

Reciprocal trust in health care relationships

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This paper examines the phenomenon of trust in health care relationships from a new perspective, that of the recipients of care for chronic illness. The authors argue that reciprocal trust is a necessary component of satisfying, effective health care relationships when the illness is of an ongoing nature. From the patient's perspective, reciprocal trust has a significant impact on the experience of being a receiver of health care and on the development of competency with illness management. Because of this, the authors claim that it is imperative for health care professionals to alter their traditional beliefs with regard to sick role and trust. With a new perspective, they may then develop the specific skills necessary to enact the caring aspect of the service they offer. The authors offer a number of suggestions for actualizing this reciprocal trust in clinical practice.

INTRODUCTION

In an era when health care is bound by economic restraint and patient dissatisfaction with care is escalating, relationships between patients and professionals are of increasing concern to practitioners and planners of health care service (Allentuck 1978, Calnan 1984, Rosenstein 1986). Much of the current theory with regard to health care relationships approaches the issue from the professional's perspective and draws its conclusions from analyses of single episode encounters between patients and physicians in the context of health care for acute illness (Fisher 1984, Jaspers *et al.* 1983).

Since chronic illness accounts for an ever-increasing proportion of health care service (Wright *et al.* 1984) and since, by its ongoing nature, chronic illness places different demands on the health care relationship (Fagerhaugh *et al.* 1980, Strauss *et al.* 1981), specific knowledge is needed to guide professionals in the care of the chronically ill (Ruffing-Rahal 1985). Such knowledge should reflect the growing awareness

of many in the health care field that the perspective of professionals is inherently different from the perspective of those who receive their care (Charmaz 1983, Kleinman *et al.* 1978, Kleinman 1980). Thus, an appreciation of health care relationships as they occur over time from the perspective of the patient in the context of chronic illness is imperative.

Trust has long been acknowledged as an ingredient of successful health care relationships. However, since the available knowledge reflects the phenomenon as it is perceived by professionals (Arney & Bergen 1984), the meaning it holds for health care recipients is less well understood. It has been generally assumed that trust in professionals is a requisite for patient satisfaction with health care. Arising from this assumption is the belief that such trust should be built and maintained at all costs. Nurses have been particularly active in this role of encouraging patients to develop trust in all of their health care professionals.

The modern escalation of dissatisfaction with health care relationships suggests that our

traditional perspective of trust may have been overly simplistic. Thus further inquiry into the phenomenon of trust in health care relationships is needed. The piece of research that will be the focus for this analysis reflects such an inquiry. For the purposes of this discussion, the portion of the research that sheds light upon the issue of trust in health care relationships from the perspective of the chronically ill patient will be presented. Analysis of the relevant findings will provide impetus for a discussion of some important implications for professional behaviour in health care relationships.

THE HEALTH CARE RELATIONSHIPS PROJECT

The 'Health Care Relationships Project' was designed to address the problem of limited knowledge about the patient perspective of the dynamics inherent in ongoing health care relationships. A qualitative approach enabled the systematic exploration of patients' perceptions of their relationships with professional health care providers when chronic illness was involved. Data were comprised of fieldnotes and verbatim transcriptions of interviews with 77 'expert witnesses' to the experience of health care relationships in the context of chronic illness. Analysis relied upon the grounded theory method of qualitative research (Glaser & Strauss 1967) and resulted in the confirmation of a three-stage process of relationship evolution (Thorne & Robinson, in press).

One potent theme that explained such phenomena as satisfaction with health care relationships and perception of high quality health care was the element of trust. The authors now recognize that variations on the theme of trust explain the progression of health care relationships through the three stages as well as the patterns of relationship stabilization in the final stage. The findings with regard to the patient perspective of trust will be presented here in two distinct but interwoven themes: (1) trust in the health care professionals, and (2) trust in the patient's competence. In view of the intimate involvement of family members in the experience of chronic illness and health care management,

both types of informants were considered to be health care recipients and will be referred to as patients. Discussion of these themes will consider the nature of trust as a reciprocal phenomenon in the chronic illness context.

TRUST IN THE HEALTH CARE PROFESSIONAL

The informants described relationships with health care professionals that evolved over time in a predictable pattern of stages with transitions linked to trust in health care professionals (Robinson & Thorne 1984). The accounts confirmed that patients entered into health care relationships with an almost absolute trust in the professionals who would provide care. This initial trust was based on the naive assumption that answers to their health care problems would be forthcoming and that the health care professional would be singularly dedicated to providing them with those answers. Should the health care problem not be resolvable, it was assumed that the professional would be able to guide the provision of care based on a shared understanding of the patient's best interests.

Because the illnesses were of a chronic nature, an easy remedy did not exist for these informants. Further, it quickly became evident to our informants that health care professionals did not generally understand or even care about the patient's perspective of his own best interest; rather, the professional based decisions upon a set of values distinct from and often contradictory to the patient's own values. Thus, the loss of initial trust was inevitable. When it occurred, disruption of health care relationships ensued. This stage was accompanied by marked distress for the patients and was characterized by adversarial relationships fraught with feelings of anger, suspicion and intense vulnerability. However, this difficult, distrustful stage was seldom prolonged as recognition of the ongoing need for professional health care, coupled with the desire to relieve existing tension, forced its eventual resolution.

In the resolution stage, trust was reconstructed based on an informed rather than a naive perspective of the skills and limitations of

professional care. This reconstructed trust permitted the establishment of an alliance that acknowledged the necessity of continued guarding while at the same time reducing the adversarial nature of health care encounters. There were four configurations or patterns associated with the stage of guarded alliance. Some informants chose to identify individual health care professionals as worthy of absolute trust even as they claimed a general distrust for the entire profession. Others evolved means of trusting certain predictable patterns in health care professionals' behaviour and beliefs. In this way, they were able to confidently manipulate the services they required. A third group of informants chose to accept the 'reality' that all health care professionals are untrustworthy. In this way, they spared themselves the agony of unfulfilled expectations. Finally, the last group sought to build intimate and collegial interpersonal relationships with their carefully selected health care professionals and negotiate mutually satisfying care.

While all of the informