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TRUST IN AN INDIVIDUAL PHYSICIAN AND ITS CONTRADICTIONS

ZAUPANJE V ZDRAVNIKA IN NJEGOVA PROTISLOVJA

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Abstract

Introduction: *This article analyses the essential contradictions in the phenomenon of trust and the dilemmas this creates for empirical Research on health and the health care system. The trust a patient places in their physician (and—though more rarely—in the health system itself) is generally regarded as an important factor in the patient's health; hence, a crucial research problem is the question of which factors influence a patient's trust.*
Methods: *In this article, we analyse the attitudes regarding the role of the state in health care - the analysis is based on Slovenian public opinion surveys (1995-2007). In the second part of the analysis we focus on an analysis of the influence of experience with medical institutions and medical personnel, the respondents' subjective evaluation of their own health and a group of sociodemographic factors relating to social inequality (Slovene public opinion, SPO 2001/3).*
Results: *Similar to the results of numerous other empirical studies, our research shows that these factors only partially explain trust in an individual physician. At the same time, we find a relatively large difference between trust in an individual physician and trust in the health service.*
Conclusion: *We explain the results by means of the contradictions and multidimensionality of the phenomenon of trust itself and the quandaries in the conceptualizations of trust.*

Key words: trust, uncertainty, vulnerability, patient, physician, health service, health system

Izvirni znanstveni članek
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Izvleček

Uvod: *V prispevku analiziramo ključna protislovja fenomena zaupanja in dileme, s katerimi se zaradi teh protislovij spoprijema empirično raziskovanje na področju zdravja in zdravstva. Zaupanje pacienta v zdravnika (in – sicer redkeje – v zdravstveni sistem) se praviloma obravnava kot pomemben dejavnik pacientovega zdravja, zato je eno ključnih raziskovalnih problemov vprašanje, kateri dejavniki vplivajo na pacientovo zaupanje.*
Metode: *V prispevku analiziramo stališča o vlogi države na področju varovanja zdravja iz raziskav slovenskega javnega mnenja (obdobje 1995-2007). V drugem delu analize se omejujemo na analizo vpliva izkušenj z zdravstveno ustanovo oz. zdravstvenim osebjem, ocene lastnega zdravja ter skupine sociodemografskih dejavnikov, ki jih povezujemo z družbeno neenakostjo (Slovensko javno mnenje 2001/3).*
Rezultati: *Podobno kot rezultati številnih drugih empiričnih raziskav tudi naši kažejo, da ti dejavniki le deloma pojasnjujejo zaupanje v zdravnika. Hkrati pa ugotavljamo relativno veliko razliko med zaupanjem v konkretnega zdravnika in zaupanjem v zdravstveno službo.*
Zaključek: *Rezultate pojasnjujemo s protislovji in večdimenzionalnostjo samega fenomena zaupanja ter z zagatami v konceptualizacijah zaupanja.*

Ključne besede: zaupanje, negotovost, ranljivost, pacient, zdravnik, zdravstvena služba, zdravstveni sistem

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1 Introduction

Trust is seen as an attribute of the patient-physician relationship, crucial for the patient's willingness to seek the physician's help.

Relatively numerous empirical studies have examined factors conductive to a patient's trust in an individual physician and the medical service. However, the researchers involved acknowledge difficulties due to the complexity of the phenomenon of trust. For this reason, in the first part of the article we will try to clarify the concept of trust and trusting and its relations with the phenomena of un/certainty, dependency and knowledge. We address some common conceptual dilemmas, such as the nature, dimensions (or components), levels, conditions for emergence, and psychological function of trust; the contradictions in the phenomenon of trust, the differences between trust and similar concepts (1); the specific characteristics of the patient-physician relationship, due to which trust is regarded as a factor in the patient's health. Here we especially highlight the patient's dependence on the physician's competencies and *commitment* to the *patient's well-being, as well as the related risks, uncertainties and vulnerability.*

In the second part of the article, we analyse the attitudes towards the public health care system as an expression of a need for safety within the health care system. This analysis is based on Slovenian public opinion surveys/SPO (2, 3, 4). Further on, we examine the effects of social inequalities, subjective health and the evaluation of personal experience with the health service on trust in individual physicians and the medical service. To examine these issues, we used data from the SPO survey 2001/3 (5). Based on data analysis and conceptual discussion, we critically explore the scope and limitations of empirical examinations of confidence and trust in individual physicians and in the medical service.

1.1 Concepts of Trust

The word *trust* usually refers to the expectation that an agent (person, group or institution) on whom our wellbeing depends will behave in a way that is beneficial to us; it refers to optimism about another's *good will* towards us. Theoretical conceptualizations (1, 6, 7, 8, 9) usually emphasize that trust can appear in the absence of faith or in the absence of information, rational proof or evidence of the other's reliability, i.e. in uncertain circumstances. In uncertain circumstances, we hesitate, we do not know how to act or what to do (if anything at all) – in these circumstances, trust creates "an outcome otherwise unavailable" (1), i.e. trust is a crucial condition for our activity. As we will see, this condition is important for distinguishing between trust in an individual physician and trust in the health service in general.

Regardless of the many differences, the majority of conceptualizations associate trust with a more or less asymmetric dependence in the relationship and with vulnerability. Dependence is both a condition for the development of trust and a resulting effect: the trust-giver depends on the competencies and/or the motives and willingness of the other person to work for the good of the trust-giver (see 1, 6, 7, 8). The dependent person is always vulnerable – she/he is at risk of harm that could be caused by the withdrawal of assistance and support. The trust-giver risks even more – he/she risks betrayal. Therefore, the term *betrayal* is not a synonym for *disappointment* (6). Through the *betrayal* of trust, the trust-giver loses not only things that she/he entrusts to others, it also usually hurts the trust-giver's self-respect. The betrayal of trust proves that the trust was unjustified and hence demonstrates the naivety of the trust-givers while, through the betrayal, the trust-receivers implicitly convey the message that they do not consider it worth making the effort to justify the other's trust in them. Due to this uncertainty and risk associated with trust, one of the most important problems connected with trust is the question of whether trust in others is well-founded, justified and reasonable (7).

However, the whole question of the rationality of trust is misplaced, insofar as it is only directed at "rational" calculation. Trust "can never be based on pertinent knowledge" and the qualities of the other are irrelevant for the understanding of trust, "even though not necessarily for the agent's rationalization of her reasons to trust." (1). Trust exists before the experience itself, or even despite negative experience. It is not dependent on our will and it can even be in contradiction to it. It holds true that the inductive generalization of past experience with a particular person (or institution), observation and analysis of her/his actions and the regulation of our relationship increase our certainty. The function or benefit of trust concerns precisely what remains—the absence of rational proof of the trust-receiver's trustworthiness. Trust "is a means of overcoming the absence of evidence without benefit of the standard of rational proof […]" (1).

