Toward Understanding and Building Trust for Practicing and Emerging Healthcare Professionals: The ASC-DOC Trust Model

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Abstract

Trust is the foundation of stable, effective, sustainable healthcare. Unfortunately, trust in healthcare has been eroding over the past several decades. New and emerging healthcare professionals face the daunting tasks to master the competence and empathy necessary to warrant and gain the trust of patients. Healthcare education needs an objective measure to recognize what trust looks and acts like, how to assess its lack, and how to address trust gaps. The ASC-DOC Trust Model provides a dialogical point of reference for healthcare faculty and learners to begin to build trusting relationships that objectively and consistently measures competency in assessing and building trust. For healthcare professionals, the ASC-DOC Trust Model is a functional framework for beginning trust discussions and an actionable means to measure and build trust with patients. The ASC-DOC Trust Model includes six dimensions in the realm of observable trust experiences: Authenticity, Safety, Consistency, Dependability, Ownership, and Competence. This model is applied in a five-step process: (1) Focus on the person; (2) Ask for input and really mean it; (3) Discover and validate current needs; (4) Affirm trust already present; (5) Build trust by facing and addressing current trust needs.

Keywords: Trust; ASC-DOC Trust Model; Healthcare education

Trust - The Bedrock of Effective Healthcare – is Waning

Trust is the foundation of stable, effective, sustainable healthcare (Piper, 2010). Patients who trust their healthcare providers report fewer symptoms, higher satisfaction with treatment, and better health-related quality of life (Birkhäuser et al., 2017). Among healthcare providers, trust creates high-performance synergy and empowers teams to solve problems and focus specialized attention on immediate needs without worrying about everything others are doing (Annison and Wilford, 1998). Unfortunately, trust in healthcare has been eroding over the past several decades. Even before the COVID-19 crisis, Gallup polls found that confidence in the medical system among
Americans had dropped from 80% to 38% between 1975 and 2019 (Baron and Berinsky, 2019). Now as a new post-COVID-19 reality evolves, many people wonder who to trust with regard to community health statistics, prevention strategies, and treatments (Rakich, 2020).

Dr. Richard Baron, President and CEO of American Board of Internal Medicine admitted that realizing his organization had lost public trust when its credibility and legitimacy were called into question (Eichenwald, 2015) wounded and humbled him, but it also made him wiser. According to Baron (2019), trust when gained should not be taken for granted, especially in the field of healthcare. Individuals and organizations need to approach trust as an ongoing journey, a continuous process that requires continuous attention, saying, "although rebuilding trust may require new technology and procedures, it isn't rocket science. It requires us to act toward others the same way we would like to be treated" (Baron, 2019, p. 24).

Healthcare education has a professional responsibility to guide and prepare learners for this journey before they enter the healthcare profession and to enhance trust knowledge and skills among healthcare professionals.

Trustworthiness, Entrustability, and Rebuilding Trust in Healthcare Education

New and emerging healthcare professionals face the daunting tasks to master the competence and empathy necessary to warrant and gain the trust of patients. Today's emerging healthcare professionals are entering a particularly challenging healthcare environment marked by heightened uncertainty, vulnerability, and distrust in a pandemic-impacted world. In healthcare education, concern is growing that trust-building and empathy-informed reflective skills are not adequately demonstrated among emerging healthcare professionals. Faculty and program directors are grappling with how to impart the skills to gain and build trust (Hendren and Kumagai, 2019) and how to predict medical entrustability (Yoon et al., 2020), especially when the educational environments in many schools and programs are high-stress, high-stakes in which trust is not cultivated (Hafferty, O'Brien and Tilburt, 2020). If learners are shaped in a high-stress, untrusting environment with no objective working model of what trust looks like and how to build it, then the ultimate result may continue to be stressed-out new clinicians who are not optimally competent at gaining or building trust. The solution, Houldsworth (2020) suggests, involves education that builds trusting relationships, which "instill mutual respect, enhance collaboration, and promote the independent thinking that results from transparent and kind mutual interactions" (Houldsworth, 2020, p. 184). These are the same skills healthcare learners will need to gain and build trust professionally. Trusting relationships also have been found to impact the learning environment itself, transforming the education dynamic into one of loyalty and support, increasing the depth and speed of learners' development (Houldsworth, 2020). Healthcare education needs an objective measure to recognize what trust looks and acts like, how to assess its lack, and how to address trust gaps. The ASC-DOC Trust Model provides a dialogical point of reference for healthcare faculty and learners to begin to build trusting relationships that objectively and consistently measure competency in assessing and building trust. This model is a functional framework for beginning trust discussions and an actionable means to measure and build trust with patients and colleagues in real time at every stage of care.

The ASC-DOC Trust Model: Conceptual Bases

The ASC-DOC Trust Model builds upon two foundational works. Mayer, Davis, and Schoorman's (1995) trust model introduced human propensity to trust in three dimensions: perceptions of ability (proven capacity to perform), benevolence (intent/motivation to act kindly), and integrity (demonstrated patterns of doing what one says). Feltmann (2008) developed a four-dimensional model, renaming ability as "competence" and benevolence as "care" and splitting the integrity dimension into "sincerity" (meaning what one says) and "reliability" (predictable/reliable behaviors). These two works significantly contributed to trust research by introducing a more holistically integrated, multidimensional understanding of trust. The ASC-DOC Trust model proposes two additional dimensions crucial to
accurately comprehend trust dynamics and address trust needs: perceived safety and ownership.

The ASC-DOC Trust Model includes six dimensions of observable trust experiences: **Authenticity, Safety, Consistency, Dependability, Ownership, and Competence.** Authenticity, consistency, dependability, and competence are based on elements of Feltmann's (2008) model (sincerity, reliability, care, and competence, respectively). To these dimensions, the ASC-DOC model adds dimensions of "safety" and "ownership." Perceived safety – the sense that one's vulnerability will not be exploited, overlooked, or dishonored – is foundational in trust research and has been embedded in the general trust discussion, but previously has not been identified to function as a distinct dimension. Similarly, ownership – the perception that trustees will bear the weight of the success or failure of what is committed to them – is related to dependability (doing what one says) and competence (the ability to do what is needed), but dependability and competence can be present without trustees taking personal ownership of outcomes or bearing the full weight of their personal contributions. These two dimensions are mission-critical in healthcare and cannot afford to be taken for granted. Trust is the bonding agent that makes every element of healthcare work, so optimizing trust in healthcare needs to include the ability to address trust gaps in these areas as functionally distinct dimensions. Whether faculty, learners, healthcare providers, or patients, trustors in the healthcare setting need to be convinced they are safe in the hands of the trustee, and that the trustee is assuming personal responsibility for the success of the solution.

To increase the functionality of the ASC-DOC Trust Model to assess and build trust, the dimensions are clustered into three "relationally sensed" elements (authenticity, safety, and consistency) and three "task/behaviorally observed" elements (dependability, ownership, and competence). The ASC-DOC Trust Model is designed to open lines of inquiry both through observation and open-ended questions and to develop intuitive "radar" for how trust in each dimension will generally behave. When trust is lacking, these lines of observational and dialogical inquiry can provide a streamlined assessment of the dimension(s) where the trust-gap exists, so building trust can be focused on dimensions that need attention.

**Dimensions of ASC-DOC**

Figure 1 illustrates how each ASC-DOC dimension is operationally expressed by the trustor toward the trustee.

**Figure 1.** The ASC-DOC Trust Model
BUILDING
TRUST?
JUST REMEMBER
ASC-DOC
ASSESSING WHERE TO BUILD TRUST
IN 6 DIMENSIONS

**BUILD**

- **AUTHENTICITY**
  - they are searching for hidden meaning or motives
- **SAFETY**
  - they feel unsafe, vulnerable, or threatened with you
- **CONSISTENCY**
  - they cannot predict what you will say or do
- **DEPENDABILITY**
  - they wonder if you will keep your commitments
- **OWNERSHIP**
  - they cannot see the weight of the outcome resting on you
- **COMPETENCE**
  - they wonder if you have the skill + experience to do what's expected

**BUILT**

- **AUTHENTICITY**
  - they take your words and actions at face value
- **SAFETY**
  - they feel safe, secure, protected with you
- **CONSISTENCY**
  - they expect your predictable behavior
- **DEPENDABILITY**
  - they expect you will do what you say
- **OWNERSHIP**
  - they see that you personally own the outcome
- **COMPETENCE**
  - they believe you have all the skill + experience to do what's expected
Applying ASC-DOC in Real Time: A 5-Step Process

Trust is, by necessity, bi-directional. It requires both parties to assume the role of the trustor and recognize their role as trustee. From the first moment of engagement, both parties begin to assess, discern, and perceive how much they can trust the other party in each dimension, and with every interaction, this entrustability perception is either built/reinforced or challenged/lost. A key to building trust is recognition that while a trustor is assessing the entrustability another person, their own entrustability is likewise being assessed. Discernment in some areas may occur based on previous experiences with others, environmental triggers, emotional states, etc., whereas discernment in other areas may be logical, intentional, or methodical. Each individual can determine in real time whether trust is built or lacking. If trust is lacking, then each individual can, and should, engage with the trustor for clarification and empathy-informed guidance to determine how to address the need.

A challenge for trust-building in healthcare is the potential risk that trust-building efforts might slow down or compromise treatment of a medical/health issue that needs attention. Healthcare providers' credentials (ten Cate et al., 2016) form the basis for initial provider-patient interactions, but from that point on, patients decide how much of their vulnerability they are willing to risk with healthcare providers, largely based on the trust that healthcare providers foster during interactions (Mayer, Davis and Schoorman, 1995; ten Cate et al., 2016). Initial trust can be gained through first impressions (ten Cate et al., 2016), reflecting care and comfort, competent diagnosis/treatment, and expressive/engaging communication (Thom, 2001). These practices should continue during ongoing dialogues of continuous, empathy-informed, trust-building engagements (Baron, 2019; Hendren and Kumagai, 2019).

The age of "blind, embodied" patient trust is a thing of the past (Rowe and Calnan, 2006), especially in the emerging global post-COVID-19 reality (Rakich, 2020). Discussion of "trustworthiness" or "entrustability" based solely on healthcare providers' behaviors and credentials is no longer sufficient (Rowe and Calnan, 2006). Healthcare providers also face the risk and responsibility to value the "trustworthiness" and "entrustability" of patients (Thom et al., 2011). The mutuality and reciprocal nature of trust (Feltmann, 2008) is now visibly pronounced in the healthcare arena. The degree to which providers appreciate patients' expertise of their own lives validates the patient-facing presumptive trust (Thom et al., 2011) just as patients' presumptive trust of healthcare providers acknowledges the healthcare providers' expertise in a specific medical discipline (ten Cate et al., 2016). Confidence in patients' capacity to engage effectively is expressed by inviting patients to ask and answer questions accurately and honestly and conveying an expectation of active involvement in their own condition (Thom, 2001). Conversely, skipping to a solution before pausing to see, hear, and value the expertise of the other person at the circumstantially appropriate level may communicate lack of trust in the patient's entrustability. Below a five-step process is proposed for healthcare providers using the ASC-DOC trust approach to enhance wellness, that does not compete with diagnosing and treating physical/medical conditions.

Step 1: Focus on the Person

How open to trusting you (the healthcare provider) does the patient seem to be? Why? How willing are you (the healthcare provider) to trust the patient? Why?

Assumed reciprocity in the trust dynamic encourages healthcare providers to pay close attention to how patients are interacting with healthcare personnel. Is the patient guarded? Distant? Confident? Emotional? Tuning into current rapport between trustor and trustee in this moment without taking it for granted (Thom et al., 2011; ten Cate et al., 2016) lays the foundation for future trust (Mayer, Davis and Schoorman, 1995; Feltmann, 2008). Further, the mutuality of trust implies that circumspect patients also can apply the ASC-DOC Trust Model to use intentional empathy and build healthcare providers' trust in them. As Thom et al. (2011) indicated, doctors are human beings who enter every patient engagement with their own set of prior experiences that shape their willingness and capacity.
to trust patients. Has the healthcare provider just pulled a double-shift? How is the additional weight of current crises (e.g., a new pandemic, a drastic natural disaster, riot violence, etc.) impacting the mental, emotional, social, and physical capacity of healthcare providers to think clearly and act soundly? An alert patient can initiate increased trust from healthcare providers by awareness of healthcare providers’ state of need, as well (Thom et al., 2011).

