



Skeptical Patients: Performance, Social Capital, and Culture

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Abstract: Public trust and confidence in the medical profession, while remaining high compared against similar institutions, has been eroding in America since the mid-sixties. This development has raised widespread concern because trust in medicine is commonly regarded as influencing effective health care, patient-physician communication, and cooperation in treatment. Performance-based accounts seek to explain this phenomenon in terms of specific organizational changes in the practice of health care, such as the increased size and centralization of health care plans, the privatization of medicine, and the growth of managed care. Social capital theories emphasize the important link between social trust and institutional confidence. In contrast, cultural theories suggest that the rise of more skeptical patients reflects a broader process of value change experienced in many modern societies, generating growing challenges to many traditional sources of authority and eroding faith in societal institutions. Analysis of the General Social Survey since the early seventies, presented in this study, demonstrates that the decline of confidence in medicine closely reflects patterns in other comparable institutions in the private, non-profit and public sectors, including education, unions, organized religion, Congress, the Executive, and the mass media. Moreover the erosion in faith in medicine has occurred throughout all major social groups. The conclusion suggests that the long-term process of value change has altered the traditional patient-physician relationship and then considers alternative normative interpretations of these developments.

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Medicine faces a major challenge today. Public trust and confidence in the health care profession in America, while remaining high in comparison with many similar institutions, has been steadily eroding since the mid-sixties. Today about 45% of the American public express 'a great deal of confidence' in medicine, according to NORC surveys, compared with about 55-61% in the early seventies (see Figure 1). There are some fluctuations over time in these figures but the pattern during the last five years has remained stable. This development has raised concern because trust in medicine is commonly regarded as contributing towards the effectiveness of health care. The concept of trust is understood here as *the expectation that others will act in one's interest*. A trusts B to do x. It can apply to particular individuals, to social groups, or to institutions like banks, airlines, or Congress. In terms of medicine, trust is commonly thought to play a vital role in patient-physician relations. Trusted doctors are those believed to act in the interest of their patients, by providing competent advice, responsible treatment, and compassionate care that contributes effectively to the well being of their patients. Trust may facilitate patient-physician communications in ways that enhance diagnosis, treatment and compliance (Scott et al 1995; Thom, Roibisi, Stewart and Like 1999; Hall, Dugan, Zheng and Mishra 2001; Clark 2002). Moreover a more general erosion of confidence in medicine as an institution may also gradually undermine the political legitimacy and scientific authority of the health care profession as a whole (Schlesinger 2002).

[Figure 1 about here]

Three alternative schools of thought have commonly sought to explain this phenomenon. *Institutional performance-based* accounts focus on specific organizational changes in the practice of health care in America, such as the increased size and centralization of health care plans, the growth of managed care, the substantial budget devoted to advertising by drug companies, and the impact of these developments upon the patient-physician relationship. *Social capital theories* focus upon the role of dense networks of associations generating social trust and institutional confidence. In particular, social capital theories look towards the strength of the face-to-face bonds between the family physician and their patients, and the way that these have been attenuated and weakened by the professionalisation of medicine, and the displacement of the general practitioner by the rise of expert specialists. In contrast *cultural accounts* suggest that the growth of more skeptical attitudes towards medicine reflects a more general process of value change experienced in many modern societies. In this perspective, attitudes towards medicine form part of a broader challenge to traditional sources of professional authority and an erosion of faith in multiple private and public sector institutions, affecting doctors as well as religious, educational and military leaders, heads of CEOs and politicians. The core explanation here focuses upon changes in mass society, notably the growth of cognitive skills and the rise of a more critical public in postindustrial nations, rather than the performance of institutions.

To examine these theories, evidence is drawn from trends in institutional confidence first monitored in Harris surveys during the mid-sixties and in the General Social Survey, conducted annually by NORC, since the early seventies. This study confirms that confidence in medicine has indeed eroded during the last three decades, but far from being sector-specific, this pattern is demonstrated to reflect trends in many other comparable institutions in the private, non-profit and public sectors, including education, unions, and organized religion, Congress and the Executive, the Military, major companies, and the mass media. Social trust is associated with institutional confidence, but only weakly. The most plausible interpretation is that a long-term process of cultural change has altered the traditional patient-physician relationship in the United States, as well as in other affluent postindustrial societies. The most convincing explanation lies in long-term changes in the mass public, notably rising cognitive-levels and less deference towards authority, rather than in the delivery of health care per se or a puzzling failure of performance afflicting all major institutions in society. Moreover the erosion of faith in medicine is not confined to certain specific social sectors, such as African-Americans, the poor, or those with health problems, but instead has occurred fairly uniformly throughout all major groups in America.

To establish this argument, *Part I* considers longstanding debates in the literature about the causes of growing mistrust about societal and political institutions, including the role of performance, social capital, and cultural shifts, which form the broader theoretical context for understanding confidence in medicine. *Part II* examines evidence for trends concerning confidence in thirteen major institutions, including medicine, based on baseline figures from Harris surveys conducted in the mid-1960s with trends updated by the General Social Survey (GSS) conducted by NORC every year from 1972-2000. The patterns of trust in medicine are broken down further by age and cohort analysis to examine the root causes of these developments. *Part III* focuses on the factors that can help explain confidence in medicine across the pooled GSS sample, using multivariate models, including the standard social background variables of age, education, race, income, gender, and religiosity, as well as exposure to the mass media, the role of social trust, and the reported state of health. To place the trends in context, the study also considers alternative indicators of attitudes towards doctors and trusted information sources in health and medicine. The *conclusion* summarizes the results and considers alternative interpretations of their implications for the future of health care and patient-physician relations.

