The Social Construction of Interpersonal Trust in Therapeutic Relationships between Young Adults and Physicians in Cameroon

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ABSTRACT

Trust is a fundamental and key component of all interpersonal relationships, and most especially of therapeutic relationships between patients and physicians. Anchored within a social constructionist theoretical framework and employing a qualitative study approach, this study which engages 350 participants sought to investigate the socially embedded nature of trust as it occurs in therapeutic relationships between young adult patients and physicians, and to identify the cognitive and affective elements that interact to build trust. Going further from social trust, the warrant for trust generally given to physicians in virtue of their training and accreditation, the encounter between the young adult patient and the doctor during consultation and treatment, produces an on-going and interactive relationship in which impressions are created, expectations of technical and interpersonal competencies of the individual physician are either met or contradicted, and interpretations are formed as the basis for behaviour and attitudes. Trust emerges as a product of social interaction, and it allows the patient to take the 'leap of faith" at the point of vulnerability where all uncertainties are suspended.

Keywords: Healthcare, Trust, Interaction, Interpersonal relationship, Technical competence

INTRODUCTION

More than seven decades ago, Simmel (1950:318)), in his social theory of trust, described it as "one of the most important synthetic forces within society" [1]. In later years, Simmel (1990:178) drew the conclusion that "without the general trust that people have in each other, society itself would disintegrate" [2]. Trust is a fundamental and key component of all interpersonal relationships, and most especially of therapeutic relationships between patients and physicians [3]. In the past four decades, scientific reflections by medical and social scientists on the contours of the phenomenon of trust have produced an avalanche of definitions and perspectives [4,5,6,7,8]. Although these definitions of trust display significant differences, reflecting the diversity of theoretical inclinations and disciplines, they share a broad understanding of trust as involving expectation, vulnerability and motivation [9]. Trust is generally defined as the optimistic acceptance of a vulnerable situation in which the one who trusts believes that the trustee will care for his or her interest [10, 11, 12, 13]. In therapeutic relationships, it is the expectation of the patient that the healthcare provider will demonstrate knowledge, skill and competence and that he or she will behave as a true agent, embodying the principles of beneficence, fairness and integrity [14].

Research on what constitutes the bases of trust has yielded a good number of perspectives, including, for example, focus on its cognitive or rational dimension [15], its affective nature [16, 17, 18]; a combination of reason, routine and reflexivity [19, 20,13], and the dispositions of the one who trusts and the one who is

trusted. Between the exclusively cognitive and affective dimensions of trust, some scholars argue for a more integrated understanding of the concept of trust, since it impossible to separate the cognitive from the affective components of trust because of the indeterminacy of the social world which makes the boundary between the two more elastic [13].

Although trust remains a defining component of therapeutic relationships, rapid and far-reaching changes both in society's perception and in the healthcare, system have, in recent times, brought much complexity to the process of trust and threatened to undermine it, especially among young adult patients [21, 5, 22, 23, 24]. Some of these changes include: rising youth interactivity and agency [25 26, 27], medical diversity or pluralism, changes in power relations between healthcare professionals and patients [28, 29], the empowerment of patients through the rapid proliferation of health information on the internet which provides unlimited access to medical knowledge on their health conditions prior to professional diagnosis [30,31], an increasing number of reported cases of gross medical errors which create perceptions of professional fallibility and diagnostic uncertainty, and encourage lay people to question the validity of medical and scientific knowledge and the trustworthiness of medical practitioners [32,33,34], and the multiplication of fake doctors. These factors have greatly contributed to the dynamic nature of trust, making it more and more the product of an interaction.

This study focuses on the dynamics of trust in therapeutic encounters between young adults and physicians. It pays particular attention to motivations or reasons and processes involved in the construction of trust. Following Erik Erikson's [35, 36] classification, we consider young adults to be within the age range of 18 to 40 years. The dynamic state of young adults, as a sociodemographic segment of the population, characterised by strong expressions of newfound independence, risky health behaviours, and the propensity for experimentation, is increasing the risks of poor health outcomes all over the world [37, 38]. In their health seeking behaviour, these young adults have to make choices among a plethora of therapeutic options, represented by healthcare institutions and medical personnel. Unless they are unconscious or completely ignorant, patients themselves decide whether to trust or distrust a healthcare provider.

METHODOLOGY

A qualitative methodology was used to explore the experiences, perceptions and observations of young adults in their encounters with doctors in the hospital setting. A total of 350 young adults (205 females and 145 males), drawn from several sectors of life, and aged between 18 and 40 years were purposively sampled for this research. There was preference for those who were either patients or have had a good number of encounters with doctors in the hospitals. Data was collected between May 2023 and December 2023 through in-depth interviews and focus group discussions, each session lasting between 45 and 65 minutes. Before each interview or focus group discussion, the purpose of the study was carefully explained to the participants and their consent (written or oral) was obtained. They were assured of the confidentiality of the data, the right to withdraw their participation without reprisal and the wish of anyone to remain anonymous was strictly respected. Permission was obtained to audiotape the discussions so that no part of the relevant data was lost. The data was analyzed using Braun and Clarke's [39] framework for thematic analysis, which involves identifying themes that reflect important trends and patterns in the data relevant to the objective of the research.

The theory of social constructionism provided the theoretical framework for this study. This theory seeks to explain the ways in which people develop, through their experience and social interactions, knowledge, perceptions, attitudes and behaviours about a given phenomenon. It emphasizes the socially created nature of social life [40]. The principal thesis of this theoretical approach is the idea that reality and the phenomena of daily life are socially constructed, and that meanings in relation to objects in the world do not inhere in

the objects themselves nor are they fixed by individual users of language; rather, meaning is constructed through social interaction in specific historical and cultural contexts [41,42,43]. This theoretical framework facilitated our understanding of how the young adults attempted to adapt personal experiences and pre-existing cultural models, modified such models in the light of new information gathered in their encounters and confronted conflict in their own interpretation.

RESEARCH RESULTS

Characteristics of Study Participants

A total 350 participants (145 males and 205 females) were sampled for this study. They were heterogeneous with regard to their ages, gender, occupation, religious affiliation, and level of education, as represented in the table below.

Table 1: **Demographic distribution of participants**

N.	Category	Frequency (n=350)	%
1	**Age**		
	18-25	66	19
	26-30	92	26
	31-35	90	26
	36-40	102	29
2	**Gender**		
	Male	145	41
	Female	205	59
3	**Educational Status**		
	No Formal Schooling	28	8
	Primary School	62	18
	Secondary School	120	34
	Higher Education	140	40
4	**Occupation**		
	Students	76	22
	Civil servants	64	18
	Self-employed	88	25
	Employed in the Private Sector	70	20
	Apprentices and Others	52	15
5	**Religious affiliation**		
	Christianity	238	68
	African Traditional Religion	39	11
	Islam	74	21

The Bases of Inter-Personal Trust

Participants were asked their motivations or reasons for trusting particular healthcare providers (physicians).

In their long list of answers, we found a combination of factors ranging from the personality, behavioural, emotional and psychological dispositions, which interacted within therapeutic settings to build trust.

1. Perception of the technical competence of physicians

Technical competence was a major predictor of trust among the participants. There was a general understanding of competence as the ability to do things the right way, avoiding errors in judgment and in execution, and producing accurate results. For the majority of the participants (65%), trust was based on their judgment of technical competence, which in some cases was largely from a layman's perspective and having little or nothing to do with scientific orthodoxy and technical skills. The young adult patients' assessment of technical competence was based on the physician's display of knowledge of their disease, and behaviours which conveyed compassion, empathy and care.

Technical competence was also presumed on the basis of social trust. Some participants (30%) gave doctors a warrant of trust even before any encounter. This was justified on the basis of their training in recognized medical schools, their accreditation by the National Medical Council, the standing of the hospitals that employed them, and the regulations guiding their practice. All these considerations were seen as ensuring technical competence. One of the participants, a thirty-one year old patient, articulated this view as follows:

I believe that anyone who has gone through the professional school is competent. I also think that a highly specialized hospital like this one will only recruit very knowledgeable and competent physicians and nurses who have been well-trained for their job. For this reason I trust in their ability to provide the treatment I need.

The experience of some participants, however, did not confirm this expectation and way of thinking. A young woman who lost her unborn child because of the evident error and wrong prescription of a gynaecologist expressed her disappointment as follows:

Just as the habit does not make a monk, so the coat does not make a good physician. It is not everyone who leaves a good school with knowledge and skills. I went to that highly-rated hospital hoping to find the highest expertise. The doctor I met did not display sufficient knowledge and skill. He did a wrong diagnosis and a prescription that caused the death of my child and put my life in jeopardy. Another significant finding is the increasing number of young adults who regularly consult the internet for medical issues. 36% of the participants admitted to having made extensive research on the internet prior to consultation or taking of medications. A participant who has collected much information from the internet on his diabetic and hypertension conditions was able contradict to the doctor's diagnosis and prescriptions:

The internet today provides ample information on diseases, their diagnosis and treatment. Before going to the hospital, I try to read up much information concerning my condition. I have been able to contradict certain prescriptions which, given my other conditions, I am absolutely not allowed to take them.

2. Effective communication skills

A significant segment of the participants (80%) reported that the good communication skills of the health care providers inspired trust in them. In their pain and frustration, some of the young adult patients were in dire need of someone who could listen attentively to them and carefully explain their illness and propose solutions. Kind gestures, attentive and empathic listening, and the use of soothing words which suggest sympathy and involvement, greatly contributed to the building of trust among the participants. Communication was made easier when a physician spoke the language which the young adults understood. The following report of one of the participants exemplifies the role of effective communication in building trust:

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The doctor I consulted the last time I went to the hospital is very good. He listened to me patiently When I entered, he called my name and tried to greet me in my dialect although as I found out he is not of my tribe. From my name he could guest my tribe. He patiently listened to my presentation of how I was feeling and assured me that a solution will be found. I felt comforted and confident that I was going to receive the much-needed help.

Similarly, another informant paid particular attention to the language and gestures of the physician.

The physician had a good smile on his face as if to say that my situation, which I thought was hopeless, could be redeemed. He held my hand and spoke some words of comfort. He really cheered me up. He listened patiently to me and explained clearly that the symptoms pointed to two diseases, and that I needed to urgently do three laboratory tests so that he may know exactly what treatment to prescribe. I just felt that the solution to my problem was already being found.

The use of simple language instead of highly technical medical terminologies to explain the problems of the patients was a highly motivating factor to trust among 52% of the participants. They felt comfortable with health care providers who could explain even complex medical conditions in simple lay terms so that the patients and their relatives understood. However, a small segment of the young adults (06%) regarded the use of the highly technical medical terminologies as a mark of scientific orthodoxy and learning.

4. Personal involvement

Although all the participants spoke about the need to feel that the physician or any health provider is concerned about their condition and is actively involved in the search for a solution, they differed in their ways of measuring the personal involvement of their healthcare providers. Some participants were concerned about the attention and length of time which was given to them during consultation (65%); others based their judgment of physician's involvement on the fact that he took personal interest in them, called them by name, and personally showed them how to get to the laboratory of a hospital big enough to pose problems to the patients:

The doctor really treated me with much consideration. When I entered, he called my name and said that I have the same name with his mother. As I described the symptoms of my illness, he showed sympathy telling me that I will get belter after the treatment. Being my first time to go to such a big hospital, he called a nurse and told her to show me the way to the laboratory and to ensure that I got back to his office when the results were ready. I felt loved and respected and that my problem is being shared. At the end of the consultation he gave me his number to call him each time I fall into a crisis.

5. Confidentiality

Concerns about confidentiality resonated with 75% of the participants, especially those within the age bracket of 30 to 40 years. In the context health, confidentiality entails the protection and proper use of sensitive or private information concerning someone's illness and treatment. Sensitive information can be manipulated as the basis for disqualification, stigma and social exclusion. There was great consciousness of the fact that a person's or his family's social image is a great value which has to be preserved or promoted. The majority of the participants manifested greater trust in complete strangers who simply knew them as patients without any further particular knowledge. This was particularly the case with participants infected with HIV/AIDS and other venereal diseases. Some consulted only physicians far from their place of residence. This anxiety was less among participants less than 25 years, many of whom conformed to parental choices.

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6. Shared cultural identity

While 45% of the participants did not care about cultural identity, others felt very optimistic when they knew that the person they were going to consult for their medical needs were people with familiar bearings such as being from their tribe. The mere mention of the name aroused hope in them that because of cultural affinity their "brother" or "sister" will treat them with great care and consideration. Culture arouses a sense of belonging and solidarity, and a corresponding responsibility to be an ally, and to take care of the interest of the other. In the minds of some participants, being of the same culture was expected to create a bonding and lay the grounds of mutual help and assurance. While a common identity was a predisposing factor, it was in the interaction between the doctor and the patient that trust was constructed. Some patients were disappointed when the reception they got from a person from their tribe was very cold, and some of the diagnoses and prescriptions were later proven to be wrong. This led one of the disappointed informants to say:

What really matters to me is the competence of the medical doctor, whether he was trained in a recognized and accredited institution and given the license to practice or not. His tribal origin is not important because they are trained to serve the world. Some doctors may never work among their people. What is in front of every doctor is a patient, a suffering person in need of help.

7. Shared religious affiliation

The majority of participants (68%) thought that religious affiliation was a strong predictor of trust. Belonging to the same religion and sharing the same faith guided the choice and trust of physicians. The general belief was that religious persons and institutions dedicated to religious care have a sense of vocation and so will be honest in their dealings, dedicated to their service, and act in perfect alignment with the ethics and deontology of the health care profession. The predominant belief was that a God-fearing physician will not seek to exploit patients financially and emotionally. Although these presumptions were debunked in a few cases, they, however, remained important factors which contributed to the development of trust among the participants. A Catholic participant made the following remarks:

I believe that a doctor who is a Christian will act according to the dictates of the Hippocratic Oath. The faith will influence his work and infuse it with such values as honesty, dedication, and integrity. He will be less likely to exploit his patients and treat them with disrespect and lack of consideration than a doctor who is not a Christian.

8. Gender

Gender was shown to predispose some participants towards who to trust in their health seeking behaviour. Sex discrimination based on social beliefs and stereotypical thinking determined who some patients trusted. The importance of gender considerations depended on the nature of the disease in question and the parts of the body affected. The opinions of the female participants were divided on whether they preferred male or female obstetrician/gynaecologists. Among the 205 female young adults interviewed, 70 % of them preferred female gynaecologists, whereas 22.2% did not have any preference and 7.8% % preferred male gynaecologists. Those who prefer a female gynaecologist argued that only a woman can experience or know the issues faced by other women, and that they will feel ashamed having to expose their nakedness to a man who is not their husband. From this perspective, then, they argued that women make better obstetrician/gynaecologists than men by virtue of their sex alone. Some other women who preferred male obstetrician/gynaecologists argued from the standpoint of their experiences with male doctors who

embodied care and patience. This opinion is echoed in the following narrative:

Men can be very caring. Women can at times be very wicked and rude to other women. I and most of my friends have male gynaecologists and we are very comfortable with the care and attention we receive.

The argument for gender concordance also resonated with 80 % of the men who preferred male physicians to attend to them for any disease that involved the examination of their genitals. The rest, 20%, did not bother about the gender of the physician provided they provided solutions to their problems.

9. The age of the physician

Rightly or erroneously, some patients associated the age of physicians with experience and competence. While some people believed that the new generation of medical doctors, although relatively younger, are better trained and equipped for their work, others maintain that they lack experience and devotion to their professional calling, and are very often derailed by the materialism of the modern world. Those who defended such an argument preferred older and more experienced physicians. While in practice competence may not necessarily be equated with age, some patients clung to age and decided on the basis of age. While 43% of participants felt more comfortable dealing with young doctors, 57 % of them opted for aged and more experienced health care providers.

10. Emotional factors

There were also emotional, non-rational components of trust reported by some participants (15%). The strength of trust in physicians was not always justified by a well-calculated assessment of objective evidence. The basis of trust for some participants was simply that they admired and loved the doctor when they saw him or her and this emotion of love became the reason for granting a warrant of trust. Strange as this may sound, attractive physical appearance, gestures and ways of communicating caused admiration and led some patients to trust the physician. In a good number of situations, also, trust arose as a coping mechanism in response to the intense psychic distress created by illness. Some participants reported that when they were facing life-threatening risks, they simply believed in the power of physicians to provide solutions. They found a positive relationship between the level of vulnerability and the level of trust as can be seen in the declaration of an informant with a chronic liver infection:

Two months ago, I was rushed to the hospital in deep, unbearable pains. I felt as if something was cutting and tearing my internal organs. I had no time to find out who it was that was attending to me. I just believed that whoever we met and whatever treatment they gave me was going to take away my pains. I just surrendered myself.