Empirical research usually focuses on the rational, cognitive elements of trust, or rather on the sources of trust, e.g. with respect to health protection or the trust-giver's experiences with their physician. However, its

emotional basis is crucial for trust (1, 10, 11), though this does not mean that trust is irrational. In highly uncertain circumstances, such as when we are confronted with an illness that there is much contradictory information about and where the results of various medical treatments are uncertain. In the absence of reliable, certain and indisputable information, only a commitment to our physician enables us to act at all. And commitment always involves emotions: "emotional apprehension and emotional engagement" (1). Thus the acting strategy in uncertainty represents an emotional choice. At the same time, trust is a rational strategy despite, or indeed even because of its emotional basis – it enables us to act under ambiguous circumstances.

The (ir)rationality of trust and its emotional basis or 'component' is treated by some authors (8, 9) as one of the criteria we use to distinguish between different types of trust, and between trust, reliance and legitimacy.

1.2 Trust, Reliance and Legitimacy

The relations between performers vary at different levels with respect to the degree and type of mutual dependence, commitment, distribution of power and the degree and type of normative control, while expectations and the degree of (un)certainty are related to this. There is also an important difference in these relations in the motives that lead a person to act or not on behalf of the welfare of others.

Acting for the good of the other is self-evident and expected in relationships between friends, lovers, parents and children, i.e. in relationships in which we want to maintain good relations due to a deep emotional attachment. This kind of trust is called *familial* trust (8) or *personal* trust (9): these relationships are less formal and dependence is usually more balanced, commitment is relatively high and trust is mutual. However, acting for the good of the other is also expected in the type of relationship we call *contractual* relationships, e.g. client/professional relationships, which includes the relationship between a patient and her/his physician. These relationships are formalized to a considerable extent, usually in order to protect the weaker and more vulnerable performer. Acting to ensure the wellbeing of the dependent person is expected due to contractual, legal and other normative obligations rather than the good will of the performer. It is, for example, a physician's duty to act in the patient's best interest. This kind of behaviour is also in the interest of the professionals—if they violate their obligations, this adversely affects their reputation and can also cause other damage. Some authors (9, 12) call the trust in these relationships *functional trust* or even assert that in functional, regulated, fiduciary relationships, it is not so much a matter of *trust* in the true meaning of the word but rather *reliance.*

However, some authors oppose this reduction or distinction between types of trust on the basis of the motives that lead the trust-receiver to act for the good of the trust-giver. The first argument against such a distinction is that the motives that lead, for example, a physician to act for the patient's good are not inconsistent with the principle of maintaining a good relationship—thus we can still refer to trust in these cases as well (13). The other argument against such a distinction is that trust is not uniquely associated with the type of relationship, since "emotional orientations might stimulate trustworthiness in the other" in various types of relationships (1): in intimate, close relationships and even between individual and collective entities.

Another strong argument against distinguishing between types of trust based on the type of relationship is that very few relationships between people are entirely unregulated or entirely regulated. Even an informal, intimate relationship between two persons exceeds their mutual relationship. The social and political climate and cultural norms influence expectations and perception of others' trustworthiness to a great extent. The growing number of social roles and their contradictory demands increase uncertainty and thus the regulation of intimate, private relationships (8). On the other hand, not even the fiduciary relationship between agents is entirely determined by legally defined rules and obligations. The regulation of a relationship does reduce uncertainty, though only rarely does it eliminate it entirely—a typical case is the physician-patient relationship. Therefore regulation does not eliminate the need for trust.

1.3 Overcoming the Patient's Uncertainty

The patient-physician relationship has a special place among fiduciary relationships in terms of the patient's heavy reliance on the physician's competence, reliability, trustworthiness and motivation to act in the patient's wellbeing. Since the physician intervenes directly in the patient's privacy, there is a widespread assumption that mutual trust and confidence are essential to their relationship. It is this protection of trust and confidence and the patient-physician relationship that should be assured by regulating their rights and obligations.

As a vulnerable performer, the patient is protected at least in part by legal norms and the institutional oversight of the physician. Legislation (e.g. 14) explicitly

obligates the physician to realize the patients' rights. The institutional framework for the patient-physician relationship also includes the right of the patients to file a complaint, to choose their personal physician, and the right to a second opinion. In this relationship, the patients therefore have a certain measure of freedom and control over the physicians (at least formally), despite their dependence. As with many other fiduciary relationships, this regulation of the patient-physician relationship can increase certainty for the weaker party. However, the regulation is not the basis of the patient's trust – as we explained in the first part of this article, trust may only emerge in uncertain circumstances. In the patient-physician relationship, regulation cannot wholly eliminate uncertainty. Not only due to the physician's right to conscientious objection, but also simply because even the most carefully thought out regulation cannot anticipate all situations and all possible complications. There is always some space left for doubt and uncertainty. This uncertainty is all the greater since it concerns health, which is of central importance for the individual's survival. Uncertainty is also deepened by the marketization of health services and related doubts of medical ethics and the complex systems of medical knowledge (e.g. 15). Therefore, a certain degree of trust in the physician is essential for the patient to even seek assistance from the physician in the first place and to realize her/his right to medical care. Before the patients decide which physician to choose, whether to seek her/his assistance and whether to act in accordance with the physician's instructions and advice (or to what extent), the patients may gather information concerning their health problems, therapies and the physician, and then generalize their experiences with the physician – but even so all this information will not provide unambiguous answers. It is trust that will ultimately govern how the patient acts. And this is precisely the reason why trust in the physician is such an important issue for health policy and why so much attention is paid to the characteristics of communication between the patient and the physician as one of the most important factors in establishing trust (see 15, 16, 17, 18, 19, 20). However, individuals interact with the health system at multiple levels (access to health care in general, the quality of health services, experiences with health workers) and in doing so they take on different social roles (19, 21). All levels are potential sources of uncertainty and enjoy more or less trust. Uncertainty can be transferred from one level to another and trust can 'intervene' in any of them. In the present analysis, we focus on social vulnerability, social inequality and personal experiences in medical institutions as crucial factors of trust (19, 20, 21) in an individual physician and the health service (i.e. two levels of the health system). The third, general level of the health system is included implicitly: we examine the attitudes towards the public health care system as an expression of a need for safety within the health care system. These attitudes are important for analysing how patients deal with uncertainty.