I: Theories of Trust and Confidence

The last decade has experienced a substantial revival of interest within sociology and philosophy in understanding the role of trust as a public and private good (Fukiyama 1995; Seligman 2000; Hardin 2002). What can explain a loss of public trust and confidence in medicine? There are at least three schools of thought on how to explain this phenomenon: those that concentrate on institutional performance, those that emphasize social capital and trust, and those that focus on cultural shifts occurring across postindustrial societies.

The Institutional Performance Model

The first model focuses on the actual performance of institutions as the key to understanding citizens' confidence in them. Health care institutions that perform well are likely to elicit the confidence of citizens; those that perform badly or ineffectively generate feelings of distrust and low confidence. The general public, the model assumes, recognizes whether institutions are performing well or poorly and reacts accordingly.

This is a popular perspective as many commentators have argued that changes in managed care have contributed towards growing skepticism towards medicine (Pescosolido, Tuch and Martin 2001; Schlesinger 2002; Mechanic 1996, 1998; Clark 2002; Schlesinger 2002). Hence Illingworth (2002) suggests that developments in health care have compromised the ability of doctor-patient relations to generate trust, blaming in particular the rise of managed care, the increased size and centralization of health care plans, the cost-containment mechanisms, increased regulatory interventions, and the price competition. As Emanuel and Dubler (1995) summarize this perspective, the ideal physician-patient relationship has been undermined by the expansion of managed health care, in particular by limiting patients' choice of health care services, by productivity requirements that increase time-pressure on health care professionals that can undermine communications, by disruptions in the continuity of care, and by increased conflict of interest due to salary schemes rewarding physicians for not using medical services. Mechanic (1996, 1998) emphasizes that the commercialization of medical care, conflict of interest, and the growth of managed health care have all challenged how far patients see their doctors as competent, responsible, and caring, and hence how far they trust them, and this situation has been compounded by mass media attention to medical uncertainty and error. Mechanic argues that trust is encouraged by patient choice, continuity of care, and consultancy time that allows opportunities for feedback, as well as patient participation in medical decisions. Institutions have responded to this concern with a variety of measures designed to restore trust, including eliciting patient feedback, providing more information for patients, improving staff training in interpersonal skills, instituting patient empowerment projects, and focusing on ethical issues.

The performance theory has three general implications. First, given accurate sampling techniques, reliable research procedures, and sensible survey questions, responses to questionnaire

items about institutional confidence are likely to be a good gauge of how well the health care system is actually performing. In other words, confidence questions are likely to provide an accurate thermometer of public life. Second, there are significant implications for public policy. The theory suggests that if medical institutions earn little public esteem, the remedy for lies in either lowering public expectations of performance (medical science can promise less) or in improving institutional effectiveness (health care professionals can deliver more).

Third, the model suggests that some may become more critical of health care performance than others, in particular we might expect that those in poor health, less affluent sections of society, or ethnic minority groups might be most negative towards the introduction of managed care. Yet at the same time performance-based explanations also suggest that there might be little differentiation across society if the general public has become more critical of health care services. This is because confidence in medical institutions is the product of their general performance in much the same way that estimation of the trustworthiness of others, and willingness to trust them, are based on the experience of how others behave (Hardin 1996). Moreover, medical performance affects individuals regardless of their particular social type. Not all citizens are equally affected by health care, but systemic medical problems such as prohibitive prescription costs, excessive delays for basic treatment, or dramatic health scares such as major failures of food safety have an impact on all citizens to a greater or lesser extent. This explains why trust and distrust in medicine would tend to be more or less randomly distributed among people with different individual characteristics such as education, income, religion, age, or gender.

The institutional performance model does not predict a very strong relationship between social characteristics and confidence in institutions. On the contrary, it leads us to expect that changes in trust in medicine will vary according to the actual or perceived institutional performance of health care. The most appropriate evidence examines trends in confidence among different institutions; if confidence declines consistently and steadily across all major social institutions such as schools *and* churches, banks *and* trade unions, Congress *and* the Executive, as well as in medicine, then unless we assume a sudden puzzling crisis in the performance of all these pillars of society, there must be something going on beyond how health care institutions perform.

