Palliative and Supportive Care

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The fragility of trust between patients and oncologists: A multiple case study

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Original Article

Cite this article: Fracheboud T, Stiefel F, Bourquin C (2023). The fragility of trust between patients and oncologists: A multiple case study. *Palliative and Supportive Care* **21**, 585–593. https://doi.org/10.1017/S147895152200075X

Received: 1 October 2021
Revised: 15 February 2022
Accepted: 7 June 2022

Key words:
Advanced cancer; Case study; Context; Oncology; Trust

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Abstract

Objectives. This study aimed to explore in a naturalistic, real-life setting the dynamics of trust in oncological consultations.
Methods. Cases to study were purposively selected from a data set of audio-recorded and transcribed consultations between oncology physicians and patients with advanced cancer, and analyzed qualitatively. The analytical approach was deductive, relying on a thematic framework of dimensions of trust, and inductive, not restricted by this framework.
Results. The multiple case study approach allowed to identify factors, which play a role in the dynamics of trust. These factors are the number of treating physicians and how they communicate, continuity of care and the capital of trust, the hierarchical position of the physician and the physician's self-trust, and the patient's personality.
Significance of results. The findings illustrate the importance to contextualize trust in the flow of oncological consultations and to conceive it comprehensively for each singular encounter between patients and clinicians.

Introduction

Trust can be defined in the medical setting as "the optimistic acceptance of a vulnerable situation in which the truster believes the trustee will care for the truster's interests" (Hall et al., 2001). The essential role of trust has been recognized for a long time, but systematic empirical research has only emerged in the 2000s (Hall et al., 2002a).

Different scales to assess trust have been developed, such as the most widely used *Trust in Physician Scale* (Anderson and Dedrick, 1990), *Wake Forest Physician Trust Scale* (Hall et al., 2002b), and *Trust in Oncologist Scale* (Hillen et al., 2013). They focus on different dimensions of trust. Among them are (i) fidelity, defined as the will to do whatever is possible in the interest of the patient, (ii) competence, relating to the medical and interpersonal skills of the physician, (iii) honesty, which requires truthfulness, (iv) confidentiality, which assures to handle sensitive information carefully, (v) caring, which implies to be attentive to the patient's needs, and (vi) global trust, which unifies all these dimensions (Hall et al., 2001, 2002a; Hillen et al., 2012b, 2013).

To our knowledge, no previous study has assessed the dynamics of trust (formation, erosion, deconstruction, breakdown, etc.) throughout real medical consultations. We found one study examining the "interactional accomplishment" of trust, but it focused on a single, and very specific consultation (second opinion in the surgical setting) and evaluated trust with regard to a professional discipline and not to the physician (O'Grady et al., 2014). The aim of our study was to explore in a naturalistic, real-life setting the dynamics of trust by taking into account the whole oncological consultation and by considering the context in which trust develops. We privileged an in-depth exploration of a restricted number of consultations (case study approach).

Methods

The study was designed as a collective or multiple case study with a qualitative method of data analysis. Data for the study were from one source: audiotaped consultations between oncology physicians and advanced cancer patients.

Material

The material is part of a data set consisting of 134 consultations between 24 oncology physicians and 134 patients with advanced cancer. The consultations were audio-recorded and transcribed verbatim in the context of a naturalistic multi-center observational study (De Vries et al., 2017); this study received approval by the ethics committee of the participating Swiss hospitals, and all patients signed an informed consent form. Patients were informed that they have advanced cancer and that they receive treatment without curative intent. The

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objective of the consultations was to discuss the results of investigations (e.g., computed tomography scans, histopathological examinations, or tumor marker levels), documenting the evolution of the disease.

Selection of the cases

Four consultations were purposively selected, based on the identification of trust-related issues (manifest or underlying). In other words, we selected the consultations based on their own merits, and their genuine interest for us, in accordance with sampling considerations in the case study approach (Crowe et al., 2011). The cases show situations where trust was challenged, already eroded, or could be undermined because it was built on a fragile base. Trust is thus present in the four consultations. It may be apparent, but based on a collusion of silence (case 1), it may depend on the treatment strategy and hopes placed in it (case 2), it may be difficult to build due to a mutual distrust between the oncologist and the patient (case 3), and it can be in a latent way the central issue at stake in a consultation (case 4). In other words, the cases illustrate the fragile balance between mutual trust and distrust, and the analysis reveal factors that play a role in the dynamics of trust.

Communication between oncologists and patients in the four cases can sometimes appear inadequate or in need of improvement. In this regard, it is important to keep in mind that these are real-life consultations and that they also reflect the reality of clinical practice. We provide nevertheless some guidance on how communication and interpersonal trust could have been improved following each case. We refer for these guiding comments to the position paper based on the third consensus meeting among European experts on communication training of oncology clinicians (Stiefel et al., 2018), and to our clinical and academic experience in teaching clinical communication (Stiefel, 2006).

