

Indicators for Medical Mistrust in Healthcare—A Review and Standpoint from Southeast Asia

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Abstract

The relationship based on trust is exceptionally important in healthcare, where life or death and quality of health are major concerns. Relational crack jeopardises the provision of quality healthcare when trust is taken for granted. Trust is believed to be the vital key to minimise medical negligence, lawsuits and patient complaints towards healthcare providers while acting as an empowering agent to significant clinical outcomes. Trust is indispensable to healthcare. However, to identify its deterioration is not a simple feature. Moreover, lack of research and public dissemination complicate this topic further. Hence, understanding medical mistrust issues and their associated indicators is urgently needed to ensure the top-notch provision of healthcare. We employed narrative review methodology together with key terms matching for the selected electronic databases for this article. Our review concluded that an “Increasing number of medical litigations and complaints towards physicians”, “Physicians’ low mastery of interpersonal communication skill” and “Patients’ demand, practice, and non-disclosure of alternative treatments” are the possible indicators to predict mistrust. Efforts to restore and strengthen trust can only be made when these indicators are well understood firsthand.

Keywords: *trust, indicator, interpersonal communication, complementary & alternative medicine, patient-physician-relationship, healthcare*

Introduction

Being able to trust each other in healthcare is a requirement for beneficial and long lasting partnership. Bonding forged with trust requires mastery of both technical and social competencies for it to last continually. This point is exceptionally important in the health sector, where life or death is a major constant concern. Patient-physician relationship (PPR) is a prime example of bonding where serious concerns need to be prioritised. The term medical trust used in this article integrates the concept of collaborative trust. It is defined as a form of trust which was birthed due to a partnership between patient and physician, where goals are shared, personal contributions to the relationship, as well as mutual respect are emphasised (1). This type of trust focuses on the exchanges of

knowledge, emotional and professional bonding developments, honesty and respect towards an ongoing relationship. When trust is left unattended, it jeopardises the core principle of healthcare profession, which is to bring forth positive health outcomes to its clients (2).

Mistrust in healthcare is associated with the increment of medical negligence, complaints and lawsuit cases. In addition, patients’ display of lack of concern and knowledge of trust and refusal to disclose their alternative treatment practices also are connected with trust issues with their physician. From the patient perspective, the physician’s low mastery of interpersonal skill is perceived as incompetence and thus contributes to patients’ mistrust. All these issues which are believed to be the outcome of taking medical trust for granted shall be discussed further. What is evident is that when a

party failed to keep their word or perform the act of betrayal, these actions can definitely diminish or destroy trust.

Interest in trust in clinical relationship is growing steadily around the globe. Brennan et al. (3) pointed out that literatures on this aspect have increased in recent years and approximately 44% have been carried out in United States. This figure reflects the crucial need for trust being the central research area in patient-physician relationships in advanced countries, specifically in health counseling and therapeutic relationship aspects. However, the situation differs in eastern culture where trust remains a secret topic due to its delicate nature. Therefore, the foundation of medical trust is not well explored and literatures highlighting its indicators are scarce (4). This justifies the necessities for trust to be thoroughly researched, fathomed and exposed to the public. These indicators are urgently needed to prevent, and to put a stop to the uprising issues associated with mistrust in PPR and consequently, in parallel with the global health need to provide the best caring services.

Overall, this review attempts to highlight issues leading to medical mistrust and its possible indicators for future prediction in health care. This scientific piece is conceived as the initial step to prevent further tarnishing medical relationships, as well as to enhance public trust and cooperation with healthcare institutions. Shedding light on medical mistrust proves to be vital for more quality and efficient health service provision in the future (5).

Methodology

Narrative review methodology is employed. Electronic databases such as MEDLINE, Google Scholar, and Google search engine (open access materials) were searched. Key term search was performed by combining “Trust” with the following subterms: “Mistrust”, “Malpractice”, “Misconduct”, “Healthcare”, and “Patient-physician-relationship”. The date of search for these databases was between the periods of 6 August 2015 to 10 August 2015. The search was performed without restriction to the year of publication using the mentioned search terms. Additionally, the search was also completed with the inclusion of the word “And” in between the terms. Supplementary key words and search methods offered by MEDLINE were avoided. The reason was to standardise the search method between MEDLINE and another two electronic

databases (Google Scholar and Google search engine) used.

The following selection criteria were employed: Return results were restricted to only original publications in the English language, from the year 1984 to 2015. Only full-text journals, published theses and online articles which contribute to the following objectives were reviewed: i) Evidence and statistic on malpractice, misconduct, complaints and medico-legal cases aimed at physician or health institutions ii) How trust is being perceived in healthcare and, iii) Modifiable indicators which possibly contribute to the deterioration of medical trust. In this paper, possible non-modifiable factors which could encompass demographic, socio-cultural determinants and political aspects were omitted.