The Social Capital Model

Posing an alternative to the performance model, some social theorists hold that the ability to trust others and sustain cooperative relations is the product of social experiences and socialization, especially those found in the sorts of voluntary associations of modern society that bring different social types together to achieve a common goal. The theory goes back to Alexis de Tocqueville and John Stuart Mill, both of whom emphasized the importance of voluntary associations and social engagement as training grounds for democracy. Many contemporary writers pursue the same theme, discussing society's ability to inculcate "habits of the heart" such as trust, reciprocity, and cooperation (Bellah et al. 1985), emphasizing the importance of civil society in generating cooperative social relations (Coleman 1990; Inglehart and Abramson 1994; Sztompka 1996), or focusing on trust or civic culture as a basis for stable and peaceful democracy (Almond and Verba 1963; Inglehart 1990, 1997a; Ostrom 1990; Rose 1994; Mischler and Rose 1997; Newton 1997; Rose, et al. 1998). A revival of interest in this idea has been fuelled in no small measure by Putnam's work on social capital, civic engagement, and good governance (Putnam 1994, 1995a, 1995b, 2000), as well as by general concern about the consequences of an erosion of trust and confidence in many major societal and governmental institutions (Braithwaite and Levy 1998; Warren 1999). Much of this work has focused on the United States but a growing literature has sought to compare whether similar trends are also evident in postindustrial societies elsewhere (Pharr and Putnam 2000; Putnam 2002; Norris 2002).

The social and cultural model essentially argues that individual life situations and experiences – especially higher education (Doring 1992), participation in a community with a cooperative culture, and involvement in voluntary activities – create social trust and cooperation, civic-mindedness, and reciprocity between individuals. This in turn helps create strong, effective, and successful social

organizations and institutions, including community groups and social institutions in which people can invest their confidence. Such organizations and institutions in turn help build trust, cooperation, and reciprocity, as well as confidence in other institutions. In short, there is a direct and mutually reinforcing relationship between the types of people who express trust and confidence on the one hand and strong and effective social organizations and institutions on the other. If this is true, we would expect to find that people who express attitudes of trust toward medicine are likely to be well integrated into voluntary associations and other forms of cooperative social activity and to display high social trust. Moreover a trusting-physician-patient relationship can be expected to occur due to repeated face-to-face encounters over a sustained period of time, building up long-term thick relationships. The ideal model here in health care would be the family GP, who is familiar to family, neighbours and friends in the local community, dealing with illnesses and life-altering events from birth to death. This association can only be tested in a limited manner here with the available data but we can examine the relationship between social trust and institutional confidence.

Cultural Shifts and Modernization Theory

Lastly cultural explanations based on modernization theory suggest that value change in post-industrial societies has encouraged the development of a more critical public who question all traditional sources of authority, whether religious, scientific or moral. Modernization theories suggest that economic, cultural and political changes go together in coherent ways, so that industrialization brings broadly similar trajectories, even if situation-specific factors make it impossible to predict exactly what will happen in a given society: certain changes become increasingly likely to occur, but the changes are probabilistic, not deterministic. Modernization theories originated in the work of Karl Marx, Max Weber and Emile Durkheim. These ideas were revived and popularized in the late 1950s and early 1960s by Seymour Martin Lipset, Daniel Lerner, Walt Rostow, and Karl Deutsch. Recently they have been developed most fully in the work of Ronald Inglehart (Inglehart 1977, 1990, 1997, 1999; Inglehart and Norris 2003).

In poorer agrarian societies, Inglehart suggests, people live with high levels of insecurity and they tend to develop cultures mistrustful of rapid change, emphasizing the values of traditional authority and strong leadership, inherited social status, and communal ties and obligations, backed up by social sanctions and norms derived from religious authorities. The rise of capitalism and the Industrial Revolution brought challenges to traditional values, and a worldview that encouraged achieved not ascribed status, individualism rather than community, innovation instead of continuity with tradition, and increasingly secular and scientific rather than religious social beliefs. During the post-war decades, Inglehart argues, post-industrial societies have gradually experienced a major shift in their basic cultural attitudes due to the modernization process. In the period after World War II, post-industrial societies developed unprecedented levels of prosperity and economic security, with rising standards of living fuelled by steady economic growth, despite occasional cyclical downturns. The growth of post-materialist values among the younger generation has been marked by a gradual decline in support for traditional sources of authority, including representative government, and established, hierarchical institutions such as the army, police, and church. Faith in science and medicine has also been influenced by these developments, as demonstrated by the growth of alternative medicine and homeopathic remedies. Growing levels of education, fuelling greater cognitive skills, increased access to information via the mass media, and long-term generational shifts are the root causes of these developments. The implications of value change is that, if correct, the erosion of faith in societal institutions is a process which is difficult, if not impossible, to reverse in affluent nations. Certain fluctuations can be expected due to 'period-effects', for example blips upwards or downwards following eras of economic boom or bust, but the general trend should be a slow but steady secular erosion of faith evident across all major societal and governing institutions, not just confined to particular sectors like health care.

II: Trends in Institutional Trust

There are many alternative measures gauging attitudes towards health care professionals and confidence in medicine. A detailed multi-item Trust in Physician Scales has been developed, with high consistency and reliability (Thom, Ribisl, Stewart and Luke 1999), but although valuable we need simpler indicators to gauge trends over time. This study draws on the baseline Harris surveys that were first fielded in 1966 and then the series of annual General Social Surveys conducted by NORC since 1973, using a sample representative of the adult population. These used the following item:

'I am going to name some institutions in this country. As far as the people running these institutions are concerned, would you say you have a great deal of confidence, only some confidence, or hardly any confidence at all in them?'

