Intern Emerg Med
DOI 10.1007/s11739-016-1410-1

CE-ORIGINAL

Do emergency physicians trust their patients?

Thierry Pelaccia[1,2] · Jacques Tardif[3] · Emmanuel Triby[4] · Christine Ammirati[5] · Catherine Bertrand[6] · Bernard Charlin[7] · Valérie Dory[8]

Received: 21 October 2015 / Accepted: 10 February 2016

Abstract The primary focus of research on the physician-patient relationship has been on patients' trust in their physicians. In this study, we explored physicians' trust in their patients. We held semi-structured interviews with expert emergency physicians concerning a patient they had just been managing. The physicians had been equipped with a head-mounted micro camera to film the encounter from an "own point of view perspective". The footage was used to stimulate recall during the interviews. Several participants made judgments on the reliability of their patients' accounts from the very beginning of the encounter. If accounts were not deemed reliable, participants implemented a variety of specific strategies in pursuing their history taking, i.e. checking for consistency by asking the same question at several points in the interview, cross-referencing information, questioning third-parties, examining the patient record, and systematically collecting data held to be objective. Our study raises the question of the influence of labeling patients as "reliable" or "unreliable" on their subsequent treatment in the emergency department. Further work is necessary to examine the accuracy of these judgments, the underlying cognitive processes (i.e. analytic versus intuitive) and their influence on decision-making.

Keywords Clinical reasoning · Decision making · Physician-patient relationship · Patients' labeling

✉ Thierry Pelaccia
pelaccia@unistra.fr

Jacques Tardif
jacques.tardif@usherbrooke.ca

Emmanuel Triby
triby@unistra.fr

Christine Ammirati
christine.ammirati@chu-amiens.fr

Catherine Bertrand
catherine.bertrand2@aphp.fr

Bernard Charlin
bernard.charlin@umontreal.ca

Valérie Dory
valerie.dory@mcgill.ca

[1] Centre for Training and Research in Health Sciences Education (CFR-PS), Faculty of Medicine, University of Strasbourg, 67085 Strasbourg, France

[2] Prehospital Emergency Care Service (SAMU 67), Strasbourg University Hospital, PO Box 426, 67200 Strasbourg, France

[3] Department of Pedagogy, Faculty of Education, University of Sherbrooke, Sherbrooke, QC J1K 2R1, Canada

[4] Faculty of Educational Sciences, University of Strasbourg, 67000 Strasbourg, France

[5] Department of Emergency Medicine, Amiens University Hospital, 80054 Amiens, France

[6] Prehospital Emergency Care Service (SAMU 94), Henri-Mondor Hospital, Public Hospitals of Paris, 94000 Créteil, France

[7] Centre of Pedagogy Applied to Health Sciences (CPASS), Faculty of Medicine, University of Montreal, Montreal, QC H3T 1J4, Canada

[8] Undergraduate Medical Education and Centre for Medical Education, McGill University, Montreal, QC H3A 2T5, Canada

Published online: 23 February 2016

Introduction

Trust refers to "an expectation that the other person will behave in a way that is beneficial, or at least not harmful" [1]. Mutual trust between patients and their physicians is a crucial element in the quality of their relationships, which is itself a key factor in effective communication and positive patient outcomes [1–3]. Yet most research has focused on patients' trust in their physicians and very little on the provider perspective—sometimes referred as to "the other side of trust" [3]—i.e. physicians' trust in their patients [1–3].

In the context of care providing, trust refers to the physician's expectations that "patients will behave in ways that fulfill their roles in providing accurate and complete histories, asking questions, complying with a treatment plan, and following up" [1]. Physician's trust in the patient is expected to reduce the asymmetrical provider-patient relationship [3], to enhance patient's trust in the physician [1], to improve the quality of care and services provided to the patients (which could in turn influence patients' compliance with the treatments) [3], and to decrease physician frustration that sometimes occurs with patients [4].

Most research in this field has been conducted in family care, oncology and palliative care [3]. The emergency medicine setting has specific characteristics that potentially impact the physician-patient relationship, i.e. physician-patient encounters generally are brief, transitory and unplanned [5, 6].

