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CHRISTIAN AND SECULAR DIMENSIONS OF THE DOCTOR-PATIENT RELATIONSHIP

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Abstract: Trust in the doctor-patient relationship is an indispensable structural element for the medical profession. The discourse concerning trust and its importance in the healthcare context, although quite old, elicits increasingly more interest in research, especially for empirical approaches. The importance of trust in the doctor and in the medical profession can be demonstrated by starting from the Christian meaning of illness and medicine; generally, the patristic sources see medicine and physicians as God's gifts. The perception of Christian *physicians* as dedicated, unselfish and compassionate preservers or restorers of health, always committed to the good of their patients is well known. The model of the Christian physician is a Hippocratic model, of one who seeks the sick so that he may bring relief to them and strengthen them. When illness occurs, Christianity affirms an ethical duty to struggle against sickness, which if unaddressed can lead to death. The moral requirement to care for the health of the body indicates it is appropriate to use healing methods that will enhance health and maintain life. The aim of this paper is to explore the dimensions of the concept of trust in the doctor-patient relationship, by starting from the Christian meaning of illness and of the role of the doctor. The paper presents a number of essential theoretical elements related to trust, as presented in the literature dealing with the doctor-patient relationship: the meaning of trust, its dimensions, its stages of development, its impact, its sources, the patient's perspectives on trust, the importance of trust for healthcare systems.

Key Words: trust, doctor-patient relationship, vulnerability, healthcare, healing, communication, satisfaction, faith, Christian meaning of suffering, Christian ethics

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Introduction

A patient's trust in a physician means that the patient is *convinced* that the doctor will act in the direction of serving the interest of the former[1] and with therefore provide the most appropriate treatment and the most adequate medical care[2]. The fact that the patient's trust in his doctor, in the context of primary medical care services, is generated by the *conviction* that the doctor has a firm commitment to the rehabilitation of the patient's health, this conviction, in its turn, is associated with a high level of satisfaction in relation to the received medical services and with a high level of loyalty in relation to that particular doctor.

The Christian meaning of suffering and the role of the doctor

From its beginnings, Christianity has displayed an interest in questions *of health, healing and the meaning of suffering*. From the ancient times, the care and healing of the sick has had a special place, and medical tasks have often been at the heart of the church's missionary thrust. It was in the vision of early Christians that in the assistance given to the sick person there should be only the "natural limits," no refrain from therapy in cases of fatal or incurable disease. Christianity inherited from Hellenistic Judaism an appreciation of Greek medicine that defined disease as a natural process, without denying God's sovereignty His interference in ordinary interaction[3]. The source of *suffering* is usually seen as outside the sufferer. What is usually identified as the origin of the suffering is the thing that causes the pain, the pain itself, the life circumstances, or the stroke of fate. On the other hand, suffering always involves a self-conflict. Both on a religious and a secular basis, the suffering has been perceived as a form of selfless service to others. An example is the crucifixion of Jesus, an evil done by others, turned by God into Christianity's central saving act and a demonstration of the power of love over suffering. Christian theology views the physical health as a good but not an absolute good[4]. Physical health could even be an obstacle to the supreme good, which was spiritual health. The church fathers emphasized that the *soul* is infinitely more valuable than the body, and that care for the latter is not to conflict with care for the former. The body should to be practically cared for, since God has provided the means for its care. The health state was considered as a blessing from God, but since it was only a relative good, it could also become an evil if given a higher priority than it deserved. Sickness could also be a good thing, and all Christians should accept and appreciate both the sickness and the health. Sickness can correct or restrain one from sin, refine, increase patience, reduce pride, cause one to be less independent and more dependent upon God.

