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Building Patient Trust in Hospitals: A Combination of Hospital-Related Factors and Health Care Clinician Behaviors

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Background: Patients' trust in their regular clinician is relatively high in the United States, but trust in the health care system and in key institutions, such as hospitals, is considerably lower. The purpose of this study was to identify the factors that build patients' trust in hospitals.

Methods: In early 2020 the authors conducted 38 semistructured telephone interviews with participants across the United States. Respondents were asked about trust in hospitals generally, as well as what makes them trust and not trust specific hospitals. Interviews were audio recorded, transcribed, and analyzed using a descriptive thematic approach.

Results: Participants identified three mechanisms through which hospitals build their trust: (1) competence (effectively treating health issues, providing a safe and clean hospital environment, and having clinicians who are knowledgeable and thorough), (2) caring (hospital culture that prioritizes patients' comfort, welcoming physical environment, and clinicians who are compassionate), and (3) communication (hospital culture of listening to patients and explaining clearly, particularly with treatment and discharge plans). The absence of these three factors resulted in loss of trust. Hospital cost also lost patients' trust in hospitals. While the cost of hospital care affected some participants' overall level of trust in hospitals, others separated the trust they had in the medical care received from trust in billing practices.

Conclusion: The findings underscore the importance of perceived quality of care and hospital safety/hygiene, as well as having an organizational culture that emphasizes caring and effective communication, for building patient trust.

Trust, which requires one's reliance on another person or entity, is a very important concept in health care. Patients seek care for health issues when they are unable to address them on their own and have to rely on clinicians' knowledge and commitment to appropriately treat their conditions and improve their well-being. More than two decades of research shows that when patients trust their clinician, they have greater continuity of care, more consistent follow-through with clinicians' recommendations, higher patient satisfaction, and better self-rated health.[1–7] Early research on patient trust in clinicians identified fidelity (working in the best interest of patients), competence, confidentiality, and honesty as the key elements of trust,[7–10] although more recent research has emphasized the importance of clinician caring and communication in addition to competence and fidelity.[11–14]

Patients' trust in health care institutions is also important—both because, for some serious conditions, care cannot be provided by one's regular clinician and because patients frequently access their clinician within a larger institution.[15–17] In the United States, trust in health care institutions is considerably lower than it is for one's regular clinician. A 2018 national survey found that only 20% of adults reported strong trust in most hospitals and that only 16% reported strong trust in the health care system, while nearly two thirds of respondents who had a personal physician reported that they strongly trusted their physician.[18] Americans' trust in the US health care system is considerably lower than trust in many other countries' systems. A 2018 survey found that 43% of US adults reported trusting the health care system to provide the best treatment, a rate lower than 13 of the 27 other countries surveyed, including Great Britain, Canada, and India, where the rates were 63%, 56%, and 51%, respectively.[19]

There is a large body of empirical research related to trust in health care institutions, but it has primarily focused on the related concepts of mistrust and distrust rather than trust. While trust is a positive sentiment that an individual or entity is working in the patient's best interest, mistrust and distrust are negative beliefs that individuals or entities may be working against patients' well-being.[15,20–30] Most of the literature on medical mistrust and distrust has used these terms synonymously.[20,24,26,28,30,31] Recently, however, researchers have differentiated the two.[32,33] Although both terms relate to having suspicion about an entity's intentions, distrust is rooted in information a person knows or has heard about a specific entity, while mistrust is a more general suspicion based on the history of unethical actions in health care. In this article, we use the term *mistrust* to

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refer to both mistrust and distrust, as most empirical research to date has not distinguished between the two.

The most commonly used measures of medical mistrust include items related to patient deception and experimenting on patients, and some measures include items on racial and ethnic inequities in care, clinical incompetence, and prioritizing money over patient needs.[20,26–28] Not surprisingly, higher medical mistrust is associated with lower utilization of health services, poorer management of health conditions, lower quality of life, and less patient satisfaction.[20–25]

Health care institutions thus need to not only address mistrust-related concerns patients have about institutions working against their interests but also actively build patient trust. If institutions are able to do this, they have the potential to improve patient utilization and outcomes and narrow racial and ethnic equity gaps in outcomes—as the literature has consistently documented greater mistrust among Black and Latino patients compared with White patients.[15,29–31,34]

The purpose of this study was to identify the institutional attributes and actions that patients report build their trust in a key health care institution: hospitals. To date, despite increasing interest in the topic of trust in health care organizations, there is little research on how health care institutions can increase patients' trust.[16,35–37]

Table 1. Characteristics of Interview Participants

	Participants ($N = 38$)
Gender, %	
Female	50.0
Male	50.0
Age in years	
18–34	28.9
35–49	23.7
50–64	47.4
Income (% of federal poverty level [FPL])	
≤ 138% FPL	44.7
> 138% to < 250% FPL	34.2
≥ 250% and < 400% FPL	5.3
≥ 400% FPL	15.8
Race/ethnicity	
Black	31.6
Latino	5.3
White	55.3
Other	7.9
Trust in health care system*	
1: Highest trust	10.5
2	28.9
3	26.3
4	21.1
5: Lowest trust	13.2

* Respondents answered one of four versions of a question on trust in the health care system (for example, "I trust the health care system" and "How much do you trust the health care system?"), all of which had a five-point response scale.

METHODS

This study uses qualitative research to better understand what increases and decreases patient trust in health care institutions, specifically hospitals. We conducted semistructured telephone interviews with 38 participants between January 16 and March 13, 2020.[38] (Only 5 interviews were conducted in March, the month the COVID-19 pandemic began shutting down the country.) All but 1 of the approximately 20-minute interviews were conducted by the first author. All interviews were audio recorded and transcribed.

Participants were respondents to the Urban Institute's (September 2019) Health Reform Monitoring Survey (HRMS), a nationally representative Internet survey conducted by Ipsos.[39] The September 2019 HRMS asked respondents one of four versions of a question about trust in the health care system, all of which had a five-point response scale (for example, "I trust the health care system" and "How much do you trust the health care system?"). We invited HRMS respondents who disproportionately trusted or did not trust the health care system—or, in other words, who were less likely to be neutral—to participate in semistructured interviews. We sought a sample that was diverse in terms of income and race/ethnicity, as lower-income and racial minority patients have historically expressed greater mistrust in health care institutions.[15,29–31,34]

The study participants lived in 21 states and were equally divided by gender (Table 1). They were disproportionately low income (44.7% had incomes ≤ 138% of the federal poverty level) and non-Hispanic Black (31.6%). Participants had a wide range of trust in the health care system. Approximately one third (34.3%) had low trust, 26.3% were neutral, and 39.5% had high trust (compared to 25%, 42%, and 34%, respectively, for the national HRMS sample).

We used open-ended questions to ask participants about their trust in hospitals, starting with how much they trusted hospitals in general and what made them feel that way. Then we asked whether there was a hospital they had had strong trust in, and if so, what about the hospital made them trust it; and whether there was a hospital that they did not trust or they had lower trust in, and why they had low trust in that hospital. In addition, we asked what recommendations they would give to hospital administrators to help the hospital gain patients' trust. Extensive probing was used to encourage participants to elaborate on their explanations.

To analyze the interview transcripts, we used a descriptive thematic approach.[40] The two authors began by reviewing an initial set of three transcripts and developing a preliminary list of codes containing the components of trust across those interviews. Then the authors coded the remaining transcripts in three batches, comparing and reconciling coding after each batch. The text blocks for each

Table 2. Factors That Affect Patients' Trust in Hospitals

Factor (Relationship with Trust)	Institutional Level	Clinician Level
Competence (positive)	• Effectively treating health issues (and not making medical errors) • Safe and clean hospital environment • Reputation • Transparency about limitations	• Knowledgeable • Thorough
Caring (positive)	• Culture that prioritizes patients' comfort • Comfortable physical environment	• Compassion
Communication (positive)	• Culture of listening to patients and explaining things clearly • Communicating the treatment plan • Discharge-related communications	• Listening to patients • Clear explanations
Cost (negative)	• High cost of hospital bills • Lack of up-front price transparency • Valuing profit over patients' needs	Not distinguished from institutional level costs

theme were further reviewed to identify subthemes. We also conducted an exploratory analysis of whether the themes we identified were consistent by participant race/ethnicity and income level.

RESULTS

Having trust in hospitals was very important, participants argued, because visits to the hospital are needed when health issues are serious. With trust, a 61-year-old Black woman explained, "I feel safe because I know they can take care of what's going on with me." Having trust in the local hospital was so important to a 49-year-old Latina woman, whose son has a chronic condition, that it affects where she lives: "I won't choose an area that doesn't have top-notch health care anymore."