Data analysis

Based on the scales most frequently used to systematically analyze trust in the medical setting, especially the *Trust in Physician Scale* (Anderson and Dedrick, 1990), the *Wake Forest Physician Trust Scale* (Hall et al., 2002b), and the *Trust in Oncologist Scale* (Hillen et al., 2013), and the resulting dimensions mentioned above (e.g., fidelity, competence, honesty, see the Introduction), we developed a sensitive framework upon which analyses were based. The analytical approach was deductive, relying on the thematic framework of dimensions of trust, and inductive, not restricted by the framework. Thematic analysis (Braun and Clarke, 2006) was used to identify factors playing a role in the dynamics of trust (our themes) and affecting dimensions of trust recognized in the literature (the framework). The analysis consisted of iterative listening to gain a comprehensive view on the cases, generating themes, and defining and describing them in detail. The analysis was conducted by a multidisciplinary team consisting of physicians (TF and FS), and a social science researcher embedded for years in the medical setting (CB). TF coded the four transcripts. The two other investigators independently reviewed the coding, and differences were reconciled by discussion. Team discussions were held for the definition and description of the themes, and to obtain in-depth understanding of the dynamics of trust in the cases.

The case study as a research approach "allows in-depth, multifaceted explorations of complex issues in their real-life settings" (Crowe et al., 2011). In this study, it enabled a contextual exploration of the phenomenon of trust and comparison between situations to generate a broader appreciation.

In the results section, the four consultations are shortened, while keeping the flow of interaction between the patient and the oncologist. This allows to grasp the dynamics of trust. The speech turns to which we refer in the following are numbered in square brackets, which relate to Tables 1–4 (transcripts).

Results

We detail in the four cases the dynamics of trust and distrust between patients, their relatives, and the oncologists. Dimensions from the thematic framework (based on the scales measuring trust) are written in italics.

I trust you

This consultation is characterized by interpersonal trust between the patient and his oncologist (see Table 1). While the literature stresses the importance of the truster's relational vulnerability (Hall et al., 2002b; Hillen et al., 2012a; Gabay, 2015), the patient seems here to obtain all he demands, and one might question if he is vulnerable. However, by entrusting his health to the physician, he accepts a certain dependency and takes a risk, which can be conceived as vulnerability.

Table 1. Case 1: I trust you

1.	Oncologist **[O]**: So, Hello Mr*
2.	Patient **[P]**: Hello Doctor
3.	O: How are you doing?
4.	P: Very good, I'm very happy
[…]	
39.	P: […] I'm very, very happy, this soft chemo that you suggested me
40.	O: Yes?
41.	P: I think it's working
[…]	
132.	O: Are you seeing Prof. * anytime soon?
133.	P: No, he told me I was in your hands right now and that I can keep going with the chemo
[They take a look at the CT scan results. The abdominal and pulmonary lymph nodes seem to respond to chemotherapy]	
186.	P: What a joy that you suggested me to do a second soft chemo
187.	O: Hmm
188.	P: It was the right decision
189.	O: Hmm
190.	P: And I want to clarify something, my wife, she knows nothing [about the disease] because I don't want to worry her. And it's working really well
191.	O: Good, very good, we never know in advance how efficient the treatment is, nor the tolerance [to the treatment]
192.	P: Of course not
[…]	
205.	O: In this case, I think that we have, that you have made the right decision

https://doi.org/10.1017/S147895152200075X Published online by Cambridge University Press

206.	P: No, you're the one who guided me, and me I
207.	O: Yes, but we are a team, right?
[…]	
210.	P: I trust you a lot and I am very happy, so I listen to you […]
211.	O: In any case, we can see that it was probably the right option
[…]	
217.	O: I would suggest that we do at least two, or even three more cycles of chemotherapy
218.	P: All right
221.	O: We could even go up to five or six […] in order to consolidate the good response to treatment
[…]	
230.	P: Because there is still a risk for a relapse?
235.	O: There is always a risk
236.	P: Yes of course, I am aware of this, but well I see the [actual] results. Are we sticking to the dates [of chemo] that you suggested me?
237.	O: Let's see
[…]	
251.	P: […] I just plan to go golfing in Spain with my wife at the end of May
270.	O: All right, but this means that we would have to postpone the fifth cycle by 15 days
[…]	
277.	P: And I also have a party on the 10th
288.	O: OK, but then it's going to be a little bit too close
[They continue to negotiate the dates for chemotherapy and finally reach an agreement. They then start talking about the patient's actual medication]	
340.	O: […] and there is this little doubt about aspirin taking
341.	P: Yes, True. I wanted to ask you
342.	O: Prof. * advised you to stop taking it, that's what he told me
[…]	
348.	O: Did you stop taking it or did you continue?
353.	P: […] In fact, I was waiting for you [to tell me what to do]
[They then discuss the patient's consumption of alcohol]	
395.	P: […] I have greatly decreased my consumption. I'm reasonable, I listen to you and Prof. *
[…]	
403.	P: And it isn't much, but of course I still shed a little bit of hair
404.	O: Yes, you are losing a little hair, huh
405.	P: And the fact that […] my hair is white might not be helping
[…]	
409.	P: But it's not that bad
410.	O: It's a lesser evil, isn't it? (laughs)
411.	P: Yes, but
412.	O: It's true that it's still always annoying
413.	P: Yes, but it's not a big deal to live with that
[They then set the next appointment and decide when the upcoming results will be delivered. Consultation ends in speech turn 444]	

Many dimensions of trust come repeatedly into play, such as the oncologist's *competence* (Hillen et al., 2013) [39–41, 186–8, 206, 210], trust related to *confidentiality* (Hall et al., 2001) [190–9], and *global* or *holistic trust* (Hall et al., 2001).