**Step 2: Ask for Input and Really Mean it**

*What is the person sensing, feeling, perceiving? How do these insights inform behaviors and responses?*

Patients want healthcare providers to listen to them (Lewis, 1994) and need to have their own expertise about their lives acknowledged. The COVID-19 crisis has brought to light the humanity and vulnerability of healthcare providers and their trust needs, as well (Jasani, 2020; Rakich, 2020). The opportunity to provide context and input and ask questions increases trust between patients and healthcare providers (Mead and Bower, 2000), especially when the dialogue makes appropriate time to exchange relevant information and involve patients in decision-making (Mead and Bower, 2000). Whenever possible, taking the time to truly listen to what trustors (whether learners or faculty, patients or healthcare providers) are sensing, feeling, perceiving – and how the situation is impacting what is most important to them – can provide crucial insights that contribute to optimal solutions (Mead and Bower, 2000).

At this point, the goal is to understand and gain context for what is being observed. For example,

- "I noticed you are [shaking/cowering, etc.]. Are you feeling unsafe? Can you help me understand what you are sensing or thinking is in danger right now? How are you sensing it will impact you? Are you able to share with me why this is having such a profound impact on you?"
- "Has something like this happened before, or is this the first time? What was said/done today that reminded you of the previous time? How did it affect you last time? What's different/the same about this time, as compared to last time?"
- "What do you sense is the most important thing that needs to happen right now? Can you share why? What is the biggest thing you want to avoid right now? How would that impact what's important to you?"
- "Can you share with me your greatest concern right now? What are you sensing/perceiving that is causing you alarm?"

**Step 3: Discover and Validate Current Needs**

*In what areas does each person seem to feel safe, oriented, and stable? Where are potential trust gaps?*

This level of discovery requires intentional empathy (Mercer, Watt and Reilly, 2001). Patients enter engagement with healthcare providers in a state of vulnerability – and with overwhelming demands on healthcare, the healthcare providers also may be in states of heightened vulnerability (Babaian, 2019). Therefore, in a healthcare context, intentional empathy translates into intuiting from words and behaviors any gaps in one another’s perceived sense of safety (threat), gaps in their perceived sense of orientation (confusion), and gaps in their perceived sense of stability (volatility). Rather than competing with the healthcare mission to bring medical solutions, intentional empathy enhances both healthcare providers’ and patients’ insights into the overall situation, making both appropriate diagnosis/treatment and mutual trust more likely throughout the engagement. Learning what the trustor needs right now can inform how the situation at hand is touching them, and why they are perceiving and responding the way they are, enabling shared decision-making for both parties (Mead and Bower, 2000). Essential needs may include and transcend the physical/medical and environmental dimensions. The ASC-DOC Trust Model helps identify what these needs are, and whether you are perceived as helping or hindering these needs from being met. Identifying needs in this moment can help bring any threats to safety, orientation, and stability down to
size. Within healthcare, these dimensions can be observed in reciprocal exchanges between parties. The necessity of bidirectional trust, however, does not mean that trust flows in both directions at equal levels. Each party needs to take on the mindful role of both trustor and trustee. Below are examples for each dimension:

**Authenticity – Trustor Believes Trustee is the Genuine Article**

When a trustee is perceived to have authenticity, the trustor believes the trustee really means exactly what they say. The trustor does not need to guess hidden meanings, because the trustee will not have any. The trustee would not intentionally lie or behave in a manner that is false. The trustee is the "real deal." The trustor can take the trustee’s words and actions at face value.

- Patient perceives healthcare provider means what they communicate; nothing is being intentionally hidden or misrepresented by healthcare provider
- Healthcare provider perceives that patient is being forthright, candid, honest, and not hiding or misrepresenting anything the healthcare provider needs to know

**Safety – Trustor Believes Trustee is Protecting and Not Threatening**

When a trustee is perceived to be safe, what the trustee says and does reduces the trustor’s desire to be defensive. The trustor does not need to look over their shoulder, because the trustee has the trustor’s back. The trustee would protect the trustor’s weakness and never exploit the trustor’s vulnerability.

- Patient feels safe, secure, and protected by the words and actions of the healthcare provider
- Healthcare provider believes the patient will not put them in danger and are confident the patient intends no harm to self or others

**Consistency – Trustor Believes the Trustee Will Do What They Have Done**

When a trustee is perceived to have consistency, how the trustee responds is predictable in certain situations. The trustor can know if the trustee would do something specific. The trustor can plan responses based on what they expect the trustee will do. The trustee has proof of performance – whether good, bad, or neutral.

- Patient feels able to expect predictable behaviors from healthcare provider
- Healthcare provider can anticipate what behaviors or words to expect from patient

**Dependability – Trustor Believes Trustee Will Keep Their Commitments**

When a trustee is perceived to have dependability, the trustor believes the trustee will keep a promise and a secret. The trustor knows the trustee will honor every commitment and would rather follow through and hurt for it than back out painlessly. The trustee will do what they say they will do.

- Patient believes healthcare provider will do what they promised related to patients’ care
- Healthcare provider believes patient will keep commitments related to supporting provider’s efforts

**Ownership – Trustor Believes Trustee is Taking Personal Responsibility for Resolution**

When the trustee is perceived to have ownership, the torch is passed. The trustor knows the trustee has a firm grasp of it, and they will see the task through to its completion. The trustee does not doubt that the trustee will put their name on the line to see the thing succeed/be resolved. The trustee will not blame others for poor results. The trustor has confidence the trustee knows and carries the weight of the ultimate outcome.

- Patient believes the healthcare provider is taking personal responsibility for patient’s outcome
- Healthcare provider believes patient is actively involved in the management of their conditions
Competence – Trustor Believes Trustee has What it Takes to do What is Needed

When a trustee is perceived to have competence, the trustor believes the trustee is able (not just willing) to do what is expected. The trustee does not doubt the trustee’s qualification to do what they are meant to do. The trustee understands the expectations and can deliver. The trustor knows the trustee will not be overwhelmed or crushed by the size or scope of the need; the trustee can handle it.

- Patient believes the healthcare provider possesses the necessary knowledge, skill, and experience to do what the patient needs
- Healthcare provider believes patient has the necessary understanding and ability to do what is expected by healthcare provider

Step 4: Affirm Trust Already Present

Reinforce the trust baseline: Where does trust exist for them, and how can you strengthen it?

The following are examples of typical "symptoms" of when trust is present and when a gap may exist in each of the six trust dimensions of the ASC-DOC Trust Model.

Authenticity

- When trust is present: Body language is tuned in, nodding, focused; speech is affirming and suggests the trustee is at ease with the trustee’s genuine intentions and authentic engagement.
- When a trust gap may exist: Trustors’ body language may include suspicious/cynical facial expressions, shaking head, “sizing up;” sarcastic, accusatory, questioning, or guarded speech implies they question the trustee’s credibility; trustors suspect either trustees are only telling part of the truth, are trying to mislead or hide information, or are not being completely forthright about the situation or their role in it.

Safety

- When trust is present: Body language may be relaxed, relieved, spread out body language/comfortable, at-ease speech suggests the trustee believes the trustee truly wants to help, protect, and support. Trustor believes the trustee will not do anything to intentionally endanger or threaten the trustor.
- When a trust gap may exist: Body language may be frozen/tense, clenched, shaking, cowering, evasive/withdrawn, or aggressive/combative, and words may be threatening, reserved, or avoidant. Trustor is threatened by, or suspicious of the trustee’s intent and/or capacity to protect, support, or keep trustor the safe.

Consistency

- When trust is present: Trustor confidently predicts, convinced of reasonable accuracy, how the trustee will respond to them in this situation; trustors act as if they know what they can expect from the trustee, and can hear a story about the trustee and recognize whether or not the narrative "sounds like them."
- When a trust gap may exist: Trustor falters in knowing how to act or what to prepare for the trustee’s behaviors; may appear uncomfortably confused, surprised, or uncertain about the way the trustee will respond to him or her in this situation; trustor may seem afraid of what the trustee could say or do next.