2 Methods

Slovenian public opinion surveys from 1995-2007 (3, 4, 5) were used to examine the attitudes towards the role (responsibility) of the state in the public provision of health care. An analysis of trust was performed using the most recent survey database, comprising a set of indicators on trust in individual physicians and trust in the health service, dated 2001. The data is representative of the Slovenian adult population (N=1093) and it was collected using face-to-face interviews (6). Even though the data set is not current, it allows the examination of individual (socio-demographic factors and subjective health) and interpersonal (the respondents' evaluations of personal experience in a medical institution) factors that affect a person's trust in her/his physician and confidence in the health service in Slovenia.

Based on the assumption that trust increases with uncertainty, independent variables were selected as follows: subjective health and socio-demographic variables related to social (in)equality (age, education, the subjective perception of social class, income per household member, gender, ethnicity and type of setting).

Social (un)certainty related to health care was assessed using two indicators measured longitudinally – specifically, attitudes towards the role (obligation) of the state in the public provision of health services.

The indicator of trust in the physician is stated as follows: "Are you certain that in your case the physician did everything possible for you, or not?" (Yes/No) (6). Before continuing, we need to provide grounds for the assumption that the assessment that the "physician did everything possible" is an expression of trust. It could be argued against our selection of this indicator of trust that it is an assessment based on experience with a physician and hence on rational evidence. It is true that the patient does have at least a few possibilities for rationally assessing the physician's competence, reliability and dedication to her/his work and the patient at her/his disposal. However, this information is usually incomplete and unreliable, especially when it concerns such a radical assertion that the physician did indeed

do everything within her/his power in a particular case. We therefore assume that the response that the physician did everything possible expresses (a relatively high degree of) trust in the physician, primarily in her/his willingness to act on behalf of the respondent's wellbeing. Our assumption is also supported by an argument of a psychological nature: the selectivity of social perception (see 22) – in our case, trust itself influences the perception of a physician's behaviour: *because I trust my physician, I bellieve she/he did everything within her/his power everything within their power.*

The indicator of trust in the health service is similar to the indicator of trust in the individual physician: "Are you sure that in the case of your illness, the health service did everything it could based on the currently available medical knowledge?" (6)

However, we are aware that we are measuring complex phenomena and that we are actually measuring (un) certainty and (mis)trust at the same time.

Interpersonal characteristics were assessed with respondents' evaluations of personal experience in a medical institution, specifically the perception of medical staff being unfriendly, the perception of privileges (i.e. unequal treatment) and the perception of the low quality of the health service. A five-point ordinal response scale was recoded in two categories ("it does bother me" and "it does not bother me").

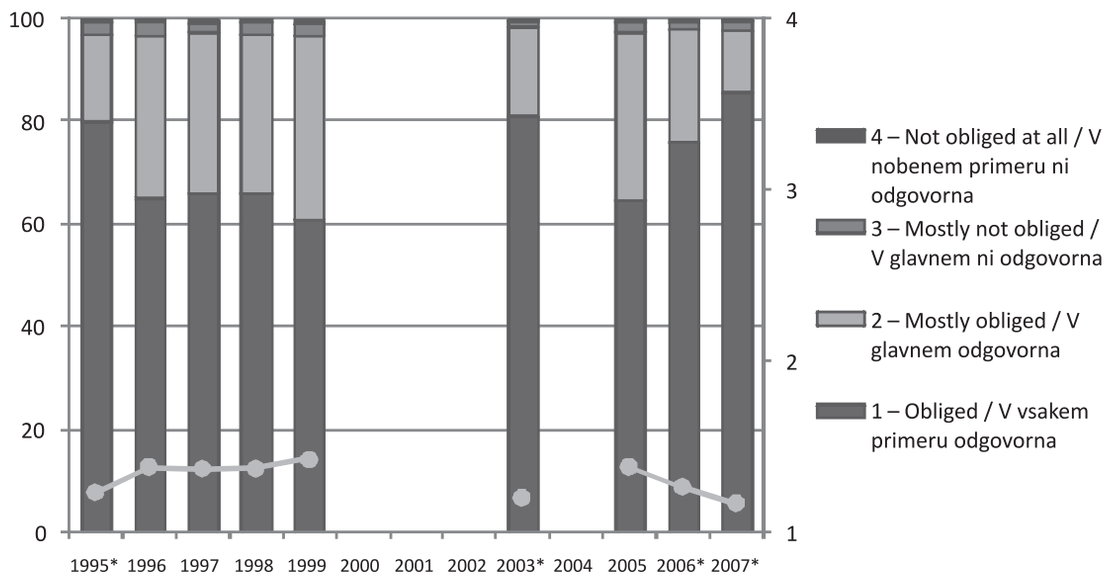
Data was analysed using the SPSS statistical analysis package, using the following methods: bar charts for presenting trends in attitudes towards the state responsibility for the public provision of health services, descriptive statistics and a chi square bivariate analysis of association, accompanied with the chi square significant tests.

3 Results

3.1 Attitudes Towards the State's Responsibility for Health Care

As can be seen from Graph 1, between 1995 and 2007, an exceptionally high proportion (96%) of respondents think that the state should take (at least some, if not complete) responsibility for the provision of health care. A very small proportion of respondents think that the state is not at all responsible for the provision of health care – a percentage not exceeding 3.2%. There is, however, some variability in the perceived strength or degree of the state's responsibility for the provision of health care. The highest proportion of respondents stating that the state is fully obliged the provision of health care was observed in 2007. The average values vary between 1.2 and 1.4, which on average holds that the state ought to take responsibility for the provision of health care.

Graph 1. The state and its obligation for the provision of health care.
Graf 1. Država in zagotavljanje zdravstvene oskrbe.



The extremely high percentage of respondents who support a high degree of obligation of the state for the provision of health care for the sick is consistent with the high percentage of those who support an increase in funding for health care. As indicated in Graph 2, respondents would like, on average, to see somewhat more funding allocated for public health (3.9 – 4.2). The average is relatively stable across 10 years (1995-2005). The majority of respondents (76% - 81%) feel that funding for the public health system should be increased (the lowest, 70%, is found in 1996). The percentage of respondents in favour of decreasing the funding is about 4%.