However, the "capital of the past" seems also to play an important role. It nurtures trust by means of past positive effects: the physician did what the patient expected, and it worked [39–41, 186–8, 210, 236]. In this regard, the literature distinguishes between trust (oriented toward the future) and satisfaction (oriented toward the past) (Thom et al., 2004; Hillen et al., 2012a). Yet, Gabay (2015) observed that satisfaction with outcome nurtures trust, and Hall et al. (2001) consider that trusting attitudes direct as much to motivations and intentions as to results. In other words, while trust is an interpersonal phenomenon, factors independent from the physician and the relationship with the patient also play an important role in its development.

In addition, there seems to reign an atmosphere of cronyism in this encounter, which might indicate a collusion (Stiefel et al., 2017). Cronyism is manifested by the demonstrative consideration and politeness [205–7, 395] or the negotiation concerning the timing of chemotherapy [217–288]. Collusion appears when the patient relates that he hides the disease from his wife [190–2], an attitude, which remains unquestioned by the physician, who seems to be more preoccupied about maintaining the therapeutic alliance, than exploring the patient's stance. Collusion, resulting in a conspiracy of silence between the physician and the patient and between the patient and his wife, can be considered as an indicator of distrust. The former indicates that the physician has not enough trust in the solidity of the relationship with his patient and the later that the patient has not enough trust in the relationship with his wife. The view that trust and distrust are mutually exclusive is not tenable. Trust is issue-related. Indeed, only a trusting relationship allows to share problems (Hupcey et al., 2001), and solidifies the working alliance (Fuertes et al., 2017).

Since trust seems here to be based on satisfaction with past results and a collusive relationship, one might question the solidity of this trust. For instance, the issue of the patient's loss of hair [403–13], a danger for the "disease secret", seems to trouble the harmony. This issue pops up at the end of the consultation and provokes a certain embarrassment, as indicated by the laughter of the oncologist [410], and the fact that the topic is quickly put aside. The relationship can be characterized as pseudo mutual because it is challenged by a disturbing topic. What would happen if the treatment stopped working, if the disease progressed rapidly or the patient had to admit to his wife that he has cancer? Therefore, underlying factors of trust formation have to be taken into account when assessing this phenomenon in the medical setting.

Comment on case 1

First, it is always tempting to focus on the success of past treatments, and by explicitly recalling it to increase the past capital of trust. However, one also has to remind that treatments may not always work. A more nuanced attitude may be the best prevention against an erosion of trust in moments when anticancer treatments are no longer beneficial. Such an attitude might be more difficult to adopt, but in the long run trust-building. Second, one can consider that it is the patients' right to not inform their significant others about their medical condition. However, having acknowledged that, the physician could also have investigated what makes it so difficult for the patient to openly discuss with his wife. Such a stance would not have

https://doi.org/10.1017/S147895152200075X Published online by Cambridge University Press

undermined trust related to confidentiality, but enhanced trust related to fidelity (acting in the best interest of the patient) as well as trust related to honesty (by expressing a desire for transparency).

Did Prof. M say something?*

Trust is here directed from the patient and his wife toward two individuals: the oncologist (a chief resident) and his supervisor (a professor in oncology) (see Table 2). The patient and his wife seem to trust the professor, but to a lesser degree the chief resident. While they do not distrust him, since this would imply the expectation of harmful behaviors (Hillen et al., 2011), the relationship with the chief resident is characterized by low trust (Hall et al., 2001; Hillen et al., 2011). The patient and his wife consider the chief resident not to be completely capable to make the (right) decisions. The patient presents himself more nuanced than his wife, as illustrated by choice of words, such as "[the professor] *might* have changed his mind" [167] or "the results are good, *that's already something*!" [346]. The prudent stance may indicate that he is preoccupied to maintain a good relationship with the chief resident. This indicates that verbal manifestations of trust, which might result from insecure attachment or dependency, cannot always be taken at face value, and have to be contextualized.

The core of this consultation is the current treatment, chemotherapy, conducted in Switzerland, and the possibility of a targeted treatment qualified by the professor as the "miracle molecule", available in the USA. Despite the fact that current chemotherapy is beneficial [21, 104], the patient's wife rapidly shows interest for the targeted treatment [99], which she associates with enhanced life expectancy [255] and superior efficacy [201, 251]. The chief resident repeatedly confirms her view: "Well, it's amazing, it [the targeted treatment] has nothing to do with chemotherapy" [202, 256]. This leads to an incomprehension: there seems to exist a treatment, more efficient than the current one, but the patient is denied to obtain it. The dimension of *fidelity*, "pursuing a patient's best interest" (Hall et al., 2001), appears to be questioned by the wife. In addition, the oncologist's *communication*, another dimension of trust (Hall et al., 2001), also seems to fail, since he does not explain the rationale of his stance.

Another determinant of trust, articulated to the two previous dimensions, favors low trust: the lack of *coordination* between the physicians. The chief resident endorses the "miracle" treatment but prefers not to provide it for the moment; and the professor seems to encourage the patient to get the treatment in the USA. The patient and his wife deplore this lack of coordination [117–8, 160–7].

The *competence* of the chief resident is constantly compared with the competence of the professor. While the chief resident's competence is never questioned explicitly, it is tacitly challenged by repeated references to the professor [99, 160–9, 177, 182–4, 339], and even by the chief resident himself [21, 117, 126, 148, 152]. One could thus consider that the chief resident also lacks trust, trust in himself. This last issue illustrates that trust can also be undermined by the trustee himself. Lastly, maybe even more relevant than the professor's competence is the trust in the "miracle drug"; the professor is maybe just entrusted to provide access to it.

In conclusion, developing trust toward the chief resident would imply "a willing dependency on his actions" (Hupcey et al., 2001), which does not occur. The consultation, therefore, ends as it started, with a negotiation concerning the treatment and a reference to the professor:

Table 2. Case 2: Did Prof. M* say something?

1.	Oncologist **[O]**: So how is it going for you?
2.	Patient **[P]**: It's going good now
[…]	
21.	O: […] I have talked with Prof. M* about the PET scan and we have observed a good response to treatment
[According to the oncologist the metastases have shrunk, but if they don't disappear completely within the next three chemotherapy cycles, the patient should be treated with a new "miracle molecule"]	
99.	Wife [**W**]: And what about going over there [USA], did Prof. M* say something about it?
[…]	
104.	O: Well it's always complicated to go to the United States. Now that you are having a good response [to chemotherapy] we shouldn't stop the treatment, don't you agree? […] Second of all, if you stay here you might as well get this molecule, OK? […] We can also give you molecules off-study […]
105.	P: Of course
106.	O: We are doing the chemotherapy now, it's working well, we'll keep going like that and see if it still works and by January or probably February, at the end of all these treatments, we can give […] you the miracle molecule […]
[…]	
117.	O: That's what Prof. M* said as well, isn't it?
118.	W: No, no, he didn't tell you that
[…]	
126.	O: […] When we [O and Prof. M*] talked last Thursday at the medical conference, we chose to continue for three more cures of chemotherapy
[…]	
130.	O: And of course, going to the States is still an option
131.	W: Yes
132.	O: […] Here or there, it's the same
133.	P: Well I
134.	W: That's not what he told us
135.	P: It would make it easier and better to treat my disease if I don't wait too long to go to the United States
136.	O: Sooner, yes
[…]	
143.	P: So, does Prof. M* prefer to complete the treatment?
[…]	
148.	O: […] If I had to make the decision I would rather stick with the current treatment, but just to make sure I'll check with Prof. M* […]
[…]	
152.	O: But I think he also wants to continue with the current treatment because it is working, and then we can see if we will give you the molecule
[…]	
160.	P: Last time I saw him, which was two weeks ago
[…]	
167.	P: […] He said the chemo, maybe it's excellent, so he might have changed his mind with these results

https://doi.org/10.1017/S147895152200075X Published online by Cambridge University Press

168.	O: Hmm.
169.	P: But he always said "it's a shame to continue with this treatment if it's not working great, we're wasting time"
170.	O: Exactly. Knowing that going to the United States will also take some time to organize
[…]	
177.	W: We have to see that with him
[…]	
182.	P: But, if for him, the response to the chemo
183.	O: Is good enough to
184.	P: Is equal to the medication, then of course we'll take the medication
[The patient evaluates the pros and cons (chemo vs. molecule) and finally concludes that for an equivalent outcome, he would prefer the chemo]	
201.	W: […] This new medication, it looks like it's way better than chemotherapy
202.	O: Well it's amazing, it has nothing to do [with chemotherapy]
[The O explains how efficient the molecule is compared to chemotherapy]	
218.	W: […] I don't want he has three more cures of chemo and then I don't know, then we get bad news and we think "damn, we should have"
[The O explains the difference between chemotherapy and targeted therapy]	
248.	O: On the other hand, we can always have [with targeted therapy] cells that become resistant to the treatment too […], all patients don't become disease-free with it […]
249.	W: No, no, it doesn't mean that if he receives it, he will be cured
250.	O: Exactly
251.	W: But I mean, he will probably be more cured than with the chemotherapy
252.	O: Exactly
[…]	
255.	W: And I think that if he takes this medication, maybe after that he can still live for years […]
256.	O: Oh, even more
[The oncologist explains that melanoma is a particular type of cancer, still poorly understood, and that the response to treatment is very unpredictable]	
304.	P: […] So well, I'll still do three more cycles of chemo, and then you will check if I'm disease-free or not
[…]	
339.	W: […] Oh well, we'll see. Are we going to see Prof. M*?
[…]	
345.	O: Yeah I have to see Prof. M*
346.	P: Well, the results are good, that's already something
[The oncologist examines the patient. The patient asks to postpone a chemo that falls between Christmas and New Year's Eve and the oncologist agrees. Consultation ends in speech turn 393]	

[99] W: And what about going over there [USA], did Prof. M* say something about it?