Other databases not subscribed by our institution and involve payment to view were excluded. Materials from the distant past were included to ensure the originality of the conceptual idea of trust is retained and comparison with the recent literatures can be made. In addition, a reference list of the retrieved articles was considered to determine other relevant literatures. This warrants the breadth and depth of the reviewed topic and objectives.

Results and Discussion

Methodology and study design used for the reviewed papers are not the main emphasis for this study because not all were clearly stated. Moreover, the main goal of this paper is to develop a preliminary conceptualisation which elaborates on the phenomenon of medical mistrust and its possible indicators based on the integration of the reviewed materials. We tried to include studies which mostly took place at clinical settings and between patients and their healthcare providers. The majority of the included papers were cross-sectional studies and consist of 15 non-randomised and eight randomised sampling studies, as well as 12 other materials which encompass review papers, reports, commentary articles and letter to editors.

Overall, a total of 40 articles which met the selection criteria were included for this write-up. These 40 articles range between the years 1984 to 2015, with 21 references were under year 2010. From the screened materials, general themes were derived based on the triangulation

method which comprises a literature review, discussion of experts and authors' opinions. Thirty-five of the articles were thoroughly reviewed and were categorised based on three themes; Medical litigation and complaints (MLC), Interpersonal communication skill (IPC) and Complementary & alternative medicine/medical practice (CAM). The number of reviewed articles with respect to the themes is proportioned as; 12:12:10 (Please refer Table 1).

From 35 papers reviewed, medical mistrust phenomenon can be theorised to possess interconnections between three indicators, namely i) Increasing medical litigation and complaints about physicians, ii) Physicians' low mastery of interpersonal communication skills and iii) Patients' demand, practice and non-disclosure of alternative treatments to the physician in charge (refer Figure 1). Most of these indicators are mostly healthcare provider-driven, particularly physician.

Prologue to Medical Trust

Medical trust is one of the prerequisites for successful caring services. It is the product of reciprocity between patients and physicians in healthcare sector. Both parties need to communicate frequently, while exchanging knowledge, developing emotional and professional ties, as well as nurturing the bond with honesty and respect (1, 6). Trust requires strong commitment from the parties to achieve one core objective, which is to work together towards a strong and ongoing relationship with mutual goals (1). They need to cast their ego aside-whether they prefer each other or not and just focus on the shared goal. This is much true in PPR where the situation requires patients to place trust in their physician whether he or she is a total stranger, merely known casually or more apparent in cases of life or death. Moreover, patients are the vulnerable party because of their ailment and limited medical knowledge. They do not have other choices but to expose their weaknesses to the tending physician and silently hugging close to their heart the possibility of being exploited. Patients have to place their bets on the physician's goodwill and competence as it is the only option viable.

In spite of being a delicate, reserved issue in eastern countries and complex to be garnered, trust has its own merits. When preserved in a medical relationship, trust is able to demonstrate its mutual clinical benefits, such as better therapeutic outcomes, efficiency in

job performance and professional satisfaction (7–8). The bond forged with it comes together with a powerful constraint which prevents trust violation from being committed markedly among individuals who share PPR, familial ties and close friendship (6). This means, upon its attainment, mutual loyalty and confidentiality are necessities to be present along PPR.

However, when we fail to realise the advantages of trust, do not try to seek or learn about it, its attainment shall become complex. One wrong step in matters regarding trust could lead to greater consequences. For instance, the increment of complaints and legal cases towards healthcare providers, exclusively physicians and the credibility of medical institutions and staffs can be jeopardised. The aftermath will definitely be disastrous as it shall snatch away quality health services and leave the citizen—everyone's health exposed to a great deal of risks and thus endangers them. Therefore, mistrust is definitely a matter to be concerned, especially in a medical setting. Its associated indicators need to be thoroughly researched and the results should be used as an ingredient to derive its interventions.

Indicators for Medical Mistrust

- (i) Increasing medical litigations and complaints about physician

In the past, Blendon et al. (9) stated that the public trust in medical leaders had critically diminished. The report also noted that about 47% of individuals with insurance and 61% of "heavy managed care" patients were more concerned about their financial security than spending on the best treatment when they are ill. Furthermore, about half of the surveyed population of total 3,700 American adults showed negative impressions about health care provided due to the decrease in quality in the past (9). A glimpse at the UK physicians' fitness to practice statistics clearly leaves us with a state of concern. An increasing trend of complaints about physicians was observed since year 2010 right up to the year 2013 with 64% increment of cases from the public were documented (10–11). The percentage of UK medical physicians halted for medical practice also showed an increment to 42% between 2010 and 2013. Overall, 17% increment in the revocation and suspension of the medical licenses was noticed between 2008 and the subsequent five years (12).

These data on medical trust disputes clearly signifies the cracks of trust in health

Table 1. Evidence table for reviewed studies

Reference	Description	Findings	Themes
9. Understanding the managed care backlash	A randomised cross-sectional survey of 3,700 American adults from United States and California using telephone interviews year 1997	47% of the insured and 61% of heavy managed care adults are more concern for their health plan to be money-saving rather than getting the best treatment for them when they are sick. 51% of United States adults and 46% Californian said that the quality of health care decreased for the past few years	MLC
10 & 11. The state of medical education and practice in the UK 2012 & 2014	All registered United Kingdom physicians year 2007 to 2013 based on The State of Medical Education and Practice in the United Kingdom Report	64% rise in the number of complaints is in regards to the physician's fitness to practice, between years 2010–2013. 42% increment of physician being prevented or suspension from medical practice	MLC
12. U.S. Medical Regulatory Trends and Actions	All registered United States physicians year 2014	A jump of 17% number of medical licences being revoked, suspended or denied between year 2008–2012	MLC
13. Playing politics with the doctor-patient relationship	*Letter to editor from a medical physician.	Complaints and doubts about the truth delivered to patients, specifically in regards to abortion. The author who is a physician mistrusts other physicians & views a number them would lie to their patients in order to get what they want, did not give full commitment or having courage to bring an end to intrusions between PPR	MLC
14. Exploring the doctor-patient relationship in clinical practice in hospital settings	*A narrative review exploring PPR in hospital setting from both subjects' perspectives	Good PPR is the crucial factor to ensure better clinical outcome and satisfaction for patients, disregarding socio-cultural determinants	MLC
15. Silent dimension: expression humanism in each medical encounter	*A commentary article which reviewed four real case examples in hospital and primary care settings, in regards to the need for humanism medical practices	Current and rapid advances of modern treatment is lacking humanistic aspects in patient care, hence limiting the quality of care and results in the lost for patients and physicians too	MLC
16. Trusting patients, trusting nurses	*An argumentative article which challenges traditional perception about PPR trust	Trust displayed in PPR is perceived as natural and should be presence because healthcare providers are registered practitioners. Despite lacking substantive foundation to such assumption, abuses of trust did occur and invited incompetency and damages healthcare relationships. Complaints due to failure to protect patients can be viewed as medical mistrust, resulting from physician's lack of efforts to prove themselves trustworthy	MLC

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Table 1. (Continued)

Reference	Description	Findings	Themes
17. The doctor-patient relationship and malpractice: lessons from plaintiff depositions	A randomised descriptive series review using 45 plaintiffs' depositions selected from 67 settled malpractice suits against a large metropolitan medical center year 1985–1987	Among the data set of 45 cases, 26.6% patients sued physicians due to the presence of a breakdown in trust caused by interpersonal issues which accompanied with adverse outcomes	MLC
18. Obstetricians' prior malpractice experience and patients' satisfaction with care	A randomised cross-sectional questionnaire survey among 963 mothers with malpractice claims experiences of their obstetricians from year 1987 Florida Vital Statistics, most interviewed using telephone and 53 mothers by in-person	Physicians who have been sued frequently due to malpractices are mostly those who received complains about their interpersonal care provision. Feeling being rushed, never received explanations for test, and being ignored were among reported interpersonal care aspect	MLC
19. Incidence of and risk factors for medical malpractice lawsuits among MOHs surgeons	A randomised cross-sectional survey among 300 United State physicians in year 2004	The more experienced or longer physician reported practicing medicine, the higher chance of having been sued	MLC
20. Factors associated with medical malpractice: results from a pilot study	A randomised review on lawsuit data, claims and underwriting from State Volunteer Mutual Insurance Company, Tennessee, United State. Stratified random sample of 51 active and 48 inactive physicians drawn from 8867 record of policyholders in June 1986	Time in practice, being group practice and length of visit are risk factors which in relation to physicians' claim incidence or frequency	MLC
21. Twenty years of evidence on the outcomes of malpractice claims	*A reviews on the body of research which investigates data on the fairness of the outcomes of medical malpractice litigation for over two decades from year 1975	Malpractice outcomes possess a good correlation with the provision of quality care to patients. Reviewed studies share a common correlation between quality of care given to the patients and the odd of settlement payment	MLC
1. The health care relationship trust scale: Development and psychometric evaluation	A non-randomised cross-sectional survey among 99 HIV positive adult patients from HIV primary care sites, Connecticut	Sense of partnership and shared decision-making, respectful communication and interpersonal connection are strong constructs to PPR	IPC

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Table 1. (Continued)

Reference	Description	Findings	Themes
6. Mandates of trust in the doctor-patient relationship	A non-randomised combination of qualitative interviews and video observations involving 16 patients and eight family physicians in urban and suburban areas, Norway	Trust was perceived to be established based on; Physician showing (i) An early interest in patients, (ii) Sensitivity to patient's emotion, (iii) Giving time to patient and the relationship – no rushing or in hurry during consultation, (iv) Establish alliances against a common adversary, not only against patient's illnesses and lastly, (v) More effort to see each other on a more personal level than staying in their roles by creating common ground or sharing a sense of humor	IPC
17. The doctor-patient relationship and malpractice: lessons from plaintiff depositions	A randomised descriptive series review using 45 plaintiffs' depositions from 67 settled malpractice suits against a large metropolitan medical center between 1985 and 1987. No details about the conducted study area	71.1% (n=32) of the malpractice cases were due to relationship issues such as physician's lack of caring or collaboration with patient. Collaboration between physicians and patients correlates with the risk of malpractice lawsuits Four main interpersonal communication issues; (i) Not understanding patients or family perspective, (ii) Dysfunctional delivery of information, (iii) Causing patients to feel deserted and (iv) Devaluing patient or family views Insufficient or unclear feedback from physician, short consultation session, and having the feeling physician is rushing during meeting are part of the communication incompetence	IPC
22. Concepts of trust among patients with serious illness	A non-randomised qualitative interview using a semi-structured protocol, 30 respondents from each groups which diagnosed with breast cancer, chronic Lyme disease and mental illness	Erosion of trust is a growing concern alongside with the major growth in health care, particularly among the medical managerial party and public leaders Physician listening carefully and providing responsive feedback, reducing interruption, maintaining eye contact, showing understanding towards patients' vulnerabilities and difficulties are important interpersonal competence cues to patients	IPC
23. Physician-Patient Communication A Key to Malpractice Prevention	*Editorial review article which referred to studies conducted in medical setting between patients and physicians	Physician communication skills are a risk factor of malpractice lawsuits. Spending more time with patients through preoperative consultations or visits would build strong relationship and decrease risk of lawsuit	IPC

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Table 1. (Continued)

Reference	Description	Findings	Themes
24. Translating primary care practice climate into patient activation	A mixed-mode survey (administrative databases, primary care visits and then questionnaire) among 2224 adult enrollees and primary care teams composed of 97 physicians and 187 support staffs at Atlanta metropolitan area year 2004	Significant positive relationship between practice climate (support and collaboration within a team) and patient trust towards their primary care physician, and hence, bringing forth activation in their health. Supportive interactions facilitate trust-building, assist in narrowing the gap between power imbalance between patients and physicians, contributing to more active roles taken by patients for benefit of their own health	IPC
25. Measuring patient-provider trust in a primary care population: refinement of the health care relationship trust scale	A randomised cross-sectional survey involving 431 adult primary care patients in a large adult primary care clinic in urban area of north-eastern United States	Further reconfirms previous study (1) that interpersonal connection, professional partnering and respectful communication possess high internal consistency towards patient-physician-trust factor	IPC
26. HIV status, trust in health care providers and distrust in the health care system among Bronx women	A non-randomised cross-sectional study using laboratory tests and guided questionnaire interviews were conducted among 102 HIV-positive patients recruited from a variety of sites	HIV patients tend to have low trust towards HIV healthcare system but not their physician. This could be due to more frequent visits and longer relationships with their physician	IPC
27. The role of trust in use of preventative services among low income African American women	A non-randomised cross-sectional population-based telephone survey among 961 African-American over 40 years old at Washington, DC.	High trust is associated with these primary care characteristics – Better communication, more-organised primary care, continuity of care and accessibility of the coordination of specialty care by one's regular physician. Primary care characteristics were more predictive of patient trust than patient characteristics	IPC
28. Trust: a continuing imperative	*A review paper about the reasons for mistrust between provider and African American patients	Interpersonal skills which lead to trust are as important as clinical skills. Therapeutic communication skills are of primary importance for trust to develop in clinician-patient relationship. This skill needs to be balance with clinical skills to develop a therapeutic bond	IPC
29. The effect of physician behaviour on the collection of data	A non-randomised interview for 74 complete visits among patients and their physician between years 1980-1982 was audio recorded and analysed qualitatively. No specific selection controls were used & research was carried out at Primary Care Internal Medicine Practice, Wayne State University	Interruption during patient's opening statements delivery occurred on average 18 seconds which is relatively short time, especially during new visits by physician. Out of 52 interrupted opening statements only one was eventually completed, whereas the rest were shifted to physician-centered, asking questions to address previous concerns. From the total of 74, only 68 visits physician inquired whether patients faced any problems earlier on	IPC