11. Influence of parents and peers

Peer influence emerged as a strong inducement to trust. When some young adults shared the experiences of their encounters with particular physicians and commended their technical and interpersonal skills, the grounds for trust were laid in their friends, who began to make up their minds about where to go when in need of medical attention. The choices of parents prevailed among those who were between the ages of 18 and 25 years.

DISCUSSION

Our ethnographic data has established the cognitive and affective bases of interpersonal trust, and projected a number of themes and perspectives which are relevant to the theoretical discussion of the interpersonal trust. This section of our study takes up four of such themes, namely, the grounds for social trust, trust as a

product of social interaction, the contribution of sociodemographic characteristics to the formation of trust and a contextual element, the broader access to health information through the internet which is altering the slant of the asymmetry of the relationship between health professional and patients

Grounds for Generalized Trust

Generally speaking, most of our informants accorded something of a warrant of trust to the healthcare providers whose services they sought. The question of how one comes to trust without any prior grounding in any specific interaction or recommendation, what Hardin [15] refers to as "trust in random others" points to the socially embedded nature of trust as 'one of the most synthetic forces within society" [1]. According to one participant, *all doctors accredited to work in the hospitals are certified. They have been trained and have taken the Hippocratic Oath, and so will do their job as prescribed*. This statement finds its justification in what sociologists and anthropologists describe as "public" or "social" or "generalised" trust, without which it will be impossible to act in the complexity of modern society fraught with risks [2]. According to Mechanic and Meyer (2000:657), "For the most part, individuals relate to others on the assumption that people generally are who they purport to be, will act in accordance with generally understood norms of behaviour and will meet their obligation." [44]. Social trust frames trust in particular healthcare providers as it allows patients to initially trust individuals about whom they know very little except for the fact that they are doctors. Persons previously unknown to each other begin to feel at ease with variable degree of intimacy. Together with the gamut of social values that man acquires in society, trust is a shared orientation which is culturally transmitted through a process of socialisation and which needs empirical evidence, the reproduction of trust-arousing acts, in order to survive and grow. The reinforcement of trust often derives from professionalism which is the bedrock of medicine's contract with society. According to Fugelli (2001) [45], and Pearson and Raeke (2000) [46], optimistic collective expectations are the basis of "social" or "system" trust in the institutions of medicine, in particular hospitals or practices, or in doctors in general. In assessing whether or not it is worth it to take the risk of trusting, patients might consider more or less tangible factors such as professional accreditation, designed to protect our interest against unscrupulous or unqualified practitioners [44].

Trust as a Product of Social Interaction

Even when begun with a "warrant for trust" [47], the encounter between the young adult patient and the doctor produced an on-going and interactive relationship in which impressions were created, interpretations were formed as the basis for behaviour and attitudes. Focusing on the evolving and transformative nature of trust, Solomon (2000:234) maintains that trusting is not just contextual; it is an "ongoing process, a reciprocal relation in which the parties as well as the relationship (and the society) are transformed through trusting" [48]. This introduces into the analysis the element of time which frames the interactional process by allowing opportunities for self-discovery, self-disclosure and perspective taking that result in behaviour that reflects the orientation of trust [49], and allows for the development of relationships. According to Cook et al. (2004:89), "because individuals in hierarchic relationships are highly motivated to make prudent and intelligent choices when it comes to trust, they monitor a variety of behaviours and the absence of behaviours to determine if they can trust the other person." [50],

From the narratives of the participants regarding the performance and actions of the doctors during therapeutic encounters, it is clear that trust is not given once and for all. It is constructed, preserved or lost through the actions of the physicians and the interpretations of the patients. The young adult patients were assessing the doctor's trustworthiness by monitoring their interactions very closely. According to Cook, in the process of the construction or loss of trust, patients implicitly and explicitly assess the physician's competence and note his communication skills and expressions of care in order to determine the degree to which the physician is motivated to provide the best possible care [50, 51]. This is consistent with the social

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constructionist perspective, according to which an individual identity is said to be very dynamic. This implies that individuals possess the ability to redefine and negotiate their identities when they find themselves in a context where they can engage in dialogues with others, and which context challenges generally accepted beliefs and assumptions [52]. The identity of the doctor held by some patients were affirmed, confirmed or destroyed when they began to interact in consultation and treatment, and this influenced the decision whether or not to trust.