3.2 Trust in the Individual Physician and the Health Service

3.2.1 The Influence of Subjective Health on Trust

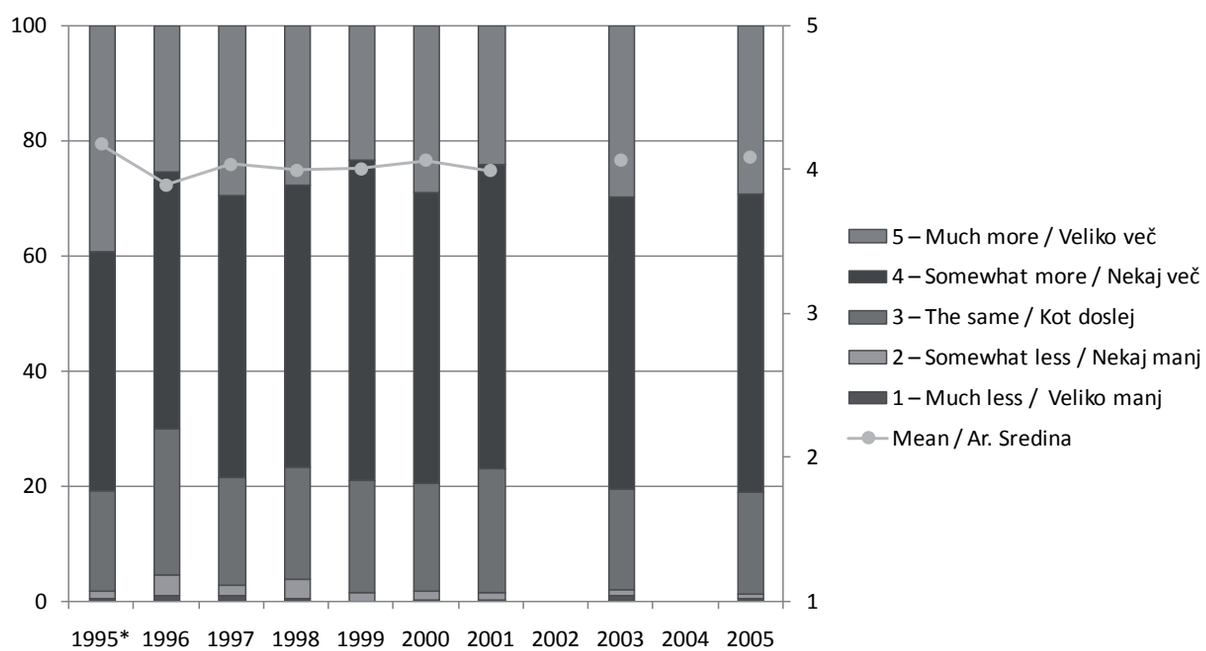
The majority of respondents (90% - 78%) believe that the physician *did everything possible* for them, regardless of their subjective health (6). Nevertheless, the proportion of respondents that trust their physician decreases with the increased perception of poor health. In contrast to trust in physicians, subjective health has no effect on trust in the health service.

3.2.2 Trust and Experiences in a Medical Institution

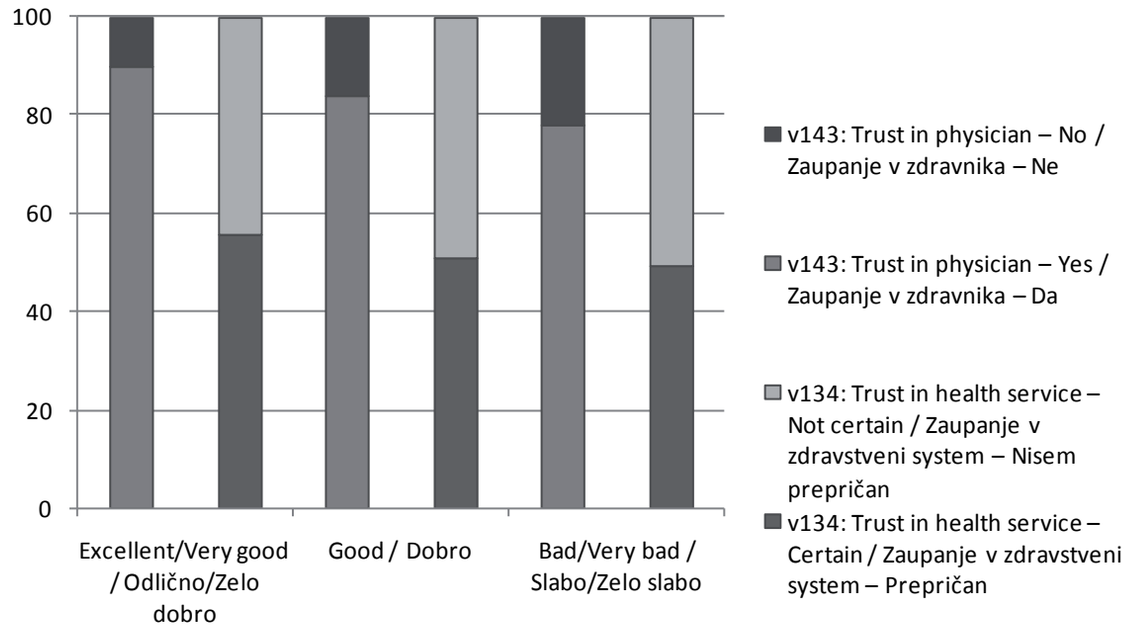
The attitude of the physician towards the patient has been demonstrated in a number of studies to be an important factor in the protection of health (e.g. 15, 16, 17, 18, 19), which is why we focus on the respondents' subjective evaluations of individual experiences in receiving medical care. Respondents were asked to rate to what extent they were bothered by three negative experiences while receiving medical care: unfriendly attitude, privileges and poor quality service[1] (6).
Overall, the percentage of respondents who were bothered by negative experiences yet still trust their physician is significantly lower than the percentage of respondents who are not bothered by negative experiences (app. 70% versus 90%). Similar to trust in one's physician, trust in the health service is lower for respondents that evaluate personal experience in receiving health services in a negative way, i.e. who are bothered by medical staff being unfriendly, by the perception of unequal treatment and by the perception of low quality medical service (app. 40% versus 65%; graphs 4, 5, 6).

[1] The categories of answers were collapsed to enhance the distinction between respondents that were bothered (bothered very much. bothered. somewhat bothered) by negative experiences and respondents that were not bothered by negative experiences (not much bothered; not at all bothered).

