83.87)	5 (16.13)	44.68±16.728	t=-2.348
Type of family				χ²(df)=4.075 (1)
Nuclear	30 (90.91)	3 (9.09)	36.55±19.294	**P=0.044***
Joint	50 (73.53)	18 (26.47)	43.22±10.402	t=-3.096
Place of residence				χ²(df)=3.707 (1)
Rural	51 (73.91)	18 (26.09)	43.67±20.232	P= 0.054
Urban	29 (90.63)	3 (9.38)	35.38±18.856	t= 3.914
Socioeconomic status#				χ²(df)=2.446 (1)
Middle and above	42 (85.71)	7 (14.29)`	37.88±20.908	P=0.118
Below middle	38 (73.08)	14 (26.92)	44.02±19.844	t= -3.029
Educational status				χ²(df)=23.278 (1)
Illiterate	8 (40.00)	12 (60.00)	52.40±8.764	**P=<0.001***
Literate	72 (88.89)	9 (11.11)	38.23±19.538	t=6.311
Occupational status				χ²(df)=6.105 (1)
Not engaged in gainful employment	55 (73.33)	20 (26.67)	42.80±22.112	**P=0.013***
Engaged in gainful employment	25 (96.15)	1 (3.85)	35.96±14.248	t=2.944
Marital status				χ²(df)=1.956 (1)
Currently married	52 (75.36)	17 (24.64)	41.88±22.214	P=0.162
Currently not married	28 (87.50)	4 (12.50)	39.22±18.574	t=1.179

* P<0.05-conveying statistically significant relationship.
# Socioeconomic status of the participants as per Modified B G Prasad scale (updated March 2023).

Table 2: Distribution of Study Participants According to the Answer to the Items in Trust in Physicians Scale (n=101)

Item	Strongly agree ,n (%)	Somewhat agree, n (%)	Neither agree nor disagree, n (%)	Somewhat disagree, n(%)	Strongly disagree, n(%)
"I doubt that my doctor really cares about me as a person"	6 (5.94)	22 (21.79)	16 (15.84)	24 (23.76)	33 (32.67)
"My doctor is usually considerate of my needs and puts them first"	36 (35.64)	19 (18.82)	11 (10.89)	31 (30.69)	4 (3.96)
"I trust my doctor so much I always try to follow his/her advice"	64 (63.37)	35 (34.65)	2 (1.98)	0 (0.00)	0 (0.00)
"If my doctor tells me something is so, then it must be true"	50 (49.50)	36 (35.64)	12 (11.88)	3 (2.98)	0 (00.00)
"I sometimes distrust my doctor's opinion and would like a second one"	14 (13.86)	36 (35.64)	2 (1.98)	12 (11.88)	37 (36.64)
"I trust my doctor's judgments about my medical care"	52 (51.49)	47 (46.53)	2 (1.98)	0 (0.00)	0 (0.00)
"I feel my doctor does not do everything he/she should for my medical care"	16 (15.84)	34 (33.66)	11 (10.89)	11 (10.89)	29 (28.72)
"I trust my doctor to put my medical needs above all other considerations when treating my medical problems"	37 (36.63)	10 (9.90)	20 (19.80)	24 (23.77)	10 (9.90)
"My doctor is a real expert in taking care of medical problems like mine"	61 (60.40)	32 (31.68)	4 (3.96)	4 (3.96)	0 (0.00)
"I trust my doctor to tell me if a mistake was made about my treatment"	26 (25.74)	11 (10.89)	4 (3.96)	24 (23.77)	36 (35.64)
"I sometimes worry that my doctor may not keep the information we discuss totally private"	4 (3.96)	17 (16.83)	22 (21.78)	16 (15.84)	42 (41.58)

Table 3: Summary of the Free-Lists and Calculated Salience Scores (Each Free-List has Multiple Responses., Total Free-Lists= 10)

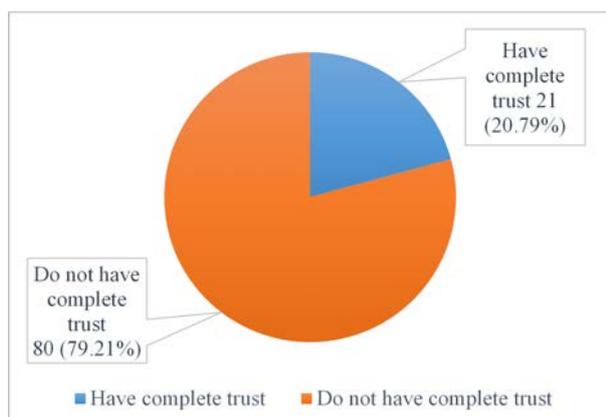| Item	Frequency of appearance among free-lists, n (%)	Salience using Smith's S score
Communication barrier	4 (40)	0.350
Hasty consultation	5 (50)	0.308
Medical jargons	4 (40)	0.248
Impolite behaviour	2 (20)	0.200
Language barrier	4 (40)	0.188
Education gap	3 (30)	0.179
Lacking privacy	3 (30)	0.175
Costly medicines	4 (40)	0.150
Negligence	2 (20)	0.146
Economic gap	3 (30)	0.143

Fig. 1: Distribution of Study Participants According to Trust in Doctors as Per Trust in Physicians-Score.(n=101)
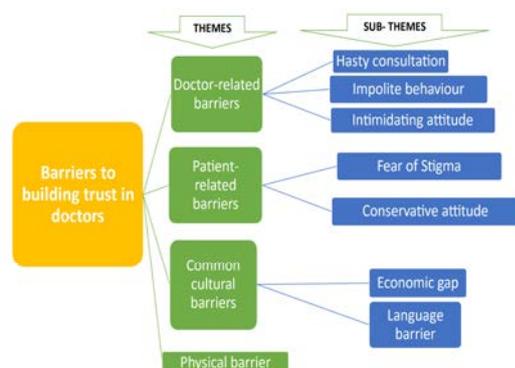

Fig. 2:Barriers to Building Trust in Doctors Among Patients

Under the sub-theme of "Intimidating attitude", defensive practice of Medicine and lack of patience emerged as concerning behavioural factors. Regarding defensive practice both K1 andK3 believed that "Doctors, now are more afraid of litigation, often they try to reduce their (patients') expectations from the beginning.". In the context of lack of patience K3 commented:

"Often we lose patience and use frightening tone, use jargons on them to make them listen."