Between 2011 and 2012, we carried out a qualitative study exploring how emergency physicians make decisions, and, in particular, how they generate and test diagnostic hypotheses [7, 8]. As is the case in almost all studies that have been published on the topic of physician/patient trust, this topic came to us as unexpected finding, not directly related to the initial objectives of our study [3]. Not only had several of the physicians interviewed come to judgments regarding the patient's reliability, they had also developed various strategies to adapt their interview and investigations to these situations. The aim of this paper is to report these findings.

Methods

This section briefly outlines our methods which have been reported in more detail elsewhere [7, 8].

Study design

We used a qualitative approach involving stimulated-recall interviews with expert emergency physicians in their workplace. Participants were first equipped with a micro-camera fixed to their temple or the leg of their glasses, to film a patient encounter from their "own-point-of-view perspective". Each participant was filmed while managing a single life-threatening or potentially life-threatening situation, and was interviewed in situ afterwards. We collected data between May 2011 and April 2012.

Population

We recruited expert emergency physicians. As length of experience is not considered a valid criterion for expertise [9, 10], we used the following set of criteria:

- Qualified as an emergency physician based on specialized training,
- Works full-time and exclusively in an emergency medicine setting,
- Holds consultant's grade,
- Designated as expert by the director.

Study protocol

TP carried out 15 semi-structured interviews until data saturation was reached (i.e. no new information related to the study objectives emerged from analysis of the final interview). We held interviews in three different French hospitals (five interviews in each hospital). During the interview, the physicians viewed the video footage of the encounter, and were questioned specifically about moments they identified as important or that the interviewer identified as being potentially significant in regards to the research objectives.

Data analysis

We used an interpretive approach based on thematic analysis with constant comparison [11, 12]. After transcribing the interviews, TP, CA and CB coded the verbatim reports using the N-Vivo program (QSR International, Melbourne, Australia). The initial inter-coder reliability was 70.9 %. It reached 96.2 % after discussions. The coded data were then summarized in the form of matrices produced by TP, JT and ET for each participant. This involved cross-referencing what the participants did during each stage of their management, and what they were thinking during these different stages. Themes emerged during the development of these matrices, and allowed data to be compared across participants. This led to the development of another matrix based on themes and participants. This analysis was conducted iteratively as interviews progressed. Coding was stabilized by the fifth interview, after the emergence of the theme of physician/patient trust. Subsequent interviews and coding were informed by these

early findings, i.e. this theme became part of the interview guide and new codes were created in regard to this theme in order to analyze subsequent interviews.

Results

The results are described according to our main findings about the theme of physician/patient trust. Excerpts from the transcripts are given. Words between inverted commas are those used by the interviewed physicians.

Judgments on patients' reliability

Several participants mentioned the fact that they had "assessed" (physician 6) the reliability of the patient they were treating. This judgment referred to the patient's trustworthiness, leading the physicians to "believe" (physicians 5 and 14) the patient's account:

> I wanted to know whether [his clinical condition] could have been affected by other drugs. The nurse had just told me that she was going to do the toxicology screen. In my mind, I thought that it wasn't necessary. The patient had told me he hadn't taken anything; I was inclined to believe him—Physician 5 (about why he asked the patient if he had taken anything other than alcohol)
> I told myself that we would believe what the patient said. It wouldn't change anything in the treatment because, it was a suspected case of beta-blocker poisoning anyway. He would require observation for a while, but I felt that he had told me the truth—Physician 14

Conversely, some physicians described taking the patient's account with a certain degree of "suspicion" (physician 6) or distrust:

> I'm starting to be suspicious of this patient now, but there may be a premise (…). It's strange, I get the impression that she's falling off the rails (…). That surely leads to a judgment. Not a value judgment, but it helps to build the personality. To know that she had an ulcer, and she is still taking [a non-steroidal anti-inflammatory drugs], it's odd—Physician 6
> These are the types of patients I don't trust, because, uh… I find they are not reliable as patients—Physician 7
> I'm insisting a bit because, well, this patient is not all that clean. He's not telling me the whole story. Maybe he can't pluck up the courage—Physician 8 (about why he asked the patient several times about when the symptoms first appeared)

When did they form this judgment?

The physicians interviewed formed this judgment at an early stage, during the first few minutes of the patient encounter, generally during the initial interview:

- This is kind of someone I'm not going to trust—Physician 7 (during the interview)
  From this moment on?—Interviewer
  No, actually since the beginning.
- You were aware at that time that his answer was inconsistent?—Interviewer
  No, from the beginning, right away. He's not very… I do take my time, I take a lot of time, that lasts a really long time; it's because he is not reliable, reliable—Physician 9

How did they reach this judgment?

In many cases, the judgment was triggered by an inconsistency or contradiction in the patient's responses.

> Well, he isn't reliable, because I ask him 'have you already had that' and he says 'no', and right after he tells me 'the last time it hurt there', so, uh…—Physician 9 (about a patient's answer to the question 'Have you ever had chest pain?')

In some instances, it was linked to a non-verbal cue—such as the patient's attitude or the way the patient looked at the physician or answered a question:

> There is a certain flippancy. She tells me 'I've had ten bouts of kidney infections' just like that, well… If I'd had ten bouts of kidney infections, I wouldn't be so flippant about them. But maybe she's flippant about her own health, which is probably not entirely true, because she says she isn't being treated, but she keeps going to the doctor, so there's something not quite right all the same in this woman—Physician 6
> In my mind, I'm thinking to myself that really, I don't know… the sort of interaction, you get a feeling that, uh… there was the way he looked at me too, I thought to myself that he really didn't look like he was lying, and I felt that he hadn't taken any medication—Physician 14

What were the consequences of judging a patient as "unreliable"?

Once a patient was deemed unreliable, this had various consequences on the rest of the encounter.

Some physicians cast doubt on the patient's account, and disregarded or at least qualified potentially significant

information. Physician 6, for example, stated that he "(-wouldn't) take anything at face value", and physician 4 wondered what the patient would "invent next!" after she mentioned "stabbing in the chest". In the following excerpt, the participant (physician 10) had asked the patient whether she was experiencing crushing chest pain, and he later qualified her answer:

> I immediately wished I hadn't asked the question. I wish she would have expressed it in her own words. Its funny eh, it's funny, because it's really interesting to look back with the feeling… I can feel it now! I shouldn't have put [the question] like that, I should have let her express what she felt, rather than asking her 'do you have crushing chest pain?'. No wonder she said 'yes', but as an automatic response to the suggestion

Other physicians took the information provided into account, but tried to make sense of it. Different terms were used by the practitioners interviewed to describe this process. It could be to "re-decode each sentence" (physician 6) or "interpret" the answers (physicians 9 and 10).

What strategies did the physicians interviewed use when they considered a patient "unreliable"?

For some, it shifted their interview technique to one they described as a "police investigation" (physician 7) to "check the information" (physicians 6 and 7) provided by the patient, so as to "confirm" or "refute" it (physicians 7 and 10):

> There are lots of contradiction in what this man said. So every time he says something, you have to check it out, try to confirm or refute it—Physician 7

The metaphors they used to describe this form of history taking included: "pick at", "scratch everywhere", "tear [the patient] completely open", to "pry it out of them", (physician 7) or "trap them" (physician 9).

> On occasion, I don't hesitate to go back and forth if I can't figure out what's going on, even if it means asking the same question several times (…). I tend to scratch everywhere to try and collect as many pieces of the puzzle as I can, and the more pieces I have, the more I hope the final picture will be clear—Physician 7
>
> I have to ask the questions several times, and he has different answers too (…). He said 'the last time I came here, it was almost the same thing', because he didn't really know… It was the same, not the same… This is why I ask the question several times. I had already asked him if it was the first time, but I asked it again after to try to… trap him a little… Not really to trap him! It's not really to trap him! But I prefer to ask the question several times, and then I wait, and then it comes back (…). There, I'm asking it for the 3rd time to try and trap him again. He annoys me, ah, ah, ah, ah! I'm trying to trap him yet again to see what happens—physician 9

It involved considerable effort, as physician 4 put it:

> You have to fight for everything to get to the details

Participants also relied on information from other sources, deemed "objective" (physicians 9 and 10), enabling them to "anchor the patient's story in reality" (physician 6). They gathered such data in multiple ways, e.g. requesting the medical record, calling the physician who had referred the patient, talking to the patient's family or friends or to witnesses of the event that led the patient to the ED.