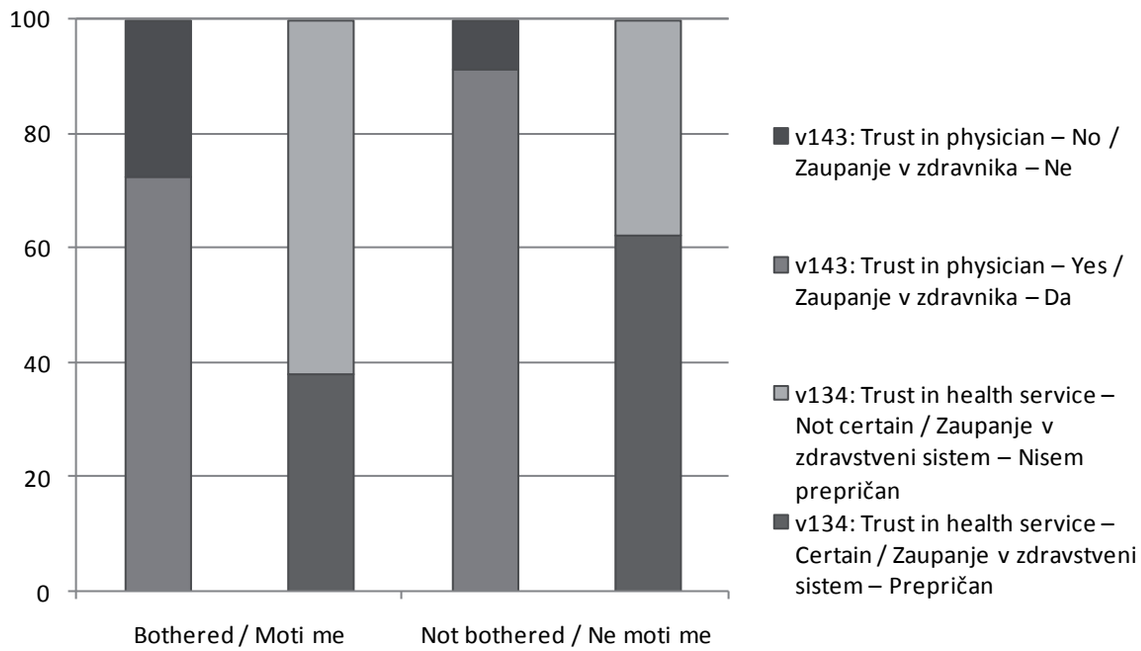
Graph 2. Decreasing/increasing expenditure for the health system.
Graf 2. Zniževanje / zviševanje proračuna za zdravstvo.



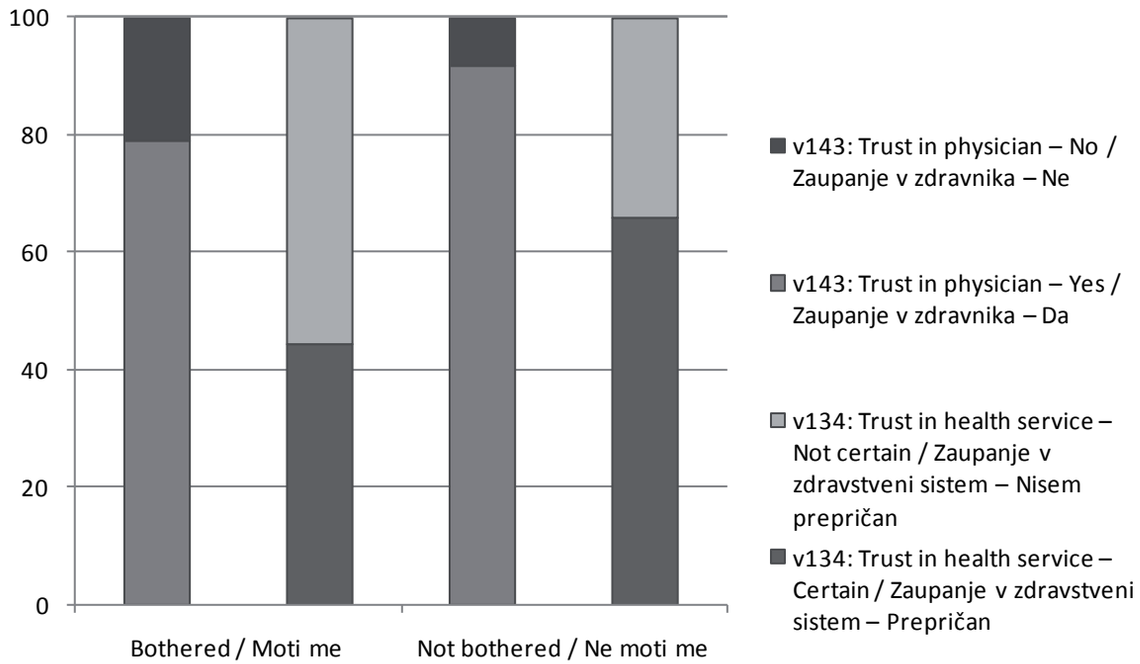
Graph 3. Subjective health and trust in the physician and the health service.
Graf 3. Subjektivna ocena zdravja in zaupanje v zdravnika in zdravstveni sistem.



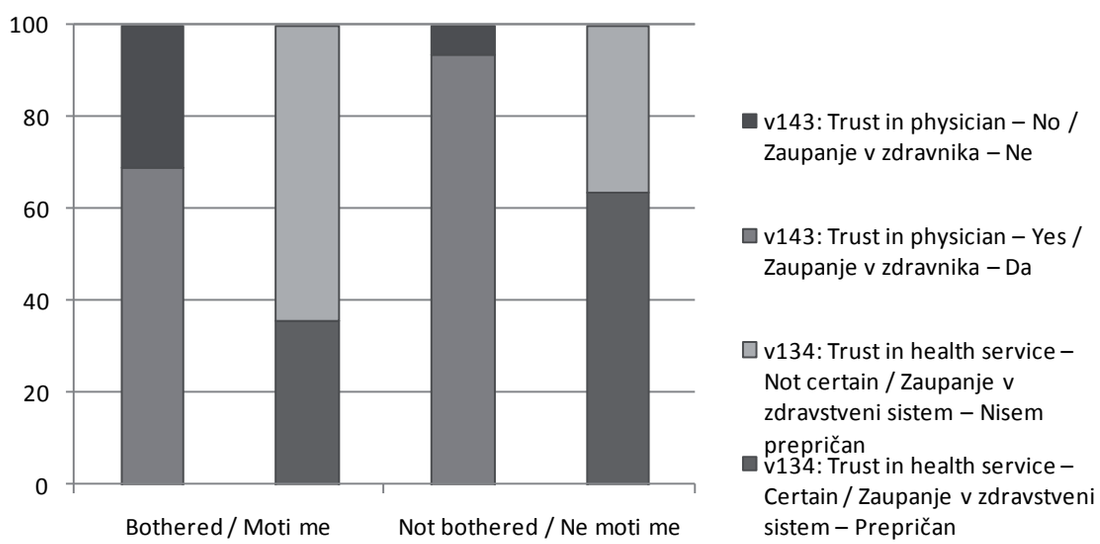
Graph 4. The perception of medical staff being unfriendly and trust.
Graf 4. Percepcija neprijaznosti zdravstvenega osebja in zaupanje.