Among the Patient-related barriers major sub-themes were "Fear of stigma" and "Conservative attitude". In case of the former,K4 believed non-disclosure of history of addictions and STD was of immense importance. Quotable verbatim by K4 was:

"I saw a patient this week, this young college girl, she came for skin problems. She knew she had HIV but kept silent even after probing repeatedly. Her mother gave up the information."

"Whenever we ask about alcohol or cigarettes, they get defensive or lie or play it down saying I have left drinking."

Regarding "Conservative attitude", gender related bias and sexual orientation related attitude came out as important attitude of the clients the doctors face. K5 said in this matter:

"Some patients only seek out my male colleagues in the OPD even if he's an intern. They even forfeit their place in the line for a male doctor, unless it's gynaecological trouble, then they need us."

"Patients and patient party both become apprehensive if they have homosexuality"

Regarding Common cultural barriers, "Economic gap" and "Communication gap" emerged as notable sub-themes. Regarding the former sub-theme, K2 believed discordance between doctor's judgement and patients' socioeconomic status is crucial:

"Sometimes they require medicines which are unavailable at pharmacy and we don't have any choice so we tell them to buy it. They get agitated. Even if we tell them to eat fruits or vegetables, they get genuinely frustrated."

Language barrier andusage of separate dialectswere found to be root causes for "Communication gap". K1 noted that she struggled due to the former. Those patients who don't understand even a little bit of Hindi are hard to communicate because my Bengali is not very fluent.". K6 commented regarding the later:

"*Patients often speak of some symptoms which are unheard of but later you will find it is just abdominal pain. They say one thing and might mean another. They often say-jontrona nai kintyu byatha ache. It's hard to understand.*"

Regarding the theme of Physical barrier K5 suggested:"*The OPD has no screen between two consulting doctors and their patients. Some patients feel hard to open up."*

Using Smith's S score to calculate salience from the free-lists, 'Communication barrier' emerged as the item with the maximum Salience (Smith's S score 0.35) among the free-lists. There are differences in the expectations, attitudes and viewpoints of both doctors and patients. The ability to understand these variations, appreciate them and treat each client as an individual is essential to the practice of medicine. This study tried to explore the perspective from both the stakeholders of interpersonal trust, i.e., in this case patients as well as their physicians. 27.73% patients agreed to the item-"I doubt that my doctor really cares about me as a person" and 'Impolite behaviour' emerged as a doctor-related barrier.34.65% patients disagreed to the item- "My doctor is usually considerate of my needs and puts them first" and 59.41% patients disagreed to the item-I trust my doctor to tell me if a mistake was made about my treatment".'Intimidating attitude'

with code:'Defensive practice of Medicine' emerged as a doctor-related barrier reflecting similar sentiment. 49.50% patients agreed to the item- "I feel my doctor does not do everything he/she should for my medical care" where 'Hasty consultation' (Codes: 1. Lack of individual counselling 2. Huge footfall of patients) was explored as a sub theme that might explain the lacunae. Significant statistical relationship was found between trust in doctors and, education and occupation. "Education gap" and "Economic gap" emerged as significant items from the free-listing. "Economic gap" also emerged as a sub theme under theme of 'Patient-related barriers'. Only 21 (20.79%) out of 101 patients had complete trust in doctors in our research which is significantly <that of Banerjee *et al.,* who found out that 61.11% had complete trust in doctors[25]. This study considered top two highest scores to convey complete trust where current research considered only top score to convey complete trust. This research also found significant statistical relationship between trust in doctors and gender. Although gender had no significant statistical relationship with trust in doctors, "Conservative attitude" due to gender related bias emerged under theme of 'Patient related barriers, in current research. Other researchers have also observed gender biases in the doctor-patient interaction[27,28]. Studies have indicated that patients report greater well-being and symptom relief when they have a high degree of trust in their primary care physician. Furthermore, they express more satisfaction[29]. The mixed-method study has merit in and of itself since it provided a comprehensive understanding of the physician's viewpoints on trust hurdles through qualitative inquiry. Because of the cross-sectional design of this study, it was not possible to explore the trends in trust that requires long time to build[30]. The current study was not able to examine certain other factors, such as the influence played by the growth in sub specialties and specialists as well as a propensity for alternative medical methods. Since recall constituted the majority of the replies, bias might continue to exist. There might also be bias due to apprehensiveness of the respondents.

CONCLUSION

The current curriculum for medical undergraduates and postgraduates needs to place more emphasis on AETCOM (Attitude, Ethics and Communication) training to inculcate relevant knowledge, attitude and skills. Medical College, Kolkata is an educational institution that trains physicians from all over the nation, hence it is necessary for non-native speakers to receive basic instruction in the local language in order to improve their ability because both health outcomes and doctor-patient communication benefit from language proficiency.30GOPD rooms that houses multiple physicians require screen(s) in between to maintain privacy of the clients.

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