According to symbolic interactionist perspective, as explained by Charon (2004), humans define the situation they are in through on-going interaction and thinking, and this forms the basis of their action [53]. Generally, human beings act towards each other on the basis of the meanings they form by interpreting the words, gestures and actions of others. In the context of health care, positive interpersonal attributes of health professionals in the course of consultation and treatment were analysed and interpreted by patients as proof of competence and benevolence, and thus trustworthiness. Interpersonal trust is therefore based both physicians' positive behavior and on patients' judgment of technical competence (medical expertise), interpersonal competence and agency [6, 11]. Trust is therefore socially situated and constructed within particularities of relationships. Being complex, symbolic and dynamics, trust is in a constant state of construction and transformation.it is worthy of mention, that there were a few cases in which doctors who had been judged as rude and uncaring were found to be medically knowledgeable.

The Role of Sociodemographic Factors in the Construction of Interpersonal Trust

Apart from technical competence, the sociodemographic characteristics (age, gender, religious affiliation and shared cultural identity) of the physicians influenced patients' perspectives and played a major role in the construction of trust.

Shared religious affiliation was a major inducement to impersonal trust. Some of the participants declared a preference for medical personnel who belonged to the same faith with them. Their expectations of benevolence and integrity were rooted in the values of the common faith which they shared, and which made of them brothers and sisters in communion and solidarity. Some participants believed professionals who are influenced by their faith in God will be more caring, empathic and honest. Many scholars have identified religious belief and behaviour as important factors in the understanding of trust [54]. As a kind of a subculture, religion creates a sense of inclusion and so can be considered a veritable in-group identifier [55]. A good number of studies have demonstrated the vital role of religious faith and practice in establishing group membership and in facilitating interpersonal trust. In a recent study on the influence of religion and political affiliations on trust and reciprocity among strangers, Fitzgerald and Wickwire (2012) showed that participants in the study tended to trust others who were within the same religious denomination, as individuals are more likely to engage with someone, they believe to be their in-group as opposed to someone in the supposed out-group [55, 56]. People generally rate members of their religious community more favourably than people in other religious groups. As an important source of sociability within communities, religion fosters generalized trust in religious individuals and those who are actively involved in religion are shown to be more trusting of others [57]. It is to be expected that people who are actively involved in the practice of religion, would have a deeper sense of responsibility and accountability. The strong feeling of being watched and of having to give an account to a higher power often increases an individual's self-control and self-regulation [58]. People with high self-control are considered more trustworthy than those lacking in self-control [59].

The relationship between gender concordance and trust resonated with a portion of the participants. Apart from a few participants who did not bother about the gender of the physician even in examinations involving the genitals, the majority preferred gender concordance. According to Michel de Montaigne (2009), the French Renaissance author, "Man is the sole animal whose nudity offends his own companions and the only

one who, in his natural actions, withdraws and hides himself from his own kind" [60]. Patriarchal

Societies emphasized gender concordance between patients and health care providers on the basis of socio-cultural and religious norms and practices which demarcated gender roles, and restricted social and physical contact between men and women [61, 62, 63]. This explains why visiting a physician and allowing for an intricate inspection and examination of our dearest possession, our body, was a source of much anxiety for many participants, especially when it concerned the examination of the genital and pelvic areas. A qualitative study carried out in Cuba, Thailand, Saudi Arabia and Argentina examined the experience of women seeking antenatal care and found that female doctors were more highly preferred by Saudi and Thai women [64]. Some studies undertaken in the USA have demonstrated that only a minority of women felt strongly about their provider's gender and based their choice more on experience, communication style and technical expertise [65, 66, 67]. A study by the department of Obstetrics and Gynaecology from the University of Connecticut found that 66.6% of patients had no gender bias when selecting an obstetrician-gynaecologist. In addition, 80.8% of patients felt that gender did not influence quality of care [68]. These numbers suggest that there are factors other than gender that come into play when choosing a gynaecologist; indeed, interpersonal style and communication appear to be the most important traits in physicians rather than gender [69]. Similarly, a study from the American Journal of Medicine reports that male obstetrician-gynaecologists claim longer visits with female patients than do female obstetrician-gynaecologists, and exhibit more patient partnership behaviour, suggesting that physician behaviour and medical education can be adapted to further address patient needs [70].