Graph 5. The perception of privileges and trust.
Graf 5. Percepcija privilegijev in zaupanje.



Graph 6. The perception of the quality of medical service and trust.
Graf 6. Percepcija slabe kakovosti zdravstvenih storitev in zaupanje.

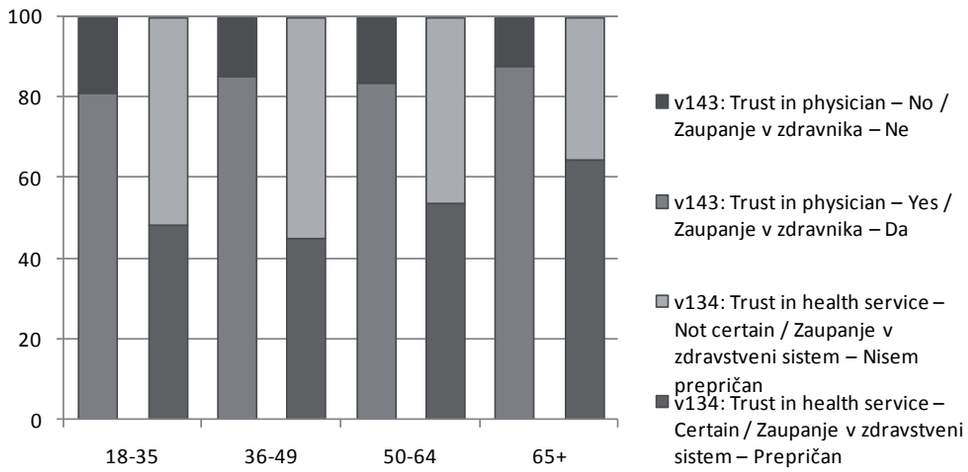


3.2.3 The influence of socio-demographic variables on trust

Individual characteristics (age, education, the subjective perception of social class, income per household member, gender, ethnicity and type of setting) have no significant effect on trust in physicians. However, some individual characteristics (age, education and type of setting) have a significant effect on trust in the health service (Graphs 7, 8, 9).

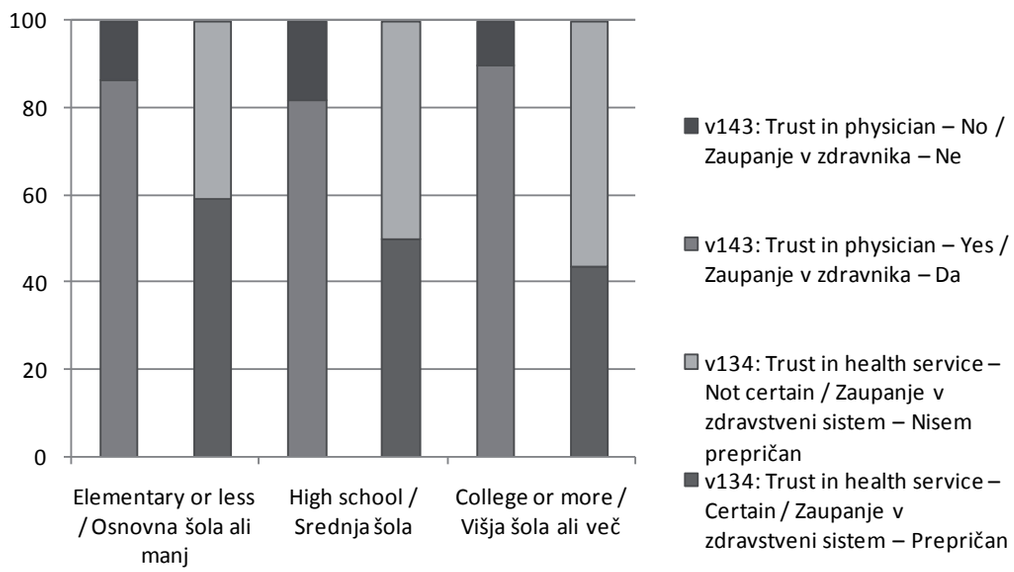
With increasing age, more respondents trust the health service (Graph 7).

Graph 7. Age and trust in the health service.
Graf 7. Starost in zaupanje v zdravstveni sistem.



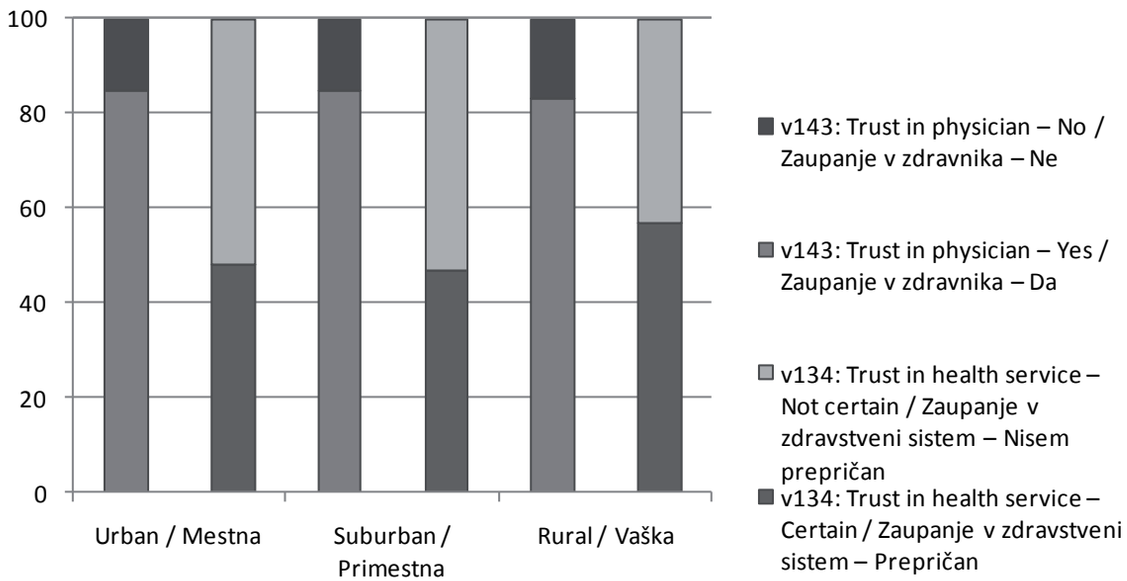
With increasing education, fewer respondents have confidence in the health service (Graph 8).