[339] W: Oh well, we'll see. Are we going to see Prof. M*?

Comment on case 2

From a communication perspective, it might be worthy to explicitly address and meta-communicate on the relational dimension, which operates within this consultation. The chief resident could for example have stated: "I observe that it is difficult for us to reach a trustful relationship, I have the impression that you prefer to rely on the professor's advice, and I believe that he and I should first coordinate our propositions and then speak with one voice." This consultation shows that to maintain trust when different physicians are involved, it is important to avoid any splitting and to coordinate both care and communication.

Are there any other therapies?

In this consultation, a lack of interpersonal trust of the physician in the patient is observed, but also of the patient in his physician and other physicians, the hospitals, conventional medicine, and the healthcare system (see Table 3). This "global" distrust — contrary to low trust in case 2 — indicates that the patient considers the physician to act against his best interests (Rose et al., 2004; Hillen et al., 2011).

While the literature focuses on patients' trust in physicians, trust — or as in this consultation, distrust — can also be directed from the clinician toward his patient. As stated by Thom et al. (2011): "[…] patient and physician trust are closely linked to expectations of behavior with respect to complementary roles." In this consultation, the patient fails to be entrusted by the physician, who considers that he does not accept the patient role and does not provide the necessary information for medical care [13, 19, 47, 53, 109]. The patient is not considered trustworthy, as these remarks from the physician seem to indicate:

[19] O: […] *most of our patients* are very anxious and call me right away to ask me what is going on!

[47] O: […] *the majority of our patients* find out themselves when there is a recurrence […]

While it is not completely clear what the physician wishes to express by this last sentence, it appears that she compares the patient to other patients, who seem to be more entrustable.

On the other side, the patient seems to be very wary of his medical care; wariness being a characteristic of distrust (Hall et al., 2001). He challenges different dimensions of trust: the physician's *honesty* [74–8] and *caring attitude* [line 222]; other physicians' *collaboration* [378–86] and *competences* [460, 474]; the hospitals, which were not capable to take care of him [20, 94, 769]; and conventional medicine (the patient favors "other therapies" without seemingly knowing them) [242–336, 460, 474]:

[244] P: […] Are there *any other therapies or other things*?

[334] P: […] what bothers me with *traditional medicine* is that it *only looks from its own perspective*

To trust implies to willingly transfer discretionary power (Grimen, 2009) to a person or an institution. This is not what the patient shows, and the discussion with the oncologist, but also with the group of physicians, ends up in a mutual struggle for power. In this context, relational elements appear in the conversation, for example, when the patient passes from the polite and adequate "vous" (in French) to the familiar and inadequate "tu" [78]. This might indicate that he fights a certain asymmetry in the relationship, which he attempts to flatten.

The patient's personality seems to play an important role in the interaction. He obliges the oncologist to contain his distrusting feelings [20, 74–8, 94, 222, 242–4, 334–6, 378–86]. This might be conceived from a psychological perspective as projective

https://doi.org/10.1017/S147895152200075X Published online by Cambridge University Press

Table 3. Case 3: Are there any other therapies?