Across the study participants, three mechanisms—competence, caring, and communication—were repeatedly described as the ways in which hospitals build their trust (Table 2). Their absence resulted in lower trust in hospitals. When participants described each mechanism affecting their trust, some of their descriptions were about hospital-related actions or environments, while other descriptions focused on behaviors of clinicians (mostly physicians, but also nurses and other health care professionals).

Of the three mechanisms for building trust, competence was the most commonly mentioned—it was described by almost all participants, whereas the other two were each discussed by more than half of participants. The vast majority of participants mentioned two or three of these mechanisms as key for building their trust, likely because these themes overlap. For example, when a clinician provides a clear and detailed explanation of a patient's health condition, the explanation can be experienced by the patient as effective communication, clinical competence, and having a caring clinician.

There was one additional key way that hospitals lost patients' trust, and that was related to the cost of hospital care. Approximately half of all participants raised the theme of the high cost of hospital care. All four of these mechanisms are described in detail below.

Competence

When participants discussed competence, they most often described examples of competence at the hospital or institutional level, although competence of clinicians was also repeatedly mentioned as is described below.

Institutional Level. The most common experience participants described related to feeling that their hospital was competent was when they or their family members had been effectively diagnosed and treated. A 34-year-old White woman with strong trust in her hospital explained, "They've always listened to me and gotten to the root of whatever is bugging me, whatever's wrong with me." Similarly, a 61-year-old Black woman described her trusted hospital: "I swear they always help me. . . . They help me with any problem I have."

Conversely, failing to address one's health needs, providing inaccurate diagnoses, or making medical mistakes were ways that people reported losing trust in hospitals. A 62-year-old Black woman who lost trust in hospitals in response to her sister dying from a medical error explained, "I really thought, when you are in the hospital, they're going to do everything they can to make you better. I don't think I realized that they make mistakes."

Related to medical errors was another component of competence—hospital safety or infection prevention. A 63-year-old White man with low trust in hospitals explained, "The best place to pick up a disease is often in a hospital." Because of concern over potential infections, several participants reported that hospital cleanliness was important for building their trust. "Maintaining cleanliness, everywhere, especially in the public bathrooms," a 49-year-old Latina woman explained, was crucial to her. Although she acknowledged that cleanliness in the bathrooms might not be related to cleanliness in the operating room, she explained, "you're always worried about germs."

There were several other less commonly reported ways participants detected a hospital's competence. These included the hospital's reputation—one participant trusted his local hospital because of "lots of external accolades that the system has received," while another trusted her hospital that was "pretty advanced in technology." Others mentioned they trusted a hospital for a particular treatment because of the volume of the procedures the hospital performed. Conversely, several participants in small towns were aware that their local hospitals had limited expertise in certain areas, and they trusted the hospital when staff were transparent about their institution's limitations and when they should seek care in larger hospitals.

Clinician Level. Participants also described competent clinicians in hospitals building their trust. For many participants, competence was discerned based on the clinicians' knowledge, given that "they're professional and they know more than I do," and they "go through a lot of schooling." Several assessed their clinicians' knowledge based on whether the diagnosis and treatment aligned with information they found online, including a 30-year-old White man who explained, "Sometimes the physicians seemed to know what they were doing and kind of aligned with what I was able to look up stuff on my own, and then it sometimes seemed as if they had no clue what they were doing."

Several participants described health care clinicians' being thorough as a component of competence. A 34-year-old Black man explained what was important for building his trust: "Making sure they are thorough. Did they really do everything they could to figure out what was going on, to save someone's life?" A few participants described having less trust in clinicians who did not follow up with them on a particular health matter. One example was a 30-year-old White man who explained, "The first hospital my wife had a complication and she happened to be in the bathroom when the physicians rounded, and they said they would come back later in the day and they never did."

Caring

A caring environment was described as a key factor contributing to participants' trust in hospitals. A 58-year-old White woman explained, "Nobody wants to be going into the hospital. Make it as positive and warm and caring of an experience as you can." Participants were slightly more likely to describe institutional level caring than caring at the clinician level.

Institutional Level. Caring at the institutional level was detected when hospitals created an atmosphere for patients and their families that felt comfortable. A 49-year-old Latina woman described her experience at a hospital that earned her trust: "Every single practitioner, every single person that I interacted with, at whatever level of their role, were very interested in providing an experience that was safe and comfortable, and as stress free as possible." Other examples of when patients felt an institutional commitment to caring and comfort were when staff "were really good and attentive and always made sure that I was okay" and when cleaners checked in and asked, "Is it okay if I clean in here right now? Would you prefer me to come back? Is there anything you need?" A 39-year-old White man explained that the hospital culture needed to be one in which patients were treated as "more than just a customer, you know, they're someone's loved one, and they're there for a reason. They're not there just because."

Several participants mentioned that in addition to the hospital culture, the physical hospital environment can make hospitals feel comforting for patients. Waiting rooms with newspapers, magazines, and private places to sit were mentioned, as were the colorful walls in a children's hospital, which were "very welcoming for kids."

Clinician Level. Participants expressed having strong trust in clinicians who "care about me as a person and not just as a disease process," or in other words, "show compassion." A 31-year-old Black man described clinician compassion as "taking care of all of the patient's needs; just checking in on them and making sure that they're all right." Other participants found comfort in having clinicians who were "friendly and welcoming and not intimidating" and who spent enough time with them so "I didn't feel like I was on the assembly line." A 50-year-old White man emphasized that not all clinicians are caring: "Some doctors do actually care, then there's other doctors who just, quite frankly . . . care about their time, and . . . push appointments and medication, even when I don't need [it]."

Communication

Most participants stressed the importance of effective communication for building their trust in hospitals. Communication was slightly more likely to be described at the institutional than the clinician level.

Institutional Level. At the institutional level, there were three key elements of effective communication. First was having a culture throughout the hospital of clinicians and staff listening to patients ("because I know my body better than anybody else") and explaining things clearly or "letting you know what exactly is going on." A 31-year-old woman of "other" racial/ethnic background (not identifying as White, Black, or Latino) described a very positive experience when her stepfather was being treated for cancer: "They explained things in a way that didn't sound like they were talking down to him or, or making it, dumbed down to, they involved him in his care and really made sure that he was well informed." This, participants said, is not always what is experienced. A 34-year-old White woman explained, "A lot of doctors, ER doctors especially, are like go-go-go, but listening to a patient completely, instead of trying to diagnose as they're talking, is a good thing."

The second component of effective communication at the hospital level was communicating the “larger picture” of the treatment plan. A 34-year-old man from an “other” racial/ethnic background emphasized the importance of helping “people understand what’s happening, so there is a greater level of calmness.” Others highlighted the importance of understanding the time line for staying in the hospital (“being up front with what to expect”) and having physicians and nurses on the same page (“the doctors and nurses keeping a good line of communication”).

Effective discharge information was also a key component of hospital communication. A 29-year-old White woman highlighted how important it was to be trained thoroughly to care for her husband after he left the hospital: “They worked really closely with us and even taught me how to give my husband the medicine for when we got home because he had to be on special antibiotics for about a month after that, so I was basically his caregiver.” Other participants expressed appreciation when hospital staff continued communicating with them following a visit or procedure. A 53-year-old White woman explained, “They’ve called twice since her last visit just to make sure how she was doing.”

Clinician Level. Key for building participants’ trust was having individual physicians, nurses, and other health professionals take time to listen to patients and provide clear explanations. Listening was described as a way to “work with us” and helped participants feel “comfortable.” Many also highlighted how important receiving clear explanations (not “over my head” and “that didn’t sound like they were talking down” to patients) and addressing patients’ questions were to building trust. A 29-year-old White woman described the hospital clinicians she trusted: “They made sure they explained everything to me in depth for whatever question it was I had.”

Cost

Health care cost differed from the prior themes in two ways. First, cost was not viewed as a way to gain patient trust but rather to lose it. Second, the issue of cost was viewed principally as a hospital institutional issue, and although many of the hospital-related bills participants received were likely for clinician services, they did not mention the problem of cost at the clinician level.

The cost of hospital care affected some participants’ overall level of trust in hospitals, but other participants separated the trust they had in the medical care from trust in billing. When asked about trust in hospitals, a 30-year-old White man’s response indicated how he differentiated the two components: “Trust to fix me or to help me? I have a lot of trust. Trust in a sense of bankrupting me because of the financial aspect? I would have no trust in that.”