Graph 8. Education and trust in the health service.
Graf 8. Izobrazba in zaupanje v zdravstveni sistem.



More respondents living in rural settings trust the health service (Graph 9).

Graph 9. The type of setting and trust in the health service.
Graf 9. Tip bivalnega okolja in zaupanje v zdravstveni sistem.



4 Discussion

The attitudes towards the state's obligation for the provision of health care are not surprising, since the respondents in all the surveys of Slovenian public opinion from 1989 onwards express a high degree of support for a welfare state and the provision of health care is at the very top of the social subsystems for which the state is expected to be responsible (almost) in its entirety (23).

The extremely high percentage of respondents (96%) who support a high degree of state's obligation for the provision of health care for the sick and who support an increase in funding for health care can be interpreted as a commitment to the principle of solidarity (23). We can also interpret it as a consequence of the uncertainty in the area of health care or searching for safety. Among the crucial sources of this uncertainty are the importance that health has for individuals, the fact that health itself is subjected to numerous factors that are difficult or impossible to control even when we know the source of risks, and the marketization of public services that can be seen in the field of health care (15, 24). It appears that this fear of the dismantling of the public health care system is a crucial factor in uncertainty—this thesis is supported by the fact that research on Slovenian public opinion in 2007 recorded the highest percentage of supporters of a high degree of obligation of the state. In 2006, the Movement for the Preservation of Public Health Care was founded and began to systematically warn the public of the danger of the deconstruction of the public health system. This probably reinforced demands for the preservation of the effective and just public health system. Fear of the dismantling of the public health care system deepens uncertainty and. going by our concept of trust as a strategy to deal with uncertainity, it may even increase patient's trust and expectations of the individual physician.

The thesis that health and health care are burdened with a high degree of uncertainty is also supported by the considerable difference between trust in an individual physician and trust in the health service. Trust in the health service[2] is relatively low, at least in comparison to trust in an individual physician. This difference indicates that the uncertainties individuals feel in the field of health care are expressed primarily in their attitude towards health services, and are overcome when it comes to trust in their physician.

[2] It should be noted that the question is directed at the health service in general; there is no distinction between public and private, general and specialist.

Among the selected independent variables, the only ones associated with trust in an individual physician that are statistically significant are experience with a medical institution and the assessment of one's own state of health. However, in these cases the percentage of those who believe that the physician did everything within her/his power to help them is in no case less than 69% (we found the lowest percentage in connection with dissatisfaction with the quality of the medical service). Some caution is needed in the interpretation, at least as far as experience in the medical institution is concerned. The question is phrased in such a way that it is not possible to conclude unequivocally whether the respondents are bothered by their own exposure to unfriendliness, unequal treatment and poor service, or "only" by the fact that these things can be observed in the medical institution. Nevertheless, the fact that the percentage of troubled respondents that trust physicians is quite high supports the assumption that trust cannot be fully explained by experiences (and other so-called cognitive factors). The other factor that was shown to be statistically significant in connection with trust in one's physician is subjective health—the higher the assessment, the higher the degree of trust. However, perhaps even more indicative than a positive statistical correlation is the fact that even among those who assess their state of health as poor or very poor, 77.9% are convinced that their physician did everything possible for them. Even so, this data draws attention to the fragility of trust—individuals with health problems clearly decline to trust their doctor more frequently. In this connection, it is worth pointing out the dark side of trust—the possibility of betrayal. A patient can consciously or unconsciously (at least in part) attribute health problems to the physician and see them as a betrayal, then direct their discomfort due to uncertainty at a particular physician, even though the physician is not the source, or at least not its sole source.

Our analysis indicates a statistically significant correlation between trust in the health service on the one hand and education, age and type of setting on the other. Fewer respondents trust the health service as education increases, with increasing age more respondents trust the health service, and respondents living in rural settings more frequently express trust in the health service. As researchers of public opinion have found, older people and those who are less educated on average express a higher degree of trust in institutions (25). We will attempt to interpret this data in the context of our conceptualization of trust. If we accept the thesis that trust is a strategy for coping with uncertainties, then we could conclude that more educated people, younger people and people from urban areas are less uncertain and hence less dependent on trust in the field of health protection – due to their higher social capital and better social integration, lower dependence on health services and greater access to them. Even if, for example, the better educated do not believe that the health services would do everything possible for them, they can still rely on their social networks and their knowledge—if necessary they can use them in asserting their rights and searching for the most effective medical institutions. Hence they can "afford" not to trust. But it must be emphasized that the differences between the individual categories are not prominent.

In contrast, our analysis did not show a statistically significant influence of socio-demographic factors on trust in an individual physician. However, we cannot conclude on this basis that social status did not have an influence on trust in physicians. It is possible that although socio-demographic factors did not have a decisive influence on a patient's assessment that a physician did everything within her/his power for them, it did influence the sources and the degree of uncertainty that was overcome by trust. In the introduction, we defined trust as a strategy for managing uncertainty and as a condition for functioning in uncertain circumstances. This means that trust cannot be measured if we do not know the level of uncertainty. The belief that the physician has done everything (or the belief that the health service would do everything within its power for the respondent) is not in fact an expression of trust in the narrow sense, but of both *certainty* and *trust*. This could mean that socially well integrated individuals (those with a high social capital) are less uncertain with respect to health care than the marginalized. Well integrated individuals might feel more competent and be more aware of the variety of alternatives if the system or physician fails or disappoints them (e.g. formal and informal complaints, choosing another physician, demanding a second opinion). For this reason, they are also less dependent on trust than the marginalized. However, another assumption is also reasonable: that medical knowledge and knowledge of the health care system (and the associated criticism) can increase uncertainty, since well-informed people might worry more about what could go wrong (e.g. 15) – this uncertainty might reinforce trust as a strategy for managing this uncertainty. Qualitative research (e.g. the general interview guide approach) could clarify some ambiguities about this uncertainty: how deep it is and what its sources are. However, since trust is the crucial strategy to deal with uncertainty, respondents might protect their trust and certainty by 'denying'.

To sum up: the differences between trust in an individual physician and trust in the health service show that it is easier and less threatening to express doubt about the health service in general than in one's own physician. This confirms the thesis that trust in one's physician is far more important in the decision of an individual to seek medical care than their attitude to the health service in general. Trust itself, as shown in this article, is highly contradictory, since it only comes into being when rational and institutional mainstays of certainty are lacking.

5 Conclusion

Due to these uncertainties and the elusive links between trust and uncertainty, conclusions on the legitimacy of health services or the health system or even the political leadership in general cannot be justified based on the measured degree of trust in one's physician – the latter can actually conceal a lack of confidence in the system. The results of our analysis, which has found high demands on the part of respondents with respect to the obligation of the state to provide health care, a high level of trust in one's physician and a rather low level of trust in the health service, support this assumption. From this we can derive another conclusion: that focusing on the individual's attitude to health and to the relationship between the physician and patient when formulating health care policy would be a mistaken strategy. Such a strategy deepens uncertainty, since it individualizes the burden of caring for health—the weight of this burden is borne primarily by the patient and the physician or health care workers. The relationship between the patient and the physician and the individualization of caring for one's own health can only have a very small effect on reducing the uncertainty of individuals in such an important area as health—the crucial factor of certainty lies in the efficient and equal access of all to health services.

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Trust in an Individual Physician: Appendix

Table 1. Subjective health and trust.
Tabela 1. Subjektivna ocena zdravja in zaupanje.

Subjective health/ Subjektivna ocena zdravja		v143: Trust in the physician v143: Zaupanje v zdravnika Yes Da	No Ne	v134: Trust in the health service v134: Zaupanje v zdravstveni sistem Certain Prepričan	Not certain Nisem prepričan
Excellent/ Very good Odlično/ Zelo dobro	%	89.9%	10.1%	55.7%	44.3%
	Count	142	16	146	116
Good/ Dobro	%	84.1%	15.9%	51.0%	49.0%
	Count	322	61	289	278
Bad/Very bad Slabo/ Zelo slabo	%	77.9%	22.1%	49.2%	50.8%
	Count	81	23	63	65
Total Skupaj	%	84.5%	15.5%	52.0%	48.0%
	Count	545	100	498	459
X^2		7.010		2.094	
P		0.030		0.351	

Table 2. The perception of medical staff as being unfriendly and trust.
Tabela 2. Percepcija neprijaznosti zdravstvenega osebja in zaupanje.

Unfriendly attitude Neprijazen odnos		v143: Trust in the physician v143: Zaupanje v zdravnika Yes Da	No Ne	v134: Trust in the health service v134: Zaupanje v zdravstveni system Certain Prepričan	Not certain Nisem prepričan
Bothered Moti me	%	72.5%	27.5%	38.3%	61.7%
	Count	179	68	116	187
Not bothered Ne moti me	%	91.4%	8.6%	62.5%	37.5%
	Count	352	33	257	154
Total Skupaj	%	84.0%	16.0%	52.2%	47.8%
	Count	531	101	373	341
X^2		40.280		41.098	
P		0.000		0.000	

Table 3. Perception of privileges and trust.
Tabela 3. Percepcija privilegijev in zaupanje.

Privileges Privilegiji		v143: Trust in the physician v143: Zaupanje v zdravnika Yes Da	No Ne	v134: Trust in the health service v134: Zaupanje v zdravstveni system Certain Prepričan	Not certain Nisem prepričan
Bothered Moti me	% Count	79.1% 288	20.9% 76	44.5% 196	55.5% 244
Not bothered Ne moti me	% Count	91.9% 238	8.1% 21	65.8% 177	34.2% 92
Total Skupaj	% Count	84.4% 526	15.6% 97	52.6% 373	47.4% 336
X^2		18.775		30.247	
P		0.000		0.000	

Table 4. Perception of bad quality of medical service and trust.
Tabela 4. Percepcija slabe kakovosti zdravstvenih storitev in zaupanje.

Bad quality of medical care/ Slaba kakovost storitev		v143: Trust in the physician v143: Zaupanje v zdravnika Yes Da	No Ne	v134: Trust in the health service v134: Zaupanje v zdravstveni system Certain Prepričan	Not certain Nisem prepričan
Bothered Moti me	% Count	69.2% 155	30.8% 69	35.7% 101	64.3% 182
Not bothered Ne moti me	% Count	93.8% 362	6.2% 24	63.7% 263	36.3% 150
Total Skupaj	% Count	84.8% 517	15.2% 93	52.3% 364	47.7% 332
X^2		66.308		52.742	
P		0.000		0.000	

Table 5. Age and trust.
Tabela 5. Starost in zaupanje.

Age Starost		v143: Trust in the physician v143: Zaupanje v zdravnika Yes Da	 No Ne	v134: Trust in the health service v134: Zaupanje v zdravstveni system Certain Prepričan	 Not certain Nisem prepričan
18-35	%	81.4%	18.6%	48.4%	51.6%
	Count	162	37	149	159
36-49	%	85.3%	14.7%	45.2%	54.8%
	Count	122	21	109	132
50-64	%	83.6%	16.4%	54.0%	46.0%
	Count	133	26	128	109
65+	%	87.8%	12.2%	64.6%	35.4%
	Count	129	18	113	62
Total Skupaj	%	84.3%	15.7%	51.9%	48.1%
	Count	546	102	499	462
X^2		2.47		17.51	
P		0.433		0.001	

Table 6. Education and trust.
Tabela 6. Izobrazba in zaupanje

Education Izobrazba		v143: Trust in the physician v143: Zaupanje v zdravnika Yes Da	 No Ne	v134: Trust in the health service v134: Zaupanje v zdravstveni system Certain Prepričan	 Not certain Nisem prepričan
Elementary or less Osnovna šola ali manj	%	86.3%	13.7%	59.2%	40.8%
	Count	176	28	170	117
High school Srednja šola	%	81.7%	18.3%	50.0%	50.0%
	Count	290	65	270	270
College or more Višja šola ali več	%	89.9%	10.1%	43.9%	56.1%
	Count	80	9	58	74
Total Skupaj	%	84.3%	15.7%	51.9%	48.1%
	Count	546	102	498	461
X^2		4.517		10.315	
P		0.105		0.006	

Table 7. Type of setting and trust.
Tabela 7. Tip bivalnega okolja in zaupanje.

Type of settings Tip bivalnega okolja		v143: Trust in the physician v143: Zaupanje v zdravnika Yes Da	 No Ne	v134: Trust in the health service v134: Zaupanje v zdravstveni system Certain Prepričan	 Not certain Nisem prepričan
Urban	%	85.1%	14.9%	48.4%	51.6%
Mesto	Count	229	40	186	198
Suburban	%	84.8%	15.2%	47.0%	53.0%
Primestje	Count	89	16	79	89
Rural	%	83.2%	16.8%	57.2%	42.8%
Vas	Count	228	46	234	175
Total	%	84.3%	15.7%	51.9%	48.1%
Skupaj	Count	546	102	499	462
X^2		0.401		8.069	
P		0.819		0.018	