In the literature of the first several centuries of Christianity, three sources of disease were identified[5]: God, demons, and nature. They were not reciprocally exclusive. Although there appears to have been a caution to attribute disease directly to God, the more his sovereignty was stressed, the more he was viewed as either sending or permitting illness through demonic or natural instrumentality. The subject of disease causality in the early Christian literature is widely spread with confusion and interpretations, especially related to the perceived role of demons. What was thought to cause disease in any given case greatly affected the choice of means of healing: spiritual/ miraculous (e.g., prayer, the sacraments, exorcism, and, beginning in late antiquity, the cult of saints and relics); medical (drugs, dietetics, and surgery—typically administered by a physician); or magical (demonic or occult practices). The first two of these approaches were often combined, and sometimes magic was employed, although its use was consistently condemned in Christian literature. Miraculous healing was absolutely denied by some, ignored by many, but most often were perceived as a spiritual gift. A Christian was to depend upon God. This dependence may be a direct one, or it may be include as intermediaries: the church itself (i.e., its clergy and sacraments) and the saints. Christianity introduced

> "the most revolutionary and decisive change in the attitude of society toward the sick.... It became the duty of the Christian to attend to the sick and the poor of the community. The Christian addressing the sick (but also all in need) was only a manifestation of Christian love but was ultimately articulated as a theology of respect for life, predicated on the concept of the imago Dei, the belief that every human being was formed in the image of God"[6].

By virtue of sharing the imago Dei, all human life was of value, and therefore need to be addressed with compassion and care.

Generally the patristic sources see medicine and physicians as God's gifts. It was well known the perception of Christian *physicians* as dedicated, unselfish, and compassionate preservers or restorers of health, always committed to the good of their patients. The Christian physician model is a Hippocratic model, of one who seeks the sick so that he may bring relief to them and strengthen them.

Therefore, when illness occurs, Christianity affirms an ethical duty to struggle against sickness, which if unaddressed can lead to death[7]. The moral requirement to care for the health of the body indicates it is appropriate to use healing methods that will enhance health and maintain life. Two means are used concurrently: spiritual healing and different forms of medicine. The first is embodied in nearly all services of the

church, in particular, the sacrament of healing, or holy unction. There is also a continuing tradition of multiple forms of prayer and saintly intercessions for the healing of body and soul. Thus, the patient can always be helped by spiritual advice. Also, the calling of the doctor is, in the Christian approach is to embody the evangelical principle of love for the neighbour:

> "A doctor's duty is to serve with love and empathy: he is called to lovingly serve the sick. If this is absent, then there is no main engine, no 'soul' and 'heart'. Then everything degenerates and medical practice becomes an abstract application of concepts of disease (morbus) and medication (medicamentum) to a patient. But in reality patients are not abstract ideas consisting of abstract symptoms: they are living beings, soulful and spiritual and suffering; each is quite individual in the makeup of his or her body and soul and totally unique in his or her illness. This is how a doctor must see the patient, understand the patient, and treat the patient".[8]

The meaning and importance of trust. The role of trust

The need for trust in interpersonal relations is a generally human one and it is manifested in all social arenas, from private and family life, to the domain of economic and business relations, the domain of political life, education, health etc. In the area of health, there is increased talk of *medical trust*[9], considered as the result of several types of trust: the patients' trust in their relationship with their physicians, the patients' trust in the medical insurance and services system, the public trust in the medical profession in general, as well as trust in the medical research. In the United States of America, medical ethics focuses on analysing trust at the level of the interpersonal relation between patients and the doctor they choose through the free exercise of option, because the trust manifested at this level is an expression of the patient's individual autonomy. Valuing patient autonomy is thus translated into a "sanctification of the doctor-patient relationship" by the society and the society's concern for judging the quality of this relationship, in which trust is one of the essential attributes[10]. Although the discourse concerning the importance of trust in the doctor-patient relationship is very old, it is only after the 1990s that an increase interest is shown to the empirical research of trust, to understanding its psychological and socio-

