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Promoting and maintaining trust in hearing healthcare services

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Patients' trust in hearing healthcare is changeable and it can be promoted and maintained by the clinician. These insights resulted from a qualitative, thematic analysis of the perspectives of adults with hearing impairment on trust in hearing healthcare.
Here, patients' trust in hearing healthcare is conceptualised in a model in four dimensions.

Introduction

The physician literature demonstrates that high trust in a physician results in better treatment adherence, increased quality of life, and improved health status.[1] Only few studies have considered trust in the context of hearing healthcare service delivery.[2,3] These studies show that patients' trust in hearing healthcare clinicians and the hearing healthcare system may be an important factor for shared decision-making[4] and for uptake of hearing healthcare services.[5,6] The purpose of the current data analysis is to identify and describe how adults with hearing impairment perceive trust related to hearing healthcare services. The aim is to build an understanding of how patients' trust in hearing healthcare can be created and maintained.

Method

Data was analyzed from a qualitative interview study conducted previously.[7] Participants were 34 adults with hearing loss from four developed countries (Australia, Denmark, the United Kingdom, and the United States of America). Semi-structured interviews explored the perspectives of adults with hearing impairment on hearing help-seeking and rehabilitation. Interviews followed an interview guide that did not include the topic of trust. Following inductive content analysis of interview transcripts,[8] trust emerged as an underlying theme in 29 out of 34 interviews. The 29 interview participants who discussed trust had varying degrees of hearing impairment and different experiences with hearing healthcare (see Table 1).

Table 1. Participant Characteristics (n=29)	Percent (number)
Experience with hearing healthcare help-seeking	
Never sought hearing help	10 % (3)
Sought hearing help but did not obtain hearing aids	14 % (4)
Obtained hearing aids but have not used within past 3 months	21 % (6)
Dissatisfied hearing aid user	17 % (5)
Satisfied hearing aid user	38 % (11)
Country	
Australia	24 % (7)
Denmark	28 % (8)
United Kingdom	24 % (7)
United States of America	24 % (7)
Age	
30-54 years	27 % (8)
55-79 years	52 % (15)
80+	21 % (6)
Gender	
Male	41 % (12)
Female	59 % (17)
Hearing impairment (n=58 ears)	
Minimal (≤ 25 dB HL)	9 % (5)
Mild (> 25 and ≤ 40 dB HL)	41 % (24)
Moderate (> 40 and ≤ 60 dB HL)	41 % (24)
Severe (> 60 and ≤ 80 dB HL)	9 % (5)

Analysis

Using thematic analysis,[9] all statements from the interviews were categorised into a hierarchy of themes. All authors contributed in an iterative process of interpreting and arranging the data in a thematic map to adequately display how individual statements, subthemes and superordinate themes were interrelated. Each statement was categorized into one of four superordinate themes: The four dimensions of trust (see Table 2).

Results

Figure 1 shows the complexity of trust in hearing healthcare. A patient enters into a hearing healthcare relationship with a level of trust on a continuum from low to high (left circle). This initial level of trust is determined by the patient's service expectations. While receiving service, the patient's level of trust may change as a result of his or her experience of hearing healthcare (centre circle). The analysis showed that trust levels could change within four components of trust (quadrants in centre circle). Component trust levels depend on the patient's experience with the hearing healthcare clinician (Interpersonal trust) and with the hearing healthcare system and clinical environment (Institutional trust). Following service provision, a patient will have an altered level of trust based on the services received (right circle). In a iterative motion, this ultimate level of trust (be it high or low) constitutes the basis for service expectations at a subsequent hearing healthcare relationship (arrow at the bottom). Patients are likely to gain trust when the clinician displays relational competence and technical competence, and the clinical environment appears hospitable and dedicated to service and care, as opposed to adopting a commercialised approach.

FIGURE 1. A VISUAL REPRESENTATION OF THE FOUR DIMENSIONS OF TRUST: THE FOUR COMPONENTS OF TRUST(RELATIONAL COMPETENCE, TECHNICAL COMPETENCE, CLINICAL ENVIRONMENT, AND COMMERCIALISED APPROACH), THE TYPE OF TRUST (INTERPERSONAL VS. INSTITUTIONAL), THE LEVEL OF TRUST (LOW TO HIGH), AND THE TIME COURSE OF TRUST.