There were two related cost concerns. Participants often described outrageously high hospital bills they and family members had received during prior hospital stays; for instance, charges for $980 bottles of saline or an $800 vaccine. This resulted in some people carefully reviewing hospital bills for errors, fighting to get bills reduced, and wishing for greater transparency in costs. A 50-year-old White man who wished there were greater cost transparency said, “I understand it’s not gonna be like going to McDonald’s where there’s a menu board, everything’s listed because . . . it’s never gonna be that simple. But I think there’s room to be a little bit more clear, give me a range of what things might cost.”

Related, a number of participants said they thought that hospitals valued profits over patient care. In fact, several participants described hospitals as “for-profit” entities, when only one in five are investor owned.[41] A 54-year-old woman of “other” racial/ethnic background said, “I am very often not at all convinced that I am being offered what’s best for me, but merely what they can get best reimbursed for.” And a 34-year-old Black man described the emphasis on making money in contrast to the hospital caring about its patients:

> Right before you actually get your care, they send the little insurance lady in to remind you, like hey, at the end of the day we are here to make money and this is a business. Every time, it makes me feel like I thought you guys actually cared, but you can get my money or my insurance company’s money.

Consistency in Themes Across Subgroups

We conducted exploratory analysis of whether the findings were consistent across different racial and ethnic groups and by income level. Almost all Black and White participants, as well as those from other racial and ethnic groups, reported that trust was built by competence. More than half of each group reported that caring and communication were also key for building trust. We also found the three themes to be consistently raised by participants with higher and lower family income levels.

We did see different patterns for reporting the issues of costs affecting trust in hospitals. Participants with lower incomes, specifically those with family incomes less than 138% of the federal poverty level, were substantially less likely to comment on hospital cost than participants with higher incomes. This was because many in the lower income group qualified for Medicaid coverage and faced little, if any, out-of-pocket costs for hospital care. A 61-year-old Black woman explained that hospital bills had not been a problem for her: “My Medicaid . . . it pays for everything that happens to me. . . . I haven’t really had no problem.”

DISCUSSION

This study finds that building patients’ trust in hospitals is multidimensional and requires hospital competence, caring, and communication. The absence of these factors, conversely, results in loss of patients’ trust. Competence in

treating patients' health conditions was the most commonly described way for hospitals to build trust, and it includes providing both high quality of care and a clean and safe hospital environment. Trust in hospitals is also built by treating patients with care and compassion, making them feel comfortable and safe in the hospital, and communicating effectively, which includes listening to patients and making sure they understand treatment and discharge plans.

High hospital costs were a concern for approximately half of the participants and resulted in loss of trust in hospitals. The extent of experiences with high hospital bills was not surprising, given extensive reporting on the increase in excessive hospital billing.[42–44] Some participants were able to separate their trust in hospitals' medical care from their trust in hospital billing, but others had little trust in hospitals because they questioned the fairness of billing practices.

For hospital administrators, the findings emphasize the importance of patients' perception of quality and safety of care and underscore the importance of developing an organizational culture that embeds effective communication and being compassionate and caring. Large hospital systems have effectively launched initiatives to improve communication and compassion, which include clinician training and leaders who model how clinicians should treat patients by how they treat clinicians and staff.[45–48] There is substantial overlap between communication training and creating a culture of greater compassion and caring; for example, the Cleveland Clinic's eight-hour physician training in communication resulted in increased physician empathy.[46] In addition to the prospect of building patient trust, these interventions may positively affect clinicians, as there is evidence that greater clinician empathy is associated with lower burnout.[46,49]

Limitations

The study's findings should be considered in light of its limitations. First, this was an exploratory study with largely White and Black participants. The findings, therefore, will need to be confirmed in a larger, more representative sample. This is particularly true for the analysis by racial/ethnic and income subgroups. In addition, participants were reflecting on past hospital experiences for conditions that varied in severity. Future research in this area should interview people soon after hospital discharge so that they are reflecting on a recent experience.

CONCLUSION

Hospitals build trust with patients though a multidimensional set of actions, including creating a caring environment where clinicians effectively communicate with patients and address their clinical needs, where the environment is clean and comfortable, and where patients do not fear very high hospital bills. Future interventions to increase patient trust in hospitals, or components of trust, should examine the impact on patient reports of trust as well as health outcomes.

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