cultural mechanisms, as well as to early attempts of building scales for assessing trust. The doctor-patient relationship is a particular context for the manifestation of the need for trust. In these circumstances, we may ask ourselves whether trust within the doctor-patient relationship is similar or dissimilar to the trust manifested in the interpersonal relations of the economic sphere or of other social arenas[11]. According to other authors[12], the manifestation of trust in the doctor-patient relationship has a number of similarities with the trust manifested within a family group, the one pertaining to fraternal and intimate relationships; in other words, it has a strong emotional and affective dimension[13]; this is the reason why sometimes it is manifested as blind faith, especially in the situations where the patient is extremely vulnerable[14]. Trust in a doctor may be explained as a mechanism through which the patient adapts to the stress and vulnerability generated by disease. Thus, especially in the situations where their lives are threatened, patients need to believe – and sometimes they do believe, apparently without basis – in the power doctors and the medical science have in providing solutions[15]. The very high, sometimes irrational, expectations may have positive effects, due to the mobilization of self-healing energies, or due to placebo-type mechanisms being set in motion, the same way they may cause, on the contrary, the patient to feel betrayed and disappointed[16]. The central role of trust in medial relations has long been recognised[17] , and some authors[18] talk about a double value of trust in medical contexts: an intrinsic and an instrumental one. *The intrinsic value* concerns the fact that trust is the defining, essential characteristic that gives meaning, importance and substance to human relations, so that most medical practices in the world have as their purpose the building, consolidation and justification of trust in the relationships formed between patients and the representatives of the medical system.

The instrumental value of trust concerns the fact that the latter serves as a factor in the facilitation and mediation of the therapeutic act, being a catalyst in the interaction between doctors and patients, with positive consequences on the efficiency of the medical intervention. In the absence of a very good knowledge of the intimate mechanisms of trust, the latter influences a wide range of attitudes and behaviours on the side of the patient, in relation to his clinical state, treatment and medical recommendations in general, which, when cumulated, result in a global favourable effect on the patient's health status[19]. Also, trust may be "a key factor for the mind-body interactions responsible for the placebo effect, for the effectiveness of alternative medicine and for the inexplicable variations in the way patients responds to conventional therapies."[20] Trust is considered one of the most important attributes of the doctor-patient relationship, responsible to the same extent for the satisfaction of frustration of both parties in the therapeutic equation.[21] An absence of

trust in the doctor-patient relationship and a climate of mutual scepticism dramatically limit "the opportunities each of the participants in the relationship might have to discover the other's knowledge and expertise"[22]. In other words, the absence of trust in the interaction between doctor and patient hinders effective communication, the identification and use of the best resources either party may have and which may be channelled towards obtaining the goal of the therapy. In the traditional medical culture, trust in the medical profession was considered an objective given, issued from the quality of expert the representative of the medical profession would have[23], in relation to which the patient would be a passive beneficiary of medical expertise. Although in the past the patients' and the families' trust in a doctor was implicit, nowadays trust is seen as something that is established progressively through a number of interactions, and patients and their families are seen as active participants in healthcare, vested with the ability to observe, manage, assess various situations concerning their health status[24]. The presence of trust in the doctor-patient relationship is associated in empirical studies with the improvement of the patient's health status, through indirect mechanisms, such as improved adherence to treatment, improved patient participation in self-care[25], a higher level of patient satisfaction in relation to medical care, the collaborative approach of the management of care, and improved decision-making processes in relation to the therapeutic effort, due to the accurate and appropriate information exchange between those involved in the process[26] etc.

As a number of recent empirical studies have shown[27] the term *trust* has very diverse connotations in the strict context of the doctor-patient relationship, from *fidelity* to *honesty* or *confidentiality* and the protection of privileged information. In the doctor-patient relationship, trust seems to work like a predictor for the continuity of a relationship between a certain patient and a certain doctor, as a motivating factor for increased adherence to general medical recommendations and to the recommendations related strictly to the treatment, for self-care behaviours and for the willingness to pay attention to health in a continued and sustained manner etc. Through all these mechanisms, trust indirectly materialises in the improvement of the patient's clinical state. In order to understand trust, it is useful to also reflect on *distrust*. The literature notes at least three possible meanings of distrust.[28] The first is simply a low level or absence of trust, coming not from an active evaluation of the situation and of the sources of trust, but rather from the fact that the patient is unable to carry out such an evaluation, due to the lack of a sufficient amount of information. Therefore, this first meaning does not refer to distrust in itself, but instead to the impossibility of estimating trust. The second meaning of distrust, that is active distrust, concerns the opposite of trust, incorporated in the patient's pessimistic

views of the intentions the doctor may have[29]. The third meaning is that of a complement to trust, corresponding to he situation in which trust and distrust may coexist[30], and thus trust is restricted and conditional. This last definition of distrust confirms the fact that trust is not specific to a type of patient and, especially, that it is not necessarily a result of a paternalistic style of communication between doctor and patient. Conditional trust is associated to a medical relation in which the patient is positioned as an active contributor, able to evaluate flexibly the data of the medical relationship, in terms of the extent to which the latter meets his expectations; distrust manifested as concern or as the need for verification or validation can turn into trust if the results in the patient's health status correspond to his expectations.

The consequences of trust

The effects of trust have been described for three levels[31]: (1) *at the level of communication between patient, family, medical staff* – mutual trust results in better information flow concerning the significant elements of the patient's health status, and this improves the decision-making process associated to the therapeutic effort; (2) *at the level of the patient-doctor-family relationship* – mutual trust is one of the major ingredients for improving the quality of the relationship, and this translates as a rule into a greater comfort and openness in relation to medical prescriptions on the part of the family[32], and into the doctor's increase willingness to commit firmly to a certain treatment and to the monitoring of patients; (3) *at the level of the family's and the patients' involvement in the healthcare process and in the improvement of care management* – mutual trust is associated with the patient's increased self-esteem, and especially esteem for his own abilities and resources in special, thus facilitating the patient's and the family's active participation in maintaining and improving health status. Although the patient's trust in his doctor has a major influence on the satisfaction of the former concerning his relationship with the doctor, trust in the doctor and patient satisfaction are not completely equivalent from a semantic point of view. While *satisfaction* concerns "the patient's opinion about the doctor's punctual actions"[33], *trust* concerns the expectations from the entire relationship with the doctor, based on previous experiences of interaction with that particular doctor or with other doctors. Empirical data point[34] to a meaning of trust that is deeper than satisfaction, as trust implies a commitment of both parties involved in the relationship. Thus, it is possible to have patients who are satisfied in relation with certain consultations, without this entailing the existence of trust in the relationship with the doctors, the same way it is possible to maintain an important level of trust in a certain doctor, despite dissatisfaction occurring at some point of another throughout the relationship, trust

being, in such situations of momentary dissatisfaction, an important source for finding the will to overlook an unpleasant moment, an error or an episode when the doctor's performance was disappointing.[35]

The impact of trust

In the sphere of medical trust, three levels of analysis – or impact – have been identified:[36] (1) *the micro level,* that of the interpersonal relationship with the doctor or another representative of the medical profession; (2) *the mezzo level*, that of the trust in medical services, hospitals and clinics; (3) *the macro level*, that of public trust in the medical system and in the medical profession in general. Of the three levels of analysis, most studies focus on trust in the doctor-patient relationship. Trust, a multifaceted and complex concept, is explored especially in terms of the possible mechanisms for building it, in terms of the factors strengthening or eroding it, as well as in terms of the consequences on the patient's health. Also there have been recent efforts to build scales for assessing the patients' trust in their doctors, which could then be used as instruments in estimating the quality of the doctor-patient relationship[37]. An idea shared by these analyses is that trust is an essential quality in the doctor-patient relationship, medical practice being impossible in its absence:

> "In order to act for the patient's good, doctors must convince their patients (people who are almost or complete strangers to them) to disclose information about their personal and family history, details about the symptoms they have, things about which otherwise they wouldn't want to discuss with anyone else, not even with people very close to them (...) moreover, to agree to submit to tests (...) and some times to even allow (...) their bodies to be invaded by knives, and parts of their bodies to be removed. In order for the doctor to be allowed to do any of these things, which are important for the good of the patient, he must be trusted. In other words, all rational doctors must admit that, in order to practice medicine, they must earn and deserve trust."[38]