[The oncologist has asked the patient to consult in order to discuss the PET Scan postoperative results with respect to melanoma metastases]	
13.	Oncologist **[O]**: […] I was a bit surprised that you had this PET CT but you never, I don't know, found a way to get the results, because it was done on April 14th
14.	Patient **[P]**: Well I said that I had this Doctor C* [the patient's surgeon in another hospital] who was taking care of it, or [you] here at the University Hospital, because it was actually the University Hospital which was sending me to the hospital
[…]	
19.	O: Well, a melanoma is always an aggressive disease, which means most of our patients are very anxious and call me right away to ask me what is going on! (laughs)
20.	P: Well […] I thought that if there was something serious going on, someone would call me […]
[After a question from the oncologist, the patient admits not checking his body for disease recurrence]	
47.	O: (laughs) I think it is important that you know that the majority of our patients find out themselves when there is a recurrence […]
[The O examines the patient]	
53.	O: OK, what is your profession? Because you have a sunburn […]
58.	P: I make people do bungee jumping, which means I'm always outdoors
59.	O: OK
[…]	
74.	P: When I was told about the results, was it you who called me?
75.	O: Yes, it was me
76.	P: Well I think it wasn't very good [it was not an adequate communication]
77.	O: Huh?
78.	P: When you [the P uses "tu" (in French)] said "there's something wrong," but you didn't say what
87.	O: […] I agree with you but I was also surprised, you had an exam, you had an appointment, but you didn't ask
94.	P: But no one told me they would find something
109.	O: […] A normal behavior would have been to come here to know how things are
[The oncologist continues to blame the patient]	
126.	P: So, what did they find?
[The oncologist explains that there are lymph nodes in the liver region according to the PET Scan, which will have to be surgically removed]	
181.	O: […] But if you were initially treated in S* [another hospital] we are in a bit of a trouble because everything gets done over there and then we have to ask for the information, because we are the oncologists
[The patient wants to know the consequences that a liver surgery might have]	
219.	O: […] I think the surgeon is in the best position to explain it all to you because he will be the one taking you to the operating room and conducting the procedure
220.	P: Hmm
221.	O: It is his job to
222.	P: I think it is also your job as an oncologist to explain me the function of this organ. What is wrong with it? […]
[The oncologist starts to explain but the patient interrupts her]	
242.	P: I have one more question: what would be another way than just always cutting out one little piece?
243.	O: Oh but yes, yes
244.	P: Is there a psychological approach for example? Are there any other therapies or other things? […]
[The oncologist explains that the only curative treatment is surgery. The patient is not satisfied, he thinks that it is possible to do more than just "cutting one piece" (2x). The oncologist goes out of the room to ask the professor about alternative therapies and then comes back alone, saying other doctors will arrive]	
334.	P: […] When there is a problem we can look at it from different perspectives and what bothers me with traditional medicine is that it only looks from its own perspective
335.	O: Hmm
336.	P: And it doesn't look broader, more holistic […]
[The discussion on alternative methods goes on. The patient then asks for a copy of his PET scan]	
378.	P: Logically, they [the CHUV] should have sent the images to Doctor C* [the patient's surgeon in another hospital], but they didn't
379.	O: But I think Doctor C* also has the code to access the images?
380.	P: Yeah but I think he wasn't informed [about the images]
381.	O: Oh yes, it's true
382.	P: […] They didn't send them
383.	O: Yes I understand, I understand
384.	P: [Talking about his different doctors] It's like they are in a competition
385.	O: Yeah?
386.	P: It looks like it. It's a bit strange
[Other doctors enter the room. Dr*, the surgeon at the CHUV, explains why some lymph nodes should be removed. The patient listens carefully and makes fewer objections than with the oncologist and addresses the surgeon as "vous"]	
460.	P: Before surgically opening, wouldn't it be better to do one more
461.	Dr.*: We have to accept the PET as it is because it is a high-quality examination, totally reliable
[…]	
474.	P: Yes but one opens everything without knowing if there's actually something […]
[The patient gets answers to his questions and the doctors plan the gastroscopy and MRI and make the appointments with the patient]	
769.	P: Do I need a phone number or something for the hospital? Because it already happened that I went there and they didn't know why I was there
[Doctors leave the room, except the oncologist who reminds the patient that a blood sample must be done]	
819.	P: With respect to the blood sample, I haven't been tested for AIDS for a while. Can we do that as well?
820.	O: Yes, of course
821.	P: Since
822.	O: Are you at risk?
823.	P : Yeah, a bit
[The patient is going to have his blood sample done. The discussion goes on and the patient again uses "tu" when addressing the oncologist. Consultation ends in speech turn 842]	

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identification (Gabbard, 2001). The patient provokes feelings of helplessness in the physician — being accused of not caring for the patient —, which the patient might himself experience (helplessness with regard to how to manage the disease). The underlying and unconscious motivation of the patient might be that he attempts — as with the resort to the transgressive "tu" — to establish a more symmetrical relationship (both feeling helpless), at the cost of trust. The following lines illustrate this observation:

[20] P: Well […] *I thought that if there was something serious going on, someone [from the hospital] would call me*

[76] P: Well I think *it wasn't very good [it was not an adequate communication*]

[77] O: Huh?

[78] P: When *you* [*P* uses "tu"] said "there's something wrong", *but you didn't say what*!

However, when the other physicians enter the room, they establish a more asymmetric relationship, particularly Dr.*: "We *have to* accept the PET as it is […]" [461]. This sentence indicates that the physician asserts his power by relying on scientific knowledge and facts (the PET scanner), sending at the same time an implicit message to the patient: your distrust is related to your inability to accept your situation. Finally, the physicians as a group decrease the patient's "combativeness," who only issues very few comments or objections [e.g., 769].

Comment on case 3

One often observes that physicians restrict the discussion to medical problems, even when other issues take over, such as emotions, existential difficulties, or relational elements, as in this case. Instead of justifying herself, the physician might rather address the difficulty of the patient to develop some trust toward medicine and healthcare professionals, and invite him to look for ways to improve, together, the situation.

I've sent you emails

This consultation reveals interpersonal distrust of the patient toward her oncologist and low institutional trust (toward the hospital) (Hall et al., 2002b; Rose et al., 2004; Goudge and Gilson, 2005) (see Table 4). Dimensions of trust questioned by the patient are *honesty* [471–3] or "telling the truth and avoiding intentional falsehoods" (Hillen et al., 2013), *caring* [lines 41–3, 441–9] or "devotion of attention to the patient" (Hillen et al., 2013), *fidelity* [260] or "pursuit of the patient's interest" (Hillen et al., 2013), *medical competence* [220–34, 246, 377–81, 427] (Hall et al., 2001), and *global trust* (Hall et al., 2001).

The issue of trust is never explicitly addressed, only remarks of the patient implicitly indicate her difficulties to trust her oncologist. For example, the email to which the oncologist is said not having replied, the sick-leave certificate, which the patient had asked for but never received, or the MRI, which had not been done in the right way. Just as satisfaction seemed to nurture trust in case 1, dissatisfaction seems here to nurture distrust.