Ethnic match also appeared as an inducement to trust. Ethnicity designates a category of people who identify with each other, based on similarities such as common ancestry, language, society, and culture. Membership is defined by shared cultural heritage (ancestry, origin, myth, dialect etc.) and symbolic systems (religion, mythology and ritual, dressing styles, art and physical appearance) [71]. The notion of concordance within health care embodies the idea of a therapeutic alliance between patients and providers [72]. Ethnic considerations may fortify this alliance by attending to one of the essential components of trust, namely, the expectation of good intention and good will of the health care provider. The consciousness of sharing a common destiny within the tribe foregrounds the patients' perception of the healthcare provider's role. This is partly so because people choose to associate with others who are similar to them in some salient respect [73].

Impact of Internet-Facilitated Access to Medical Knowledge on Trust relations,

Although the physician-patient relationship is still largely asymmetrical as a result of the specialised knowledge and technical skills which physicians possess, the expansion of patients' access to medical knowledge through the internet and related sources is narrowing the gap. The testimonies of participants who were able to contradict the prescriptions of some physicians with the aid of information gathered in the internet are an effective illustration of a changing situation. The past three decades have registered a significant evolution in doctor-patient relationship and consequently, the nature and bases for trust. Traditionally, patients and society as a whole placed high level of trust in health care professionals and institutions. The relation was between a patient seeking help and an "all-knowing" doctor whose decisions were dutifully complied with. These asymmetrical or imbalanced relations were characterised by a type of blind, embodied trust [74]. However, these relationships have been fundamentally altered by changes in the organizational structure of medical care, and the culture of health care delivery which have been prompted by wider social changes such as growing lay medical knowledge. There is greater access to medical knowledge and patients are increasingly interested in knowing what their condition is and in comparing the diagnosis of different health professionals using cues from the internet and other sources. Public attitudes towards professionals and their authority as medical experts are changing, reflecting a more general decline in spontaneous appeal to authority and trust in experts and institutions, together with increasing reliance on personal judgments of risk [75, 76].

Beliefs about the limits of medical expertise together with concerns about the effectiveness of professional regulatory systems to guarantee high standards of clinical care, amplified by the media coverage of medical errors and examples of medical incompetence, have eroded trust in the medical professions in general, and in health systems as a whole. Media representations of alleged medical errors often fuel perceptions of professional fallibility and diagnostic doubts and encourage lay people to question the validity of medical and scientific knowledge. This may lead them to question the trustworthiness of the medical personnel.

CONCLUSION

Anchored within a social constructionist theoretical framework and employing a qualitative study approach, this study sought to investigate the socially embedded nature of trust as it occurs in therapeutic relationships between young adult patients and physicians, and to identify the cognitive and affective elements that interact to build trust. Given the uncertainties that characterise health issues, the risks associated with professional competence, the asymmetry of the relationship between health professionals and patients, and the associated vulnerability of patients, social trust forms the foundation of all trust relationships. Physicians are accorded a warrant of trust on the basis of their training, accreditation and supervision; but each individual physician in his encounter with the patients is expected to embody the profile and deontology of the profession. Except when they are unconscious or completely ignorant, patients rely on good reasons to trust. Their assessment based on cognitive and affective parameters together with manifestations of the technical and interpersonal competencies of the physician constitute the process of the construction of interpersonal trust. Understanding the complexity of the relationships that affect patient trust is essential to understanding initiatives that can be undertaken to improve trust in healthcare personnel. This is vital because trust has been associated with positive health outcomes including, for example, greater disclosure of relevant, sensitive information and greater adherence to medical advice and prescribed treatment.

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