Table 1 shows the proportion of the public that expressed 'a great deal of confidence' in thirteen major public and private institutions in each decade. The results show that almost three-quarters of the public (71%) expressed confidence in medicine in the 1966 Harris survey, the most highly rated institutions in the comparison followed by the military, education and the Supreme Court. The 1973 NORC survey revealed a sharp fall across all institutions, with confidence in medicine down to a bare majority of the public (55%). Of course some of the difference may be due to fieldwork and sampling differences between the two organizations, but previous detailed analysis by Lipset and Schneider (1987) suggests that there was a real shift during this era, and one that was closely associated with the 'hot-button' politics of these tumultuous years in American life, including the generational divisions over Vietnam, the issue of civil rights and race conflict, and the rise of new social movements. In 1973 medicine was still the most highly ranked institution in the comparison, followed by science, education and religion. By 1980 confidence in medicine remained fairly stable before slippage in subsequent decades. By 2000, 44% expressed a great deal of confidence in medicine, just behind science and the ahead of the military. A comparison in the change across all institutions where we have the full time-series data suggests that confidence in education has slipped more badly, but the loss of faith in medicine is roughly similar to that experienced in Congress and major companies (prior to the Enron debacle). The evidence suggests that far from being sui generis, trust and confidence in medicine has experienced similar erosion to that found in other major institutions in American life, both public and private.

[Tables 1 and 2 about here]

Age and Cohort Analysis

To examine this further, confidence in medicine was broken down for each decade by age group and by cohort of birth (see Table 2). The results suggest that throughout the 1970s to 1990s confidence in medicine has correlated inversely with age: the young have always had more confidence in medicine than the old, possibly because they have been less dependent on it. The association between age and confidence has stayed about the same throughout the period, but may have weakened very slightly in the 1990s. However, the level of confidence in medicine fell between the 1970s and 1990s among the public as a whole and in all age categories. The largest declines in confidence are among the middle age categories - the 35-64 year olds. This reflects a 'cohort' effect: the younger the cohort in the 1970s, the steeper the decline. This suggests that possibly there has been a sharper fall in confidence in all institutions among the 1970s young cohort, as a post-Vietnam, post-Watergate phenomenon, which has affected attitudes to medicine along with everything else.

III: Explaining Confidence in Medicine

Social Groups

If the performance explanation is correct then we might expect to see those groups that are most vulnerable to the changes in health care --including ethnic minorities, the less educated, those in poor health, and the lowest income households-- becoming most disillusioned with services. Table 3 used the sample from the General Social Survey pooled by decade and then examined the distribution

of trends in confidence in medicine by these groups. The results without any prior controls show that there are a few groups where confidence has eroded further and faster than others, including women more than men, those living in the south, and those with just high school qualifications, but the patterns are far from consistent. By the last decade, confidence in medicine was greater among men than women, and it was stronger among those who reported having excellent health, but the differences among social groups are less striking overall than the similarities. Confidence has eroded in recent decades fairly uniformly among rich and poor, black and white, and among all regions of America.

[Table 3 about here]

To examine these patterns more systematically, and to see if similar factors predicted confidence in medicine as in other major institutions, ordinary least squares (OLS) regression analysis models were used in Table 4 with the pooled GSS sample including the year of the survey, the standard social background variables of age, education, race, income, gender, and religiosity, as well as exposure to newspapers and to television, the role of social trust, and the reported satisfaction with the respondent's health. For comparison a similar model was analyzed using the Confidence in Institutions scale, which summed trust in nine institutions (listed in Table 1), excluding medicine.

[Table 4 about here]

The results of the multivariate analysis show that five factors were significantly (at the conventional .05 level) and positively related to confidence in medicine, namely the younger generation and men (as already discussed), as well as religiosity, social trust, and satisfactory reported health. Other factors that were significant at the .10 levels included the year of the survey, family income, and exposure to newspapers (that was positively related to trust in medicine). The amount of hours of television watched proved insignificant. Many more factors predicted the Institutional Confidence Scale, indeed all variables proved significant except for sex and race. The strongest associations were with religiosity, suggesting that regular church going was linked to greater support for institutions, and social trust was also moderately strongly related to institutional trust. Nevertheless it should be stressed that the significance of these coefficients could be attributed to the generous size of the pooled sample, all were fairly weak, and the overall level of variance (R^2) explained by either of these models proved extremely modest.

Comparative Trends in Institutional Confidence

To see whether the trends in the United States are distinctive, or whether there has been a fall in institutional confidence across many countries, we need to turn to comparative evidence. Previous studies have debated whether or not there has been a significant or long-term erosion of public confidence in modern institutions across different post-industrial societies (see Listhaug and Wiberg 1995, 298-322; Nye, Zelikow, and King 1997, 263-64; Dalton 1999; Newton 1999). Some assert that the figures show a mixed pattern, with no clear trends for any given set of institutions, nations, or periods of time. In some instances, the confidence figures fall, but in others they rise, and in others still they are more or less constant. After examining public confidence in ten sets of public and private institutions in 14 Western European nations between 1981 and 1990, Listhaug and Wiberg (1995, 320) concluded: "*The data from the two European Values Surveys do not demonstrate that there has been a widespread decline in the public's confidence in institutions during the 1980s.*" Although they observed a decline of confidence in "order" institutions, they noted that "*confidence in other political institutions is either stable, as in the case of the civil service and parliament, or, as with the education system, has become stronger.*" Listhaug and Wiberg based their conclusions on data up to 1990. Newer evidence from a wider range of nations suggests that the world may have changed since then (Norris 1999). Klingemann (1999) demonstrates how support for parliaments suffered a marked erosion during the 1990s, while Inglehart (1999) documented a decline in confidence in hierarchical and traditional institutions including the military and the church.