The impact at mezzo and macro level – *trust in the medical profession* – comes from the extremely specialised nature of medical knowledge, as well as from the public perception of the medical profession and of its moral commitment to serving patients:

> "The permission granted to others to see, touch and treat our bodies, to know our secrets, implies an important investment of trust. Trust in professionals is based on technical abilities, acquired after long and rigorous training, on mastering specialised knowledge and abilities and on their dedication to acting responsibly in the patients' interest."[39]

Despite the fact that part of literature talks about a decline of public trust in the medical system and in the medical profession, there are authors that consider, on the contrary, that the medical profession remains at the top of professions in terms of population trust.[40] However, although trust remains an important characteristic of health systems, the sources and the strategies used in order to build and consolidate trust are constantly changing. Opinion polls made in Germany, the Netherlands and the UK show that there is an important gap between the public level of trust in doctors and the medical profession in general on the one hand, and in medical services on the other hand. Thus, the average level of trust in doctors, in general, is much higher than the level of trust in medical institutions and services; in terms of trust in institutions there is a trend towards a decrease and erosion of trust. Also, other analyses highlight a number of paradoxes, such as the fact that an increasingly larger percentage of the population demands additional information about the quality of doctors and hospitals, and that the need for information is not correlated to a communication deficit in the doctor-patient relationship. This situation is interpreted as a change that has occurred in the patterns of trust building, in which the trend towards additional information among the population occupies a central place.[41]

Trust, an element which in traditional medical culture is more or less based on affect, is supplemented increasingly with rational criteria and requires to be backed by evidence. Trust in the medical profession is an imperative, concerning the very future of this profession. Currently, the main resource of trust comes from the history of the medical profession and from the capital of trust and of prestige consolidated by previous generations of doctors. As beneficiaries of their predecessors' credibility, as well as those who will create the reputation that will be inherited by the next generation of doctors, physicians also have the responsibility of acting in such a way as to make sure the medical profession will continue to enjoy the necessary trust. A study that aimed to identify the factors that allow the formulation of predictions of trust at the three levels in the same population group came up with the following conclusions:[42] (1) there are a number of common factors responsible for all three levels of trust – micro, mezzo, macro – as well as elements of difference; (2) socio-demographic variables (age, income level, health status) were found as

weak predictors for all types of trust; (3) relational factors are the most important common predictors: previous relationship with the same doctor, with insurance companies or with other representatives of the healthcare system, the frequency and seriousness of disputes with doctors or insurers, the intensity of contact with the latter (frequency of interaction, age of relationship etc.).

Dimensions of trust

The concept of trust occurs in a multitude of disciplines, such as sociology, psychology, philosophy, organisational research, anthropology, being commonly defined as the "optimistic acceptance of a vulnerable situation in which the trustor believes the trustee will care for the trustor's interests."[43] Gilson identifies in the definition above several *dimensions* of trust[44] that are relevant to the relationship between a doctor and a patient: the relational dimension, the voluntary dimension, the expectations dimension, the intentionality dimension, the reciprocity dimension and the temporal dimension[45].

The relational dimension: in terms of a doctor-patient relationship, this means that trust is not a quality or an attribute of the interacting individuals, but instead a characteristic of the very interaction, being often brought up as a relevant indicator of *the quality of the relationship* between the doctor and the patient.

The voluntary dimension, associated to a response to a situation where one of the parties is vulnerable. As a rule, the patient's trust in a doctor is connected to one of the parties' illness-generated vulnerability situation in relation to the other.