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Table 1. (Continued)

Reference	Description	Findings	Themes
30. Does being informed and feeling informed affect patients' trust in their radiation oncologist?	A non-randomised cross-sectional study between 15 radiation oncologists & 101 new patients from Academic Medical Centre in Amsterdam. A week prior to physician's consultation, patients were mailed and requested to answer one questionnaire. Another follow-up questionnaire was also mailed after one week of the meeting	One in every three patients, no discussion were made about prognosis information at all between patient and their physician	IPC
31. Determinants of public trust in CAM	A non-randomised cross-sectional postal questionnaire survey of 915 Dutch Health Care Consumer Panel members, year 2001, Netherlands	Public trust in CAM is lower than public trust in conventional medicine. CAM users' trust were significantly due to media exposure, institutional guarantees, information from other social network acquaintances, and users' personal experience. This study rejected the relationship between physician's influences towards patient's CAM practices. Similarly, there is no relationship between public trust in conventional medicine and public trust in CAM was found in CAM non-users and CAM users, which is in contrast to the previous study (34)	CAM
32. How cancer patients build trust in traditional Chinese medicine	A non-randomised descriptive qualitative study among 12 cancer inpatients and outpatients of a medical center in Taiwan which practices both conventional and alternative medicine, using semi-structured guide	Knowing the stage and how advanced the stage diagnosed to cancer patient can assist in building trust towards CAM practice. It elevates understanding about patients' medical care-seeking behaviour in CAM. Recommendation by physician to use CAM increase patient's trust in CAM	CAM
33. Integration of CAM in primary care: what do patients want?	A non-randomised cross sectional survey involving mixed-methods approach (questionnaire and focus group discussion) on 416 Rheumatoid arthritis patients or suffering joint complaint. Patient recruitment was done through email and internet. Focus group consists of 10 patients who suffer from a variety of joint diseases	It is the current trend that patients purposely look for CAM because they desire for integrative or more holistically alternative, not due to reasons of having negative experience with modern medication Physician only referred a small amount of patients (9%) in Netherland to CAM practitioner, which against what their patients wants. Physician need to take seriously about patient's CAM use, listen carefully then inquiring patient about CAM and providing its related information, as well as collaborating with CAM practitioners	CAM

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Table 1. (Continued)

Reference	Description	Findings	Themes
34. CAM disclosure to the health care providers: A qualitative insight from Malaysian cancer patients	A non-randomised purposive sampled qualitative study using a semi-structured interview guide among 12 Malaysian oncology patients year 2010	Fear of termination of therapies and perceive anger upon its disclosure to physician, perceived simplicity of T&CM and physician's lack of interest in T&CM were excuses why patients reluctant to disclose their T&CM use	CAM
35. CAM therapy use among Chinese and Vietnamese Americans: Prevalence, associated factors, and effects of patient and clinician communication	A non-randomised cross-sectional study among 3258 Chinese & Vietnamese Americans patients who visited in one of the 11 community health centers within 30 days throughout United States. Interviewees were mail-surveyed using a questionnaire and followed-up with telephone reminder calls	Among 3258 interviewees, two thirds had used some form of CAM therapy before but only 7.6% patients or one among 10 have disclosed its practice to their physicians. Not stated whether patients who reported CAM usage disclosure because being inquired by the physician or self-willingly triggered the discussion Those who practiced CAM therapies a week before their clinical visits and decided to disclose and discuss its usage with their physician during the visit, 26% among of them reported better overall patient ratings of quality care for the visits. These patients were more likely to have more confidence and trust in the doctor, said they were treated with respect and courtesy, as well as have recommended the health center to other parties	CAM
36. Use of CAM by breast cancer patients: prevalence, patterns and communication with physicians	A non-randomised survey among 148 United States breast cancer inpatients using questionnaire. The questionnaires were completed over computer-aided telephone interviewing method	Interviewees may have avoided CAM usage disclosure session because physician did not asked about it or fear being criticise by the physician CAM use has grown in popularity among general population as well as cancer patients 73.8% of the respondents indicated that they have communicated about CAM usage with their physician. Factors such as higher income, married or living with a partner, received chemotherapy and radiation therapy were associated with informing physician about CAM use. The possible reason conjectured by the author is patients used CAM to offset the potential side effects caused by their current conventional treatment regimen	CAM

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Table 1. (Continued)

Reference	Description	Findings	Themes
37. What people 50 and older are using and discussing with their physicians	A randomised cross-sectional study of 1013 United State population aged 50 and above, telephone survey using questionnaire, year 2010	National Health Interview Survey Data indicated that 33% among adults who practiced CAM in the past 12 months disclosed their CAM usage to their health care providers, with physician being the most likely to be disclosed to Patients (55%) were the most likely individual who begin the discussion about CAM with their health care providers, whereas health care providers (not only physician) being the second place, 26% Two major reasons why patients and their health care providers do not discuss about CAM were the provider never ask and patients did not know that they should disclose it	CAM
38. Disclosure of CAM use to medical practitioners: A review of qualitative and quantitative studies	*A review of 12 articles within year 1993-2002 focusing on to patient's disclosure of CAM use to practitioners	Three major reasons for non-disclosure of CAM usage: i) Patients perceived they did not need to inform physician because physician do not have knowledge of CAM; ii) Physician did not ask about their use and; iii) Fear of a negative response from medical practitioners	CAM
39. Communication between physicians and cancer patients about CAM. Exploring patients' perspectives	A non-randomised cross-sectional survey using stratified purposeful sampling followed by qualitative interview among 113 cancer patients (93 CAM users and 30 non-users) from all four major Hawaiian Islands, exploring experience on C AM use	Three main barriers which bring about unsuccessful communication about CAM use between patients and physician, from patients' anticipation: i) Physician opposed or being indifference towards CAM use; ii) Physician focus on scientific evidence and; iii) Physician shall give negative response about CAM use	CAM
40. CAM use by Malaysian oncology patients	A non-randomised qualitative exploratory study design was utilised to employ a semi-structured interview among 20 cancer patients in Oncology ward, Penang General Hospital, Malaysia. Purposive sampling was used	Patients reported that primary principle for using CAM was to prevent disease recurrence, as well as to lessen side effects and regaining strength prior to the current conventional treatment they are receiving The key reason for not disclosing or opening a discussion CAM use is fear of termination of therapy by physicians	CAM

^aAbbreviations: ATP = alternative therapy practice; CAM = complementary & alternative medicine/medical practice; IPC = interpersonal communication skill; MLC = medical litigation and complaint; PPR = patient-physician relationship.

* Research methodology was not well discussed.