To trust implies to be vulnerable *and* to accept one's own vulnerability, without having a guarantee of a benefit for the truster (Goudge and Gilson, 2005; Bachinger et al., 2009; Grimen, 2009; Hillen et al., 2011). In this case, the patient questions whether the physician took her vulnerability (life-threatening situation) seriously and thus does not entrust her [e.g., 234–46, 297–98, 337–81, 427–34, 471–72]. To trust requires coping with uncertainties, but here uncertainties, which naturally exist in oncology, motivate distrust.

Table 4. Case 4: I've sent you emails

[The patient consults to receive results. She mentions feeling a little pain in the lower back and having told that a few times already]	
41.	Patient **[P]**: […] I've sent you emails but apparently there's been a problem maybe, because you never answered me
42.	Oncologist **[O]**: But when did you send this email?
43.	P: It's just to tell you that I've sent you, I think, two emails but you didn't answer
44.	O: But when?
45.	P: Well it was more or less at the same time that I contacted Dr*
46.	O: Wait, let's have a look
[The patient repeats she has sent emails but the oncologist stresses that she has only one in her mailbox, which she received before their last appointment]	
83.	O: […] It's true that this is the only email I've received from you
84.	P: But I've sent you another one
85.	O: But there is no other one in this mailbox as you can see
86.	P: Maybe there was a computer problem, right?
87.	O: Yes, but […] here [in the email] you're asking for a certificate proving that you are capable of working at 50%
[The discussion continues about the emails and the certificate. Finally, the oncologist calls a colleague to have an appointment for a neuropsychological assessment for the requested certificate]	
212.	P: [About the certificate] But it wasn't my priority at all, today I want to know about the MRI results, that's what's worrying me […]
215.	O: […] I've seen the MRI with the radiologists and there's a little contrast enhancement, very little. We've seen the images together with Dr* and for him that's just something to control in three months, these changes might only be due to the chemotherapy
220.	P: Don't you have a report from the radiologist?
221.	O: […] There's no report yet, but I can show you the images […]
[The oncologist explains that the disease was stable on the MRI from February]	
234.	P: Yes, but it's also because you have booked an exam with the 1.5 tesla magnetic field and it's true that, even the radiologist's report says that, it's written at the end, "the cavernous angioma has a reduced aspect, reduced dimensions, because the magnetic field is less powerful" so with a 3 tesla we can infer that they were able to assess more precisely […]
[…]	
246.	P: But I chose this example to let you know that in this context of assessing the evolution of a cavernous angioma, a change in the magnetic field is very important—and I think you are well aware of it […]. It was just a way to tell you that even in assessing something very little it's fundamental, and you know, but I think you are well aware […]
[…]	
259.	O: Are you afraid concerning the examination results?
260.	P: No, no I'm not afraid, I just think it is normal to be worried about the results
[Rise in symmetry about an email sent by the patient to Dr* in which she describes her symptoms. According to the patient, the oncologist should have read this email, but she didn't]	
297.	P: I was thinking that you are his right hand and that he would have forwarded the email. But it was a deduction that I had because I told myself "they are working together, she's his right arm"

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298.	O: We are working together, a lot, but I receive hundreds of [emails]
[…]	
313.	P: I just wanted to say that there isn't enough communication […]. There's been so many changes among the doctors lately, among the residents
318.	O: It is because of these changes that I have been taking care of you since February, and I haven't received any email or message since then
[…]	
321.	P: But I was convinced that Dr* would forward my email to you
322.	O: […] he does send me all the emails, I receive about 10 emails a day, but I didn't get anything [from you]
325.	P: I can assure you that I have it [the email] saved in my computer
326.	O: OK, but now you're here, and you can tell me about these symptoms!
[The discussion continues about the un-forwarded email. The patient then asks about her latest MRI results]	
337.	P: You don't have the radiologist's report, it's a bit blurry
338.	O: I said that it takes some time in this hospital, it takes a little while till we get the radiologists' reports […]
[…]	
369.	P: But did my tumor […] cross the line?
370.	O: […] The MRI shows that your blood vessels are more permeable here. […] There can be different reasons for this: it might be due to the tumor, it might be radiation-induced, and it might normalize after a while […]. But it is not significant and does not explain your actual symptoms
373.	P: I find that a bit blurry […]
374.	O: Yes, but unfortunately, that's how medicine works
377.	P: Yes, but what I wanted to say is simply that […] in the latest radiologist's report, there was a distinction between the radiation-induced lesions and the lesions due to the biopsy for example. Every time they were making differences […]
378.	O: Yes
381.	P: And now you are telling me that we don't know if it is radiation-induced or if it is the tumor mass that is changing
[…]	
394.	O: I will send you the report as soon as I have it, OK?
397.	P: So for now you can't tell me anything more?
398.	O: No, I can't
403.	P: […] and according to Dr*, it is not necessary to consider a new treatment at the moment right?
404.	O: Absolutely. That's what I have told you many times…
[…]	
427.	P: But you, I mean are you, are you an oncologist or a general practitioner? […]
434.	O: […] I'm a chief resident in medical oncology
[…]	
441.	P: But I just think that a patient, especially when his/her health condition is unstable, should be allowed to ask questions
442.	O: I think I have told you all the answers
445.	P: There is no need to get angry, madam
446.	O: […] Mhm
449.	P: […] We can totally have a quiet talk, the person who talked to me in the radiology department she was very kind, very quiet, she even answered my complicated questions […]
[The patient and the oncologist agree that the symptoms haven't changed since the last appointment]	
471.	P: […] You can understand that if you tell me there will be a control in three months instead of two. I may infer that something has changed […]
472.	O: I told you there was a change, but for now it doesn't need any therapeutic intervention
[P and O agree to wait for the radiologist's report. Consultation ends in speech turn 482]	