The expectations dimension – it concerns the expectations associated to the relationship with the other, in relation with one's own interests. As a rule, such expectations cover as much the behaviour level, as the level of the other's intentions, attitudes and values, in other words the domain of "ethics, integrity and motives"[46], define trust between doctor and patient as a *process* that evolves in time, consisting of varying levels and having certain dimensions: expectations, mutual intentions and reciprocity. Trust as a *process* is viewed firstly in its dynamic, temporal dimension, evolving in relation to context and going through stages of growth, stabilisation or erosion. Thus, especially in the situation of chronic diseases, patients or their families "may go from complete and unreserved trust in the health system to a state of disappointment, only to return later to a state of trust limited at certain individuals."[47] Therefore, trust does not emerge instantaneously, instead being built or eroded in time. Moreover, we can talk about a path taken by the doctor-patient relationship in terms of trust, especially in relationships that are configured in the long term, such as the relationship between patients and their GPs, or between patients

and their attending physicians in the case of chronic diseases. Also, the dimension of *expectations* concerning the other's behaviour or attitude generates an important reference point for trust: the latter may develop, consolidate, or, on the contrary. It may turn into scepticism of distrust, depending to the extent to which each of the interacting parties will be able of meeting the other party's expectations. The authors quote a number of empirical studies discussing the two dimensions mentioned above, the temporal dimension and the expectations dimension, in an attempt at determining the stages of this process of trust building between the patient and the medical system.

Another important dimension of trust in the doctor-patient relationship is that of *mutual intention and reciprocity*[48]. The former concerns the fact that in his relationship each of the parties pursues something: to trust or to earn the other party's trust. In this respect, literature mentions that one of the needs the patients have in relation to the healthcare system is the need to have trust-based relationships with medical personnel.

Rowe & Kellam consider that in the strategies of health care providers trust should be *a mandatory intentional element, "a permanent imperative"*[49] in order to prevent vulnerable populations from having resistance behaviours and attitudes in relation to medical prescriptions and authority. Intentionality implies admitting the fact that trust is built over time, through a collaborative process, and therefore it is, in the clinical relationship, more of a desiderate than a starting point. The authors suggest the concept of "collaborative trust", which refers to "sharing knowledge, emotional connection in the clinical paradigm, respecting professional ethics and confidentiality, mutual respect of the other's culture and beliefs, honest manifestation in the relationship with the other and developing certain reciprocity in terms of participation in decision-making"[50]. Reciprocity is also mentioned among the key features of a *successful relationship*[51] between families and patients on the one side and the medical staff on the other[52]. Trust, viewed in its reciprocity dimension, has the role of harmonising the differing perspectives of the main actors in interaction, the medical personnel and the patient, facilitating collaborative attitudes and behaviours. The lack of reciprocity is generally associated to the lack of collaborative behaviours and is characterised by the concern of one of the parties (or both) for intensifying or extending control over the run of things, as well as for restricting the other's participation in making decisions about health care and the therapeutic process.

Stages in the development of trust

In the first stage of interaction between the patient and the doctor or another health care worker we can talk about a *naive trust,*[53] in the absence of previous mutual knowledge between the actors and of an assessment of the probability that the expectations of both sides will be met. At this stage, some authors state that there exists an almost universal need for trust on the part of the patients, created by the vulnerability generated by sickness. The consequence is that "the patient grants doctors, clinicians and institutions discretionary powers, so that they can restore his health and possibly even save his life".[54] Although the analysis of vulnerability and of the mechanisms that generate it would constitute a study in its own right, it is important to mention that vulnerability is enhanced by the asymmetry of information, due to the specialised nature of medical knowledge, as well as by the uncertainty and the element of risk in connection with the competence and the intentions of the practitioner on whom the patient is dependent.[55] Therefore, uncertainty, risk, the impossibility of generating a definition for the situation that would result in a solution for health creates the premises for *the patient's need to trust* the medical system; at the beginning of the interaction with the medical system, this need may take the form of naïve trust – blind faith. The second stage is seen as a stage of *disenchantment in the relationship*, when the illusion of the total satisfaction of expectations is dispelled. This is the stage where the mutual expectations of patients and healthcare staff are forged in concrete contexts, and trust is questioned or reconfigured more realistically by comparison to the previous stage. The main difference between the two stages comes from the change in the *nature* of trust: in the first stage it is predominantly emotional and affective; it is based on beliefs, whereas in the second stage it becomes much more rational. Finally, in the third stage, the trust between the patient and the doctor or another healthcare worker takes the form of a *conditional alliance:* trust may be developed, consolidated or undermined, depending on context, based on information exchange and on the quality of effective cooperation in the matter of healthcare. Of course, building and consolidating trust are facilitated by a reasonable level of mutual expectations and depend directly on the extent to which these are met; trust is eroded when expectations are not met or when the perspectives of the parties involved in the interaction diverge or even conflict. Although most studies about trust in the doctor-patient relationship recognise the dynamic nature of this phenomenon, there are very few empirical studies exploring the manner in which doctors and patients see trust in motion and in diverse circumstances, as well as the contents of trust in such a relationship.[56]