Most studies of confidence in institutions have been confined to Western Europe or North America, but we can compare public opinion in a wider range of postindustrial democracies included in both waves of the World Values Survey (WVS) conducted in the early 1980s (1981-84) and the early 1990s (1990-93). These include almost 47,000 respondents in 17 established democracies (listed in Table 5). This group of nations comprises most of the established democracies in the world, and it is broadly representative because it includes both major economic powers like the United States, West Germany, and Japan as well as smaller social-democratic welfare states such as Belgium and Norway. These nations also possess a wide array of political systems and institutional structures, such as presidential versus parliamentary executives, federal versus unitary states, and consensus versus majoritarian systems, which is important if we are to be able to generalize about systematic variations in institutional confidence. The World Values Survey included a four-point scale using the following question: "Please look at this card and tell me, for each item, how much confidence you have in them. Is it a great deal (4), quite a lot (3), not very much (2) or none at all (1)?" The survey compared public support for ten institutions, which can be divided into public-sector institutions, understood as those most closely associated with the core functions of the state (including parliament, the civil service, the legal system, the police, and the army), and other institutions in the private and non-profit sectors (the education system, the church, major companies, trade unions, and the press).¹ Two scales were developed from this data, one for the public and one for the private institutions.²

[Table 5 about here]

Cross-national comparison on the basis of these scales (see Table 5) confirms a striking and important pattern: during the 1980s, *confidence in public institutions declined consistently, if in varying degrees, in all but one society* (Iceland). In contrast, the pattern of confidence in private institutions proved more mixed: it fell significantly in Finland, the United States, and Britain, but increased significantly in Spain, Italy, Denmark, West Germany, and France. Based on this evidence, we conclude that there are important cross-national variations in confidence in particular public and private institutions, as we would expect, in terms of both the level of confidence and the direction of trends over time. Although this shows clearly that there is no general loss of support for all social institutions in the countries under comparison, the evidence does indicate declining confidence in *public* institutions in virtually all nations during the 1980s. The political and governmental problems that have been so widely discussed in the United States are not *sui generis*, but are evident to a greater or lesser extent elsewhere.

Attitudes towards Doctors

Yet although confidence in medicine has eroded over recent decades in the United States, reflecting broader patterns of declining trust that are found in many institutions in many societies, has this influenced public opinion towards doctors? Here we lack systematic time series data from either the World Values Surveys or from the General Social Survey, but the latter monitored attitudes using a wide range of indicators in the 1998 GSS. The results in Table 6 show that attitudes vary widely depending upon the particular statement but overall the results are relatively positive news for the profession. There was widespread agreement with the statement that 'I trust my doctor's judgment about my medical care' (81% agreed or agreed strongly), and with the statement 'I trust my doctor to put my medical needs about all other considerations when treating my medical problems'. By contrast, most of the negative statements about doctors usually received little support although there were a few items where the public was more evenly divided, for example concerning how well doctors explained medical problems to patients, their respect for patients and their use of surgery.

[Table 6 and 7 about here]

Moreover when asked in a September 2002 survey by Gallup about trust in various information sources about health and medicine, despite the multiplicity of information sources that are now available in print, on the airwaves and on line, nevertheless doctors remained by far the most trusted source (see Table 7). Nurses and books were the next most trusted sources, followed by the Internet. And although newspapers, magazines and TV are inundated by ads for drug companies, with a

proliferation of 'Heath Beats' on network and local evening news, nevertheless the mass media were regarded as the least trustworthy source of information on these subjects.

Conclusions

The results of this study suggest certain important clues about the nature and consequences about declining trust in health care. This study confirms that confidence in medicine has indeed eroded in America during the last three decades, as many claim. Yet trends must be kept in balance: many indicators suggest that, even if faith in medicine has eroded, nevertheless overall levels of trust in physicians remains relatively high.