Dependability

- When trust is present: Trustor behaves as if the trustee has already accomplished whatever the trustee has committed to do; communicates verbal or nonverbal confidence that the trustees will keep their promises/commitments related to this situation.
When a trust gap may exist: Trustor may communicate dread that trustee will not follow through; trustor may verbalize "plan B" scenarios and contingencies in anticipation of trustee failing to keep commitments.

Ownership

- When trust is present: Trustor can "pass the torch" to the trustee and not be compelled to take it back or check to confirm the trustee has fully assumed responsibility. Trustor appears at ease that trustees are taking their role in the situation seriously, affirms verbally or nonverbally that they believe the trustee will personally take responsibility for resolution.
- When a trust gap may exist: Trustor verbalizes or bodily demonstrates nervousness that the trustee will not take personal responsibility for the situation and may compulsively keep following up to make sure the trustee has not allowed the trustor to fall through the cracks.

Competence

- When trust is present: Trustor's behaviors support and rely upon the trustee's perspective and response. Trustor may actively seek out the trustee for advice and follow/model the trustee's behaviors. Communication confidently conveys conviction that the trustee understands the situation and knows how to help.
- When a trust gap may exist: Trustor may question the trustee's comprehension of the situation and/or the trustee's full ability to resolve the situation, whether due to a perceived lack of experience, skill, or empathy. Trustor may request an alternative trustee or request proof/documentation that the trustee has responded appropriately to the need.

As the trustor is assessing the trustee in initial engagements, intentional empathy can compel the trustor to reassure the trustee by reinforcing any perceived already-present trust in real time. For example, if the patient seems to feel at ease with the healthcare provider's authenticity, then the healthcare provider can affirm and reinforce: "I am going to be straight with you. If you have any questions or need me to back up to explain something, stop me anytime, okay?" If a new team member senses the team trusts dependability, then they can affirm and reinforce: "Okay, I will make sure X is done. I won't let you down." In any area where some level of trust is sensed, the trustor can strengthen its existence by naming it and recognizing his/her commitment to protect and strengthen it.

Dimensionalizing/ compartmentalizing trust helps to stabilize the overall trust relationship so any gaps can be localized within the specified dimension and not generalized to jeopardize the entire trust relationship (Feltmann, 2008). This approach can help minimize sensed vulnerability embedded in the risk of trust (Luhmann, 1979).

Step 5: Build Trust by Facing and Addressing Current Trust Needs

How can you address trust needs/concerns?

Once the trust relationship has been stabilized as much as possible, the trustee can begin to address trust gaps. Below are proposed questions to engage in intentional empathy and attempt to identify specific trust gaps between individuals and teams in the healthcare arena in each dimension of the ASC-DOC Trust Model, including: potential trust-gaps in Authenticity (questioning one’s genuineness), Safety (questioning one’s intent to keep one from danger), Consistency (questioning the predictability of one’s actions), Dependability (questioning one’s reliability), Ownership (questioning one’s assumption of responsibility), and Competence (questioning one’s ability to do what is needed. The questions themselves require willingness to be vulnerable to the other party which can open the door for greater potential trust (Feltmann, 2008). Listening for clues about trust needs (Lewis, 1994) also can include asking for stories of what someone did for the trustor in the past to gain trust in a given dimension.
**Potential Authenticity trust-gap:** "You seem to be wondering if I am being genuine…"

- (Healthcare provider or patient): How can I help you feel more confident I am telling you the truth and not trying to mislead or hide anything from you?

**Potential Safety trust-gap:** "You seem anxious …"

- (Healthcare provider): How can I help you believe I want to help you feel safe, and will not do anything to put you in danger?
- (Patient): How can I show you I want to help and not sabotage your efforts to help me?

**Potential Consistency trust-gap:** "You seem to be unsure what I will do…"

- (Healthcare provider or patient): How can I help you know what to expect from me? What behaviors or responses do I need to be aware of from you?

**Potential Dependability trust-gap:** "You seem like you might be wondering if you can depend on me…"

- (Healthcare provider): How can I help you trust me to keep my promises/commitments related to your care?
- (Patient): What would help you trust I will keep my commitments to do what is necessary regarding my care?