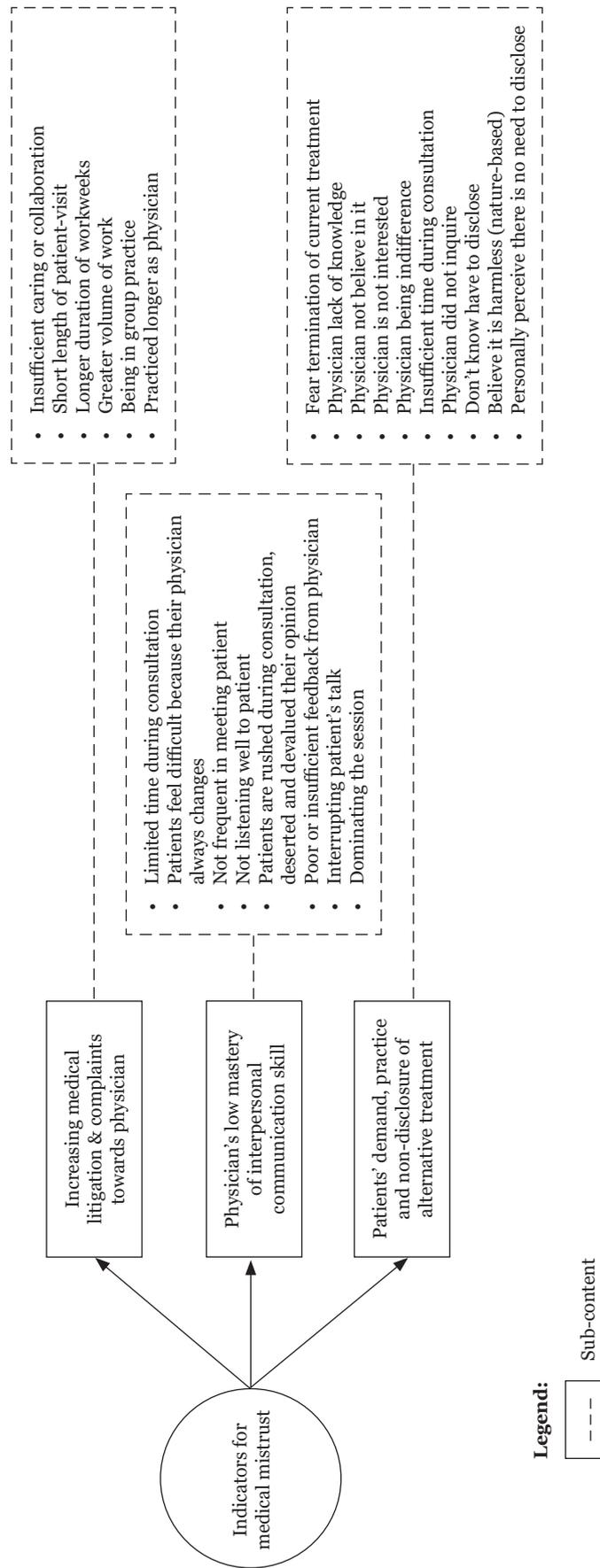


Figure 1. Framework indicators for medical mistrust

professionalism and requests us to reinstate the respective parties' trust (13–14). Adding up to the previous point, the growth in comorbidity and mortality rates also triggered a great concern about the quality of care provided. Current advancements in medical care were said to be lacking in humanistic aspects, particularly patient care (15). This matter does not end easily as it further infects other patients' psyche, taints the grace of the healthcare professions, defiles health institutions' dignity and is capable of paralysing the entire country's healthcare system (16).

In regard to potential risks leading to a greater volume of malpractice, literatures suggest these factors were related to physicians; low interpersonal communication skill mastery, patients' perception of insufficient caring or collaboration, short length of patient-visit, long duration of workweeks, greater volumes of work, being in group practice and having longer working experience as a physician (17–20).

A study by Philip and Peters (21) which took evidence from two decades concluded that claims on medical malpractice were strongly correlated with the quality of care provided and contributed to the shaping of trust. Hence, it is indeed important and timely that these issues be revisited with trust in mind. The foundation of trust needs to be thoroughly researched and revealed to the public to permit more effective management on relevant matters, as well as restore public trust and appreciation of health professions.

(ii) Physician's low mastery of interpersonal communication skill

Rejection of social trust in healthcare is not uncommon. It is said to be closely bound to the physician's roles (6, 22). Beckman and his teammates concluded that physicians' interpersonal communication incompetency accounted for more than 70% of malpractice cases in the past (17). This figure was also highlighted by a malpractice attorneys' report published back in the year 1985, which states that communication problems is the prime reason for patients to issue malpractice suits and accounted for more than 80% of the cases (23). When these reports were compared, physicians' low mastery of interpersonal communication skills remained to be an issue which has prolonged for at least eight years until currently.

More recent studies by Beckner and Roblin (24), Bova et al. (25), Cunningham et al. (26) and

O'Malley et al. (27) found significant connections between patients' trust and physicians' interpersonal communication (IPC) skills. To further illustrate this point, difficulties to possess a regular physician, limited length of time with the physician and infrequent meetups with the tending physician are the IPC components which correlate with trust. Similar findings were reported by the previous four different studies, ranging from year 2004 to 2012.

Findings from Rowe and Kellam (28) indicated that patients could (and they did) differentiate between physicians' clinical competence and their IPC skills. Although separable, when it comes to shaping patients' trust in their physician, these two criteria have a fine line in between. Patients perceived physicians' interpersonal communication skills are on par with their clinical skills (technical competence) if not more than it is definitely of no less importance (28).

Listening is one of the prominent interpersonal communication skills. A physician who is in a hurry to end their conversation or not able to stay long, may cause patients to get discouraged. Patients could not reveal the true story behind their ailment or decided to keep their questions to themselves (6, 24). Despite being able to understand the physician's busy schedule, patients dislike being deserted, their opinions devalued, have limited time during routine visits, rushed during consultation and poor or insufficient feedback from their doctor (17, 29). Additionally, Beckman and Frankel (29) uncovered that physicians prefer to interrupt patients' talk every 18 seconds, and most of the conversations were dominated by the physician with questions, instead of being patient-centered. Such discourteous habits further demerit patients' trust in the respective health authority and forbid them from disclosing further their qualms and details.