The patient's perspectives on trust

Skirbekk et al. interpret trust in the doctor-patient relationship as *an expression of "the patient's implicit willingness* to accept the doctor's judgment"[57] in matters of interest for his health status. This implicit nature of trust, as well as its multifaceted character makes the capture of the matter trust in empirical studies very difficult. Skirbekk's study,[58] which uses qualitative data collection methods, interviews and observation of routine interactions between doctors and patients, reports that, although all the patients taking part in the research had declared they had a certain level of trust in their doctors, this was never "blind faith", but rather a certain *gradient of trust*, a kind of conditional or critical trust. Trust is built through a mechanism of *conditional mandating*, meaning that patients authorise to a certain extent the doctor (and vice-versa) to judge and act in certain areas of interest for the patient's health status. As a rule in the patients' accounts trust is connected to the doctors' role performance and to the extent to which this meets the patients' expectations. However, the patients' expectations may vary greatly: some wish to be heard and helped to find a solution (not necessarily to have their problem solved), others wish that the doctor be honest in his information concerning the diagnosis, his knowledge and previous experience in the domain; others wish that the doctor limit his interaction with them at strictly medical information, while others desire a less formal and technical manner of interacting with the doctor. Some patients want short appointments, with brief and concise communication about medical issues, others want to be listened to, to have the feeling that they can relate to the doctor also outside the strictly medical sphere. Therefore, matter of trust and of *mandating the doctor to judge and make decisions in the sphere of a patient's health*, despite the diversity of expectations that it may bring about, seems to be a matter of adapting the doctor's role performance to the patient's expectations.

The sources of trust and the factors facilitating trust in the doctor-patient relationship

Among the conditions that facilitate the patients' trust in their relationship with the doctors we find both descriptors of individual behaviours, attitudes and practices, as well as elements pertaining to the context where the doctor-patient interaction unfolds.[59] *The doctor's professional competencies*, manifested in the technical skills and in various elements of practical expertise; also, there are studies pointing out that oftentimes patients and their families seek out medical personnel that would recognise, respect and value the patients' or the families'

experience and competencies. *The doctors' communication skills*, their ability to provide information and appropriate explanations, adapted to the patients' and their families' level of understanding, so that a common language can be found; another important element for both doctors and other categories of medical personnel is the ability to negotiate in tense situations, to manage conflict and to have an open attitude in relation to alternative solutions. *The medical staff's respectful and non-judgemental attitude*, sensitivity to cultural specifics; the ability to take the patient's or the family's point of view seriously and to encourage their participation in the decision-making process in terms of healthcare, as well as respect its autonomy[60]. *The doctor's accessibility* and ability to go beyond a technical approach of a professional relationship, showing genuine interest for the patient *as an individual* rather than an object of professional attention.

Conclusion

Trust is an important concept in the doctor-patient relationship. The patient must be able to trust those who care for him, the way those providing care must trust the patients to tell the truth about themselves. The provider must offer an environment in which the patient feels comfortable with self-disclosure in medical, social and psychological terms. Trust is a necessary condition for medical practice, it is the "fundamental moral law for medicine"61, and earning trust and the proof they deserve it must concern every representative of the medical profession. Health policies and the management of healthcare institutions must integrate in the medical profession and in the healthcare system the reflection on trust, as well as on the interpersonal trust occurring in the doctor-patient relationship.

Notes

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