> Since I didn't really know where I was going, I said to myself that I'd take the referring physician's number anyway, because if I really need more information, I could call him—Physician 7
>
> When people are not very accurate like that, if they have already been in hospital, you can get the old record 24 h a day. In fact, we have all the reports, and from time to time that helps a lot—Physician 7
>
> It continues to corroborate what I think, but that said, I'm still undecided as to whether I'll talk to the patient's colleagues anyway, or at least those who have seen him, to see if they confirm it or not—Physician 10

Finally, some participants switched from a focused history to a more systematic history, hoping to "catch" (physician 7) information or "fuel other hypotheses" (physician 6):

> At first, I couldn't work out what had happened at all, so I go back to something systematic and see whether I can find some information to help orient me, because he said nothing at all about his disease, so I look at his past medical history where I might end up catching something—Physician 7
>
> I think that when you are at this stage, when I start to ask the question for this particular case, I realize that starting with the patient and her symptoms won't get me anywhere, so I tried to start elsewhere, from her various risk factors, in order to fuel other hypotheses—physician 6

Discussion

Research on expertise traditionally conceptualizes decision-making as a rational process [13]. Likewise in medicine, the dominant view has been that decision-making

should be objective and free of affective and emotional considerations, including in the initial steps of data gathering [14]. Yet interactions between a patient and a physician involve a relationship between two human beings, likely to generate, whether consciously or not, feelings [13, 15].

One of the affective components of reasoning involves the concept of "labeling", i.e. attributing generally negative characteristics to patients [14]. For example, patients might be labeled as "difficult" or "whiny". Our study has revealed instances where emergency physicians rapidly assigned a label of "unreliable" to their patients. This labeling was triggered by inconsistencies in patients' accounts or non-verbal cues identified during the history (e.g. patients' attitudes, the way they looked at the physician or responded to their questions).

The concept of patients' reliability warrants further attention. According to Rogers, the medical interview explores two aspects of the reliability of patients' accounts [2]. The first questions the patient's sincerity and honesty in terms of whether the patient can describe events without exaggerating or omitting facts. The second, which the author refers to as "epistemic competence", is based on the patient's ability to identify what information medicine has defined as relevant for diagnosis or management decisions. Rogers hypothesized that, generally speaking, physicians believe in their patients' honesty, in so far as the complaint initially described is considered to be the patient's subjective perception of their problem. However, this justifies physicians in seeking out information deemed more objective, such as data from the physical examination, and in lending more credence to these 'objective' data (i.e. considering them to be more reliable). It also explains why physicians' ability to identify inconsistencies in the patient's account and to uncover issues that were not raised by the patients themselves is often considered a hallmark of medical competence [2]. While this quest for objectivity is considered a normal part of medical practice [2], our study finds that it is amplified when a patient is labeled as unreliable as the compensatory strategies used by our participants demonstrate.

Our study brings light on two underexplored aspects of the physician/patient relationship. First, it allows us to better understand what are the factors, in the emergency medicine context, that lead some physicians to assign a label of "unreliable" to their patient. The emergency physicians interviewed seemed to rely mainly on the ability of the patient to provide accurate and complete information, which has recently been shown as one of the main criteria used by physicians to appraise patients' reliability [1]. They also relied on non-verbal cues. To our knowledge, this has never been reported in the medical literature. Second, it reveals that unlike what some authors suggest—i.e. physicians should enhance trust and agreement towards their patients when it is lacking (e.g. by using open-ended questions or by actively listening to the patient's concerns) [4]—the physicians interviewed in our study rather tried to deal with their judgment and to "get through" to the patient by using diverse strategies designed to catch the truth in the patient's account.

Our study did not allow us to document the nature of the labeling process, i.e. whether it proceeded at a conscious or subconscious level, and did not try to determine whether this judgment was valid with respect to the situation. According to Rogers, the fact of "believing" or "not believing" someone is a somewhat intuitive process based on our stereotypes, rather than a deliberate and analytical judgment based on rational reasoning [2]. While the use of non-verbal cues may indicate a more intuitive process, the identification of inconsistencies and the pursuit of a cross-examination form of history taking suggests as least in part a more analytical mode of reasoning. Whether these are used to justify intuitive prejudices post hoc cannot be ascertained from this study.

We have previously acknowledged the limitations of our chosen methods [7, 8]. In particular, as with any qualitative research based on interviews, we cannot be certain that what participants told us of the reasoning reflects their actual reasoning during the encounter. Moreover, although we managed to saturate the data relative to the study's initial objectives, we cannot be certain that we did so for these findings that emerged during analysis.

Conclusions

Our findings have several implications. From an educational standpoint, the development of the skills in appropriately forming a judgment regarding when to trust a patient's account versus when to press further and seek more objective data should be explored and perhaps taught more explicitly. From an ethical standpoint, they pose the question of the appropriate attitude to take when faced with a patient considered to be unreliable. Although it is morally desirable for physicians to believe their patients and trust them, reducing the power differential between them [2], it might be clinically prejudicial to believe patients who are not reliable. This could in fact alter the very nature and goal of the physician-patient relationship, as well lead to an inappropriate distribution of resources and medical time [2]. However, such patients do exist [2], and our work has revealed that they are sometimes identified as such by experts, within the context of emergency medical practice. Finally, from a research perspective, further work is warranted on the nature of the process

involved (i.e. how trust relations are forged and what are the circumstances and factors that influence physician's trust in their patients [1, 3]), and potentially the errors avoided or caused by attributing these labels. We also believe that it would be interesting to extend the study to non-expert physicians in order to determine if the ability to label a patient as reliable or unreliable is a hallmark of expertise.

Acknowledgments We thank all the doctors who took part in the interviews. Their contribution to the research is invaluable. We thank doctors who helped us to recruit. We thank Pierre Paillé, senior qualitative researcher, for his contribution to the study design. We also thank Annick Bourget, Associate Professor and Nicolas Pelaccia, Consultant, for their contribution to this research.

Compliance with ethical standards

Conflict of interest The authors declare that they have no conflict of interest.

Statement of human and animal rights All procedures performed in this study were in accordance with the ethical standards of the institutional or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards. The study was approved by both a university ethics committee (Education and Social Sciences Research Ethics Committee of the University of Sherbrooke, Canada—#CER-ESS 2010-71) and a hospital ethics committee (Committee for the Protection of Persons Northwest 2, Amiens University Hospital—#A01586-37).

Informed consent We obtained written consent from all the interviewees. The patients concerned or trusted third parties received an information leaflet about the study. They were asked to give verbal consent.

Funding This study was supported by a grant from the French Society for Emergency Medicine (SFMU). The grant was used to buy the camera, and to pay TP's travel expenses needed for data collection.

References

1. Thom DH, Wong ST, Guzman D et al (2011) Physician trust in the patient: development and validation of a new measure. Ann Fam Med 9:148–154
2. Rogers WA (2002) Is there a moral duty for doctors to trust patients? J Med Ethics 28:77–80
3. Brennan N, Barnes R, Calnan M et al (2013) Trust in the health-care provider-patient relationship: a systematic mapping review of the evidence base. Int J Qual Health Care 25:682–688
4. Levinson W, Stiles WB, Inui TS et al (1993) Physician frustration in communicating with patients. Med Care 31:285–295
5. Croskerry P, Sinclair D (2001) Emergency medicine: a practice prone to error? CJEM 3:271–276
6. Weingart SD (2008) Critical decision making in chaotic environments. In: Croskerry P, Cosby KS, Schenkel SM et al (eds) Patient safety in emergency medicine. Lippincott Williams & Wilkins, New York, pp 209–212
7. Pelaccia T, Tardif J, Triby E et al (2014) How and when do expert emergency physicians generate and evaluate diagnostic hypotheses? A qualitative study using head-mounted video cued-recall interviews. Ann Emerg Med 64:575–585
8. Pelaccia T, Tardif J, Triby E et al (2015) Insights into emergency physicians minds in the seconds before and into an encounter. Intern Emerg Med 10:865–873
9. Guist CB, Regehr G, Tiberius RG (2001) The life long challenge of expertise. Med Educ 35:78–81
10. Choudhry NK, Fletcher RH, Soumerai SB (2005) Systematic review: the relationship between clinical experience and quality of health care. Ann Intern Med 142:260–273
11. Pope C, Ziebland S, Mays N (2000) Qualitative research in health care. Analysing qualitative data. BMJ 320:114–116
12. Green J, Thorogood N (2004) Qualitative methods for health research. Sage, Thousand Oaks
13. Croskerry P (2012) Perspectives on diagnostic failure and patient safety. Healthc Q 15:50–56
14. Croskerry P, Abbass AA, Wu AW (2008) How doctors feel: affective issues in patients' safety. Lancet 372:1205–1206
15. Glassman NS, Andersen SM (1999) Transference in social cognition: persistence and exacerbation of significant-other-based inferences over time. Cognit Ther Res 23:75–91