**Potential Ownership trust-gap:** "It seems you may be concerned I may not be feeling the weight of this personally."

- (Healthcare provider): How can I help you trust I am taking your condition seriously, and I am personally going to see the solution through to resolution?
- (Patient): How can I help you trust I will take personal responsibility for my condition, and I will stay actively involved in managing it?

**Potential Competence trust-gap:** "It seems you are uneasy I might be in over my head…"

- (Healthcare provider): What would help you feel confident I truly understand your condition and know how to help you?
- (Patient): How can I set you at ease? I understand you and I can do what you expect me to do so you can do your job.

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**Open Trust Conversations: Multi-Dimensional Trust Statements**

As trustors and trustees have trust conversations, trust statements can become multidimensional. Trustors can use the ASC-DOC Trust Model to affirm where trust is already present, identify where it is lacking, and describe what it would look like if it were present. For example, here are some multidimensional trustor-to-trustee statements from a patient to a healthcare provider:

- "I trust you are telling me the truth about my condition [authenticity], but I am uneasy with your lack of experience in this treatment [competence]."
- "I am confident you will keep your commitment to be here for all my treatments [dependability] and you want me to feel safe and secure with you [safety]. I am just struggling because I wonder if there is some information you are withholding from me [authenticity] because you are concerned about how the information will impact me."

Here are some examples of multidimensional trustee-to-trustor questions from the healthcare provider to the patient:
• "It seems like you know I have plenty of experience in helping people with your condition [competence], but you may be wondering if you can trust what I'm telling you [authenticity]. What would help you feel confirmed that I'm honestly telling you all I know?"
• "You seem like you know I am telling you the truth [authenticity], but maybe you need more information [authenticity]. What have you seen or heard that is causing concern? How can I help put your mind at ease? I am taking personal responsibility to give you the best treatment available for your condition [ownership]."

Conclusions

The purpose of this paper is to develop a way to improve competence and empathy necessary to warrant and gain the trust of patients. Additionally, there is a need within healthcare education to have an objective measure to recognize what trust looks and acts like, how to assess its lack, and how to address trust gaps. In an effort to help address healthcare’s growing need for established methods to build situational trust, the ASC-DOC Trust Model (Authenticity, Safety, Consistency, Dependability, Ownership, and Competence) can be used in real time within the healthcare environment. This model is applied in a five-step process: (1) Focus on the person; (2) Ask for input and really mean it; (3) Discover and validate current needs; (4) Affirm trust already present; (5) Build trust by facing and addressing current trust needs.

The ASC-DOC Trust Model provides a dialogical point of reference for healthcare faculty and learners to begin to build trusting relationships that objectively and consistently measures competency in assessing and building trust. For those practicing in healthcare, the ASC-DOC Trust Model is a functional framework for beginning trust discussions and an actionable means to measure and build trust with patients. This model/process can be applied as an educational resource to aid current and emerging healthcare professionals in assessing immediate trust needs and building trust with patients throughout the continuum of care. This initial work creates a shared language so all trust stakeholders in the healthcare environment can effectively communicate and meet each other’s trust needs.

Future research in this area should include formal validation of the ASC-DOC Trust Model and the five-step process for application. The educational setting lends itself to an excellent place for application and validation of this model in multiple settings (i.e., family medicine, pediatrics, emergency medicine, psychology, physical therapy). Additionally, this paper discussed the use of the ASC-DOC Trust Model at the individual level, yet the model can be scaled to apply to teams within departments, organizations, and entire healthcare communities, making the trust dialogue more empathy-informed, objective, constructive, and meaningful.

Take Home Messages

- Trust is required for optimal healthcare
- Healthcare providers and patients need to trust each other
- Trust includes six dimensions: Authenticity, Safety, Consistency, Dependability, Ownership, Competence
- Empathy-informed inquiry and observation enable trust-assessment and building
- Trust building should be actively practiced throughout the continuum of care

Notes On Contributors

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Appendices

None.

Declarations

The author has declared that there are no conflicts of interest.

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Ethics Statement

This manuscript discusses the development of a trust model based on the literature and opinions of the authors. No data was collected for this manuscript that would require ethics approval.
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