Lastly, a sense of partnership or precisely, shared decision-making and information is a strong trust-determinant in PPR. Repeated similar findings on this linkage were documented in the past (1, 25, 30) denoting that there is a high priority to believe physicians' IPC skill is an indicator for patients' medical trust. Smets et al. (30) found that one in every three patients was not informed at all about their prognosis details, hence leaving question marks on the credibility of the physician in charge and the health care decisions which were supposed to be made together with their clients.

- (iii) Patients' demand, practice and non-disclosure of alternative therapies

Complementary & Alternative Medicine (CAM) usage is more prominent in rural inhabitants who had more preferences for traditional modes of healing, despite well established modern medicine. Lacking in the numbers of studies which detail out the relationship between trust in conventional medicine (medical trust) and CAM usages leave us in the dark. We have only discovered one such study throughout our review (31). This study concluded that there is no relationship between public trust in conventional medicine and public trust in CAM practices. The same paper also emphasised that patients' practice of CAM and physicians' influence on, or recommendation for, them to try it have no connection, which is in contrast to another study (32).

Although aware that the prescribed treatment regimen by physicians must be strictly followed, some patients decided to deviate from obedience. They wish to try alternative treatments which integrate with their current treatment plans; meanwhile some other perceived CAM offered a more holistic approach (33). However, such a decision was made unnoticed, let alone being approved by the in-charge physician as patients refrain themselves from disclosing it. The attitude to not disclosing CAM practice or related information to physicians is viewed as an act of secrecy and being cautious against their healthcare provider. To be explicit, patients were behaving so possibly due to low levels of trust in physicians.

The disclosure rate to physicians varies, with as low as 7.6% which is one among 10 patients to 73.8% of the patients who used CAM according to three studies (35–37). They were worried about the setbacks after disclosing it. Patients were afraid physicians may get upset and terminate the existing treatment regimen (34). While others discerned physicians' lack of CAM knowledge, showed low interest in it, did not believe in it or showed indifference towards it, had insufficient time during consultation, physicians did not inquire about its practices, and patients do not know they have to disclose it, believe CAM is generally harmless as it is nature-based thus not affecting their current treatment and patients personally perceived that there is no need to disclose it (35–39).

To ascertain the previous point, the study conducted by Miek et al. revealed that patients

insisted on having a physician who is willing to listen carefully, talking seriously about patients' CAM use, inquires and is equipped with knowledge of both modern and traditional medications, as well as providing CAM information and knows who else they should communicate with in regard to CAM matters. However, only a minute amount patient, 9% were actually being referred to CAM practitioners by their physicians (33).

While the misfit between patients' expectations and physicians' incompetence to fulfil their requests existed, mistrust too was invited along. We believe the reasons why public demand and emphasis on CAM usages were due to its cost effectiveness, ease to comply and its being much more non-invasive than modern medication (39–40). Moreover, some of CAM therapies were proven scientifically and deemed effective by the users. Additionally, patients insisted on its advantages to prevent disease recurrence and to cushion the potential side effects due to conventional medical practices, such as chemotherapy (36, 39–40).

The current review has a number of limitations. Aside from limited resources and databases assessed, possible non-modifiable medical mistrust indicators such as patients' and physicians' ethnicity, gender and other cultural, societal, psychological, and political factors were excluded. This study is also limited by the search terms used, journals included, as well as the time period of the referred publications. Future reviews can be further improved by addressing a wider scope of studies by including more recent materials covering psychology and social sciences-based databases, implementing more systematically review designs and excluding studies without a well-defined methodology.

Conclusion

Study results suggest that patients' trust in conventional practitioners is probably diminishing. From the conducted review and its limitations and selection criteria in mind, investigators proposed three potential indicators for medical mistrust; (1) Increasing medical litigation & complaint about physicians, (2) Physicians' low mastery of interpersonal communication skills and (3) Patients' demand, practice and non-disclosure of alternative therapy practices to their physician.

Patient-health provider trust is a significant scope which shall be the answer to many

questions about quality and effectiveness of healthcare provision and important clinical outcomes aimed by all health institution. Undeniably, it assists in promoting public policies and strengthening other forces which endanger the patient-physician relationship. Future studies on patient-health provider trust are encouraged to fill these gaps: (1) Prevalence of mistrust in physicians and health care with more emphasis on eastern continents, (2) Factors leading to medical negligence litigation, (3) Other modifiable and non-modifiable factors, which can promote patients' trust in physicians and, (4) Mistrust-related interventions to end this medical dispute permanently. The first step to prevent medical mistrust from reoccurring is to have more of its indicators researched and understood, especially by medical and health professionals and then promote awareness to the public.

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Authors' Contributions

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