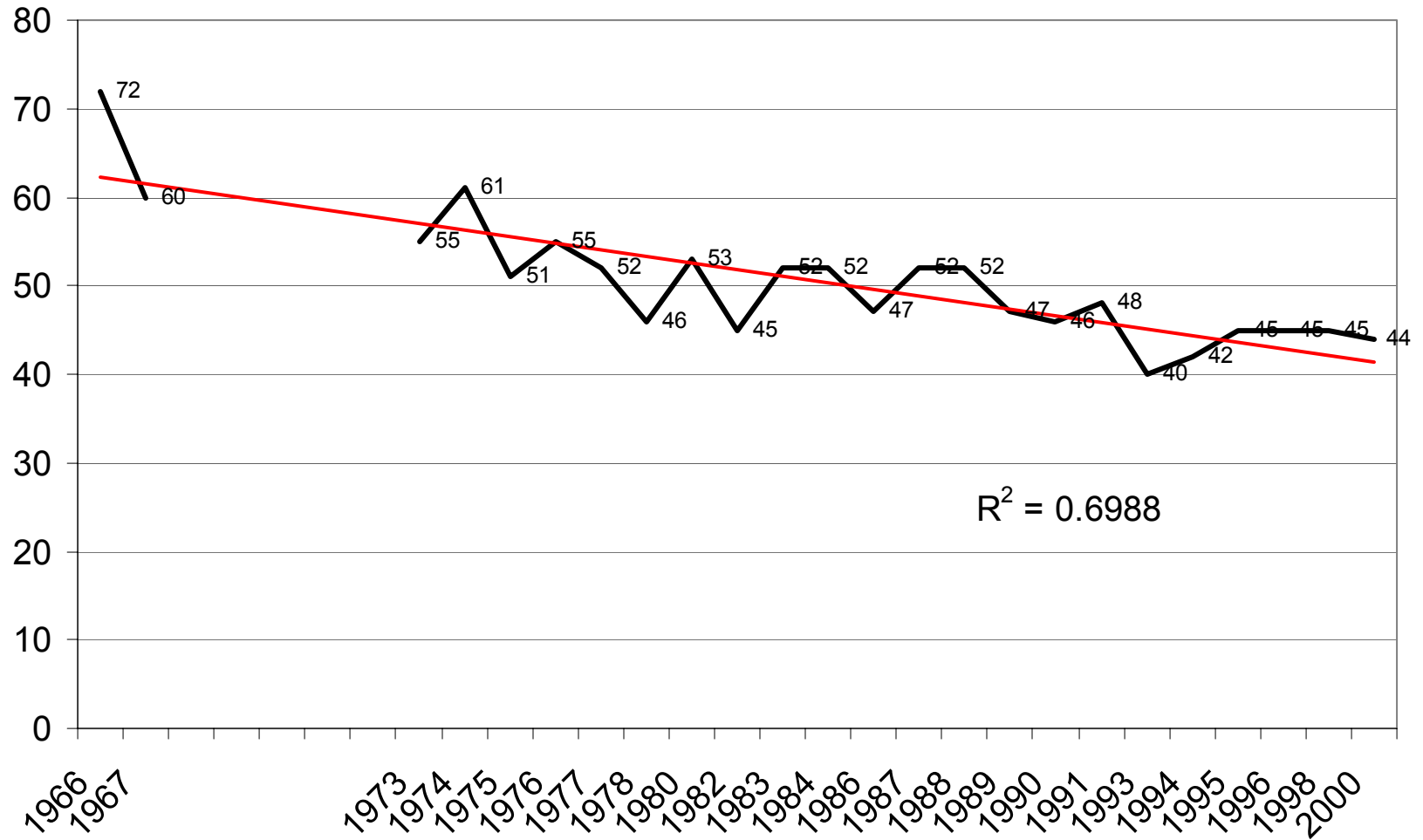
Moreover far from being a problem that is specific to health care, this pattern is demonstrated to reflect trends in many other comparable institutions in the private, non-profit and public sectors, including education, unions, and organized religion, Congress and the Executive, the Military, major companies, and the mass media. Social trust is associated with institutional confidence, but only weakly. The analysis suggests that a long-term process of value change has altered traditional attitudes towards medicine that lie at the heart of the patient-physician relationship in America, as well in other postindustrial societies. The most convincing explanation for this phenomenon focuses upon long-term changes in the mass culture, notably rising cognitive-levels and less deference towards authority, rather than shortcomings evident in the delivery of health care per se, or a puzzling failure of performance afflicting all major institutions in American society. The study found that the erosion of faith in medicine is not restricted to certain specific social sectors, such as African-Americans, the poor, or those with health problems, but instead has occurred fairly uniformly throughout all major groups in America.

Nor does the much-discussed tendency of the contemporary mass media to report scandal, corruption, and disaster provide an adequate explanation. Although the amount of time people spend watching television entertainment is associated with some indicators of political apathy and disaffection, viewing television news and reading newspapers is associated with civic mobilization and support for political institutions (Norris 2000). Consistent with other research, the evidence in this study shows that regular newspaper readers expressed greater than average confidence in institutions, not less. Regular newspaper readership and television watching was not significantly related to lower levels of trust in medicine. Thus, we have to look elsewhere for plausible explanations.

It is important that the evidence demonstrates a loss of confidence in many public and private institutions, not just medicine, suggesting that the cause is beyond a simple change in health care performance. This makes the search for causes both easier and more difficult. It suggests that the problem is a general culture shift affecting all, or even many, aspects of modern life, not just a specific problem for medicine. Therefore overall the cultural theories of societal modernization provide a more satisfactory explanation of this phenomenon, rather than any of specific changes in the organization of medicine associated with the introduction of managed care in the health service.

Interpreting the implications of these developments, especially from the perspectives of the general public, is not straightforward. Medical professionals often regard the rise of more skeptical patients as detrimental to health care. Yet alternative interpretations suggest that from a societal perspective this development should not necessarily be regarded as wholly negative. Further research is required to explore the consequences of these developments but these trends may have led towards less deference towards the authority of medical professionals, and less willingness to follow medical advice blindly, and also as a result perhaps patients with the cognitive skills to understand more technical medical matters, more motivated to learn about a range of traditional and alternative health options through diverse information sources, and also more demanding of health care than in the past. Social changes may have thereby undermined more paternalistic models of medicine. Patients will act differently if they are skeptical of medicine and health care professionals will need to respond to these changes. Some will regard this as a threat, and others as an opportunity. How the profession responds will be one of the challenges facing medicine in the 21st century.

Figure 1: Confidence in medicine, US 1966-2000



Note: 'I am going to name some institutions in this country. As far as the people running these institutions are concerned, would you say you have a great deal of confidence, only some confidence, or hardly any confidence at all in them?' Percentage 'a great deal of confidence in medicine.'

Source: Harris surveys 1966-67; NORC US General Social Survey 1973-2000.

Table 1: Institutional confidence, US 1966-2000

	1966	1973	1980	1990	2000	Change 1966-2000
Education	61	38	31	27	27	-34
Congress	42	24	10	16	13	-29
Medicine	72	55	53	46	44	-28
Major companies	55	31	29	26	29	-26
Executive branch	41	30	13	24	14	-26
Military	62	33	40	34	40	-22
Press	29	23	23	15	10	-19
Supreme court	50	33	26	37	34	-16
Organized religion	41	36	37	24	29	-12
Organized labor	22	16	16	11	14	-8
Banks and financial institutions		33	33	18	30	
Television		19	16	14	10	
Science		41	46	41	45	
<i>Average of all above</i>	<i>48</i>	<i>32</i>	<i>29</i>	<i>26</i>	<i>26</i>	<i>-22</i>

Note: NORC Q. 'I am going to name some institutions in this country. As far as the people running these institutions are concerned, would you say you have a great deal of confidence, only some confidence, or hardly any confidence at all in them?' Percentage 'a great deal of confidence in medicine.'

Source: Harris surveys 1966-67 in Lipset and Schneider Table 2.1; NORC US General Social Survey 1973-2000.

Table 2: Age and cohort analysis of the percentage with 'a great deal' of confidence in medicine

Age group	1970s	1980s	1990s	Change 1970s to 1990s	Cohort effect
Under 25	64	61	57	-7	
25-34	55	50	47	-8	
35-44	52	47	42	-10	-22
45-54	51	47	39	-12	-16
55-64	50	46	40	-10	-12
65-74	46	49	41	-4	-10
75+	48	45	44	-4	-6
Difference	16	16	13		

Source: NORC US General Social Survey 1973-2000, sample pooled by decade.

Table 3: Percentage with 'a great deal' of confidence in medicine

	1970s	1980s	1990s	Change
ALL	53	50	44	-7
GENDER				
Men	53	52	47	-6
Women	53	48	42	-11
RACE				
White	53	50	44	-9
African American	53	47	44	-9
HIGHEST EDUCATIONAL QUALIFICATION				
Less than high school	52	48	46	-6
High school	56	50	43	-13
Junior college	48	51	40	-8
Bachelor	50	53	47	-3
Graduate	47	47	46	-1
REGION				
New England	55	53	46	-9
Mid-Atlantic	52	46	49	-3
E. North Central	53	50	44	-9
W. North Central	56	55	48	-8
South Atlantic	54	49	43	-11
E. South Central	59	51	41	-18
W. South Central	57	53	44	-13
Mountain	50	47	42	-8
Pacific	49	49	40	-9
REPORTED HEALTH				
Excellent health	60	52	50	-10
Good health	53	50	43	-10
Fair health	51	48	42	-9
Poor health	54	45	41	-13
HOUSEHOLD INCOME				
Highest income quartile	54	49	46	-8
High income quartile	54	51	44	-10
Low income quartile	55	51	46	-9
Lowest income quartile	50	50	44	-6

Source: NORC US General Social Survey 1973-2000, sample pooled by decade.

Table 4: Models explaining confidence in institutions and in medicine

	Confidence in Institutions				Confidence in medicine			
	B	Std. Error	Beta	Sig	B	Std. Error	Beta	Sig
(Constant)	197.5	31.5		.000	7.029	2.520		.005
Year of survey	-.067	.016	-.046	.000	-.002	.001	-.022	.074
Age of respondent (years)	-.058	.007	-.083	.000	-.004	.000	-.114	.000
Sex (Male 1/Female 0)	.152	.235	.006	.517	.041	.015	.032	.006
Race (White1 /Black 0)	.146	.343	.004	.671	.017	.023	.009	.446
Education (Highest year of school completed)	-.122	.045	-.031	.006	.001	.003	.004	.798
Total family income	-.179	.047	-.044	.000	-.005	.003	-.025	.061
Religiosity (How often R attends religious services)	.488	.044	.111	.000	.012	.003	.051	.000
Exposure to newspapers	.695	.103	.071	.000	.012	.007	.022	.080
Exposure to TV (Hours/day watching TV)	.129	.055	.024	.020	.005	.004	.018	.141
Social trust	2.355	.251	.097	.000	.086	.016	.066	.000
Satisfaction with condition of own health					.024	.005	.054	.000
R	.19				.16			
Adjusted R ²	.035				.024			

Note: Ordinary least squares regression models presenting the results of the unstandardized coefficients (B), the standard errors, the standardized coefficients (Beta), and their significance where the confidence in institutions scale and the confidence in medicine are the dependent variables. The institutional confidence scale is composed of the first ten items listed in Table 1 excluding medicine. The scale is standardized to 100-points.

Source: NORC US General Social Survey 1973-2000, sample pooled by decade.

Table 5: Confidence in Public and Private Institutions in the Postindustrial Societies

NATION	PUBLIC INSTITUTIONS CONFIDENCE SCALE			PRIVATE INSTITUTIONS CONFIDENCE SCALE		
	EARLY 1990s	CHANGE 1981-90	SIG.	EARLY 1990S	CHANGE 1981-90	SIG.
Finland	12.69	-1.61	**	11.96	-0.74	**
Norway	13.69	-0.90	**	12.91	+0.03	
Spain	11.80	-0.90	**	12.35	+0.40	**
United States	13.36	-0.69	**	13.16	-0.38	**
Ireland	13.58	-0.50	**	13.23	-0.12	
Sweden	12.78	-0.50	**	12.07	+0.14	
Belgium	11.67	-0.42	**	12.36	+0.06	
Canada	13.03	-0.41	**	12.85	-0.09	
Britain	13.57	-0.41	**	11.55	-0.43	**
Italy	11.33	-0.40	**	12.24	+0.82	**
Denmark	13.54	-0.36	**	12.34	+0.20	*
Japan	11.96	-0.34	**	11.16	-0.16	
W. Germany	12.61	-0.25	**	11.66	+0.15	*
Netherlands	12.49	-0.23	*	11.92	+0.10	
N. Ireland	14.01	-0.20		12.59	-0.36	
France	12.41	-0.07		11.99	+0.27	*
Iceland	12.69	+0.73	**	12.62	N/a	
ALL ABOVE	12.57	-0.62	**	12.31	-0.01	

Note: Mean confidence in five public and five private institutions in 17 advanced industrial democracies. 'Public' includes parliament, the armed services, the legal system, the police, and the civil service. 'Private' includes the education system, the church, major companies, the press, and trade unions. The significance of the difference in group means is measured by ANOVA. *p>.05 **p>.01 N/s = Not significant.

Source: World Values Survey 1980-84, 1990-93.

Table 6: Attitudes towards doctors, 1998

	% 'Agree' or 'Agree strongly'
My doctor is willing to refer me to a specialist when needed.	86
I trust my doctor's judgments about my medical care.	81
I trust my doctor to put my medical needs above all other considerations when treating my medical problems.	74
My doctor would tell me if a mistake was made	62
My doctor is a real expert in taking care of my problem	61
Doctors do their best to prevent patients worrying	52
Doctors aren't as thorough as they should be	51
Doctors always treat their patients with respect	51
Doctors never recommend surgery (an operation) unless there is no other way to solve the problem.	44
Doctors cause people to worry a lot because they don't explain medical problems to patients.	41
Sometimes doctors take unnecessary risks in treating their patients	35
Doctors are very careful to check everything when examining their patients	34
I worry that I will be denied the treatment or services I need.	24
I worry that my doctor will put cost considerations above the care I need	24
Doctors avoid unnecessary patient expenses	22
I worry that my doctor is being prevented from telling me the full range of options for my treatment.	22
Doctor does not do everything for me	20
I hardly ever see the same doctor when I go for medical care	19
The medical problems I've had in the past are ignored when I seek care for a new medical problem	18
I doubt that my doctor really cares about me as a person.	16

Note: Q. "As you read each of the following statements, please think about the medical care you are now receiving. If you have not received any medical care recently, circle the answer based on what you would expect if you had to seek care today. Even if you are not entirely certain about your answers, we want to remind you that your best guess is important for each statement. Do you agree strongly, agree, are you uncertain, or do you disagree or disagree strongly?"

Source: NORC US General Social Survey, 1998.

Table 7: Trust in information sources about health and medicine, 2002

	Doctors	Nurses	Book	Internet	Magazine	Newspaper	TV
A great deal	61	38	36	20	13	12	14
Moderate amount	32	45	46	42	49	52	45
Not much	5	10	12	14	23	25	31
None at all	2	6	5	17	12	10	9
Don't know	-	1	1	7	3	1	1

Note: Q "How much trust and confidence would you have in information about health and medicine that you could get from each of the following sources?"

Source: Gallup Organization September 8 2002 National adult telephone survey N. 1004

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¹ As previous studies have suggested (Lipset and Schneider 1988), it should be noted that the precise dividing line between state and non-state institutions is not clear-cut. The education system is often largely but not exclusively within the public sector, for example. In the same way, established churches can be seen as part of the state. This study nevertheless distinguishes between those institutions that can be regarded as most closely associated with the functions of the state and those in the non-profit and public sectors.

² The measures of confidence in the ten institutions were summed to form two consistent 20-point scales measuring confidence in public institutions and confidence in private institutions. These scales proved suitable for analysis because the separate items were highly intercorrelated, producing scales with a normal and non-skewed distribution with high reliability (Cronbach's Alpha = .77 for the confidence in public institutions scale and .66 for the confidence in private institutions scale).