In addition, the patient shows low trust in the hospital: she criticizes specific aspects of its functioning, such as the communication between healthcare professionals, and a lack of continuity of care [297, 313]. Her observations may be facts, but they do not automatically have to create low trust. The status of the oncologist is also questioned — is she really the right hand of the chief of service? [line 297], is she a qualified oncologist or "only" a general practitioner? [line 427] —, indicating low trust.

Here, the capital of the past is a capital of distrust, which has accumulated and can thus be considered as long-term distrust (Hillen et al., 2012a).

Comment on case 4

The oncologist, instead of dealing with distrust, attempts to affirm her competence and defends herself [46–87, 297–98, 313–25, 337–404, 427–34], which leads to an increasing confrontation of protagonists (Watzlawick et al., 1967), nurturing distrust. Containing negative emotions, avoiding the temptation to enter into symmetry and, again, addressing the relational components might be a more constructive way to attempt to restore trust instead of defending oneself or justifying one's actions.

Discussion

While we observed different dimensions of trust previously described in the literature, we have also identified factors, which appear to play a role in the dynamics of trust and affect trust or nurture distrust. These factors are the number of treating physicians and how they communicate, continuity of care and the capital of trust, the hierarchical position of the physician and the physician's self-trust, and the patient's personality.

In the cases, factors related to the setting seem to be relevant for trust in the patient–physician relationship. Among them are the number of treating physicians. Since oncology is interdisciplinary, care relies on different treatment modalities, and often needs specialists' advice; patients may thus encounter multiple physicians. However, with an increased number of physicians, a certain diffusion of the sense of responsibility for patients — decreasing their trust — may develop. This phenomenon, already identified by Balint as a "collusion of anonymity" (Balint, 2000), is even more potent when communication between physicians is not coordinated, or when physicians provide different or even contradictory information.

Second, continuity of care also plays an important role with regard to trust. This is especially difficult to maintain in tertiary care centers, in which residents undergo rotations. The dangers of a lack of continuity of care has been observed by Hillen et al., who stated: "Although patients' trust in their physician is generally

https://doi.org/10.1017/S147895152200075X Published online by Cambridge University Press

reported to be strong, there is concern that this solid trust is eroding, due to changes in health-care organizations that might pave the way to less continuity of care and less personal attention to the patient" (Hillen et al., 2011). The possibility of developing a capital of trust may therefore suffer. On the other side, longstanding relationships with physicians may also harbor a risk that physicians lack a critical stance toward the patient, as revealed by the above identified unhealthy collusion (case 1), which may mimic trust.

Inter- and intrapersonal factors were also identified as affecting trust. Indeed, hospitals are hierarchically organized, and patients know that. Therefore, clinicians who occupy lower hierarchical ranks — with regard to clinical responsibility or academic achievements — more often face doubts with regard to core competencies. Trust might thus be hampered by reasons independent of the physician or the relationship he has established with the patient. To know this is important to question the origins of distrust and to avoid to attribute it immediately to oneself (and to not feel self-trusting). The same holds true with regard to the patient's personality. Distrust might be a general characteristic of the patient, such as in patients with paranoid personality traits, and thus develops independent of the clinician's behavior.

Besides these factors, we observed indicators of eroding trust in the low trust and distrust consultations. What is striking is that patients and physicians did not explicitly address trust or distrust. While it is difficult for patients to address this issue, since they are in a situation of dependency, it is also difficult for physicians, given their prosocial motivations. However, addressing the issue can reveal origins of eroding trust, which might be related to the setting (e.g., continuity of care) or to the patient's anxiety, attachment difficulties and uneasiness (e.g., manifested by introduction of third party agents). Distrust merits to be addressed, since it might be attenuated when expressed; confusion, erroneous interpretations, and projections may diminish after clarification and its causes might at times be eliminated.

Trust is at the core of the medical encounter. This case study reveals that trust is a dynamic phenomenon, affected by contextual, interpersonal, and intrapersonal factors, which all can enhance or erode trust. The Gestalt of trust can only be approached and grasped by examining the singular situation. In this respect, our study is original because trust issues were examined throughout the consultations/cases, demonstrating how trust is both a dynamic and fragile phenomenon, and that trust and distrust can co-exist closely in the same consultation. Our findings also show that trust in oneself, in others and in the world is not only necessary for patients to find their way to care, it is also a constitutive element of the patient–physician relationship and a challenging and invested issue for the physician.

Funding. This study was supported by Swiss Cancer Research (grant no. KFS-3459-08-2014).

Conflict of interest. The authors declare that there is no conflict of interest.

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https://doi.org/10.1017/S147895152200075X Published online by Cambridge University Press