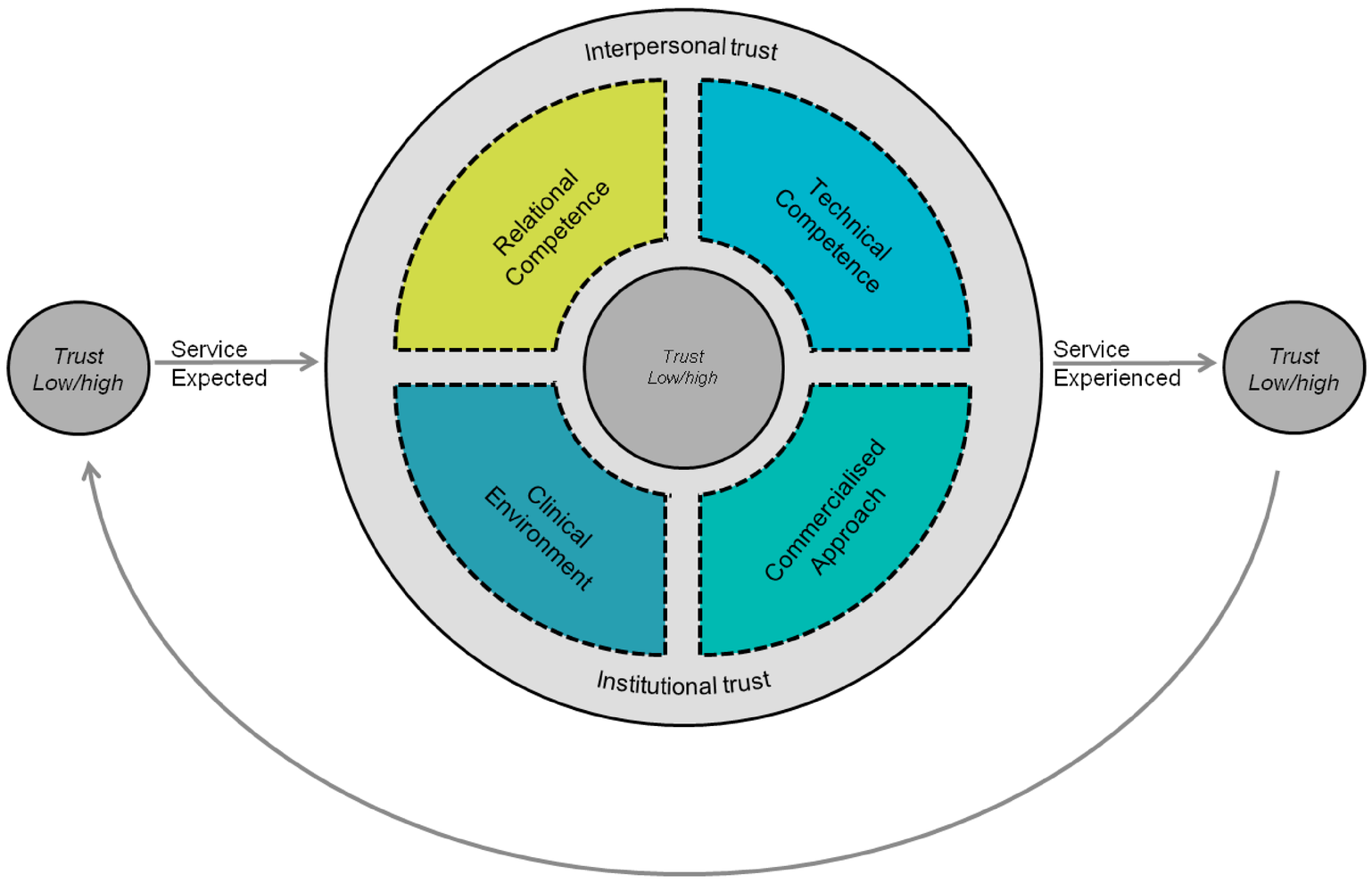

Table 2. Four Dimensions of Trust

1. The Components (and subcomponents of trust)

- Relational Competence
  - Communication Style
  - Empathy
  - Instruction for Self-Management
  - Promotion of Shared Decision Making
- Technical Competence
  - Based on Services Received
  - Based on Reputation or Education
- Commercialized Approach
  - Solicitation
  - Focus on service vs. Focus on Sales
  - Cost of Hearing Aid
  - Public vs. Private Healthcare System
- Clinical Environment
  - Clinic Setting
  - Clinical Services
  - Public vs. Private Hearing Healthcare

2. The Assignment of Trust

- Interpersonal Trust
- Institutional Trust

3. The Level of Trust

- Varies from Low to High

4. The Time-Course of Trust

- The Level of Trust prior to receiving Hearing Healthcare Services
- The Level of Trust after receiving Hearing Healthcare Services

Conclusion

Patients' trust in hearing healthcare change as a result of experience with hearing healthcare. Hearing healthcare clinicians promote and maintain patients' trust by practicing good communication, providing empathy, displaying technical competence, promoting shared decision-making and patients' self-management of hearing aids, and avoiding a focus on hearing aid sales. Hearing healthcare clinics that engender patients' trust appear professional, provide comprehensive hearing rehabilitation, and focus on service provision.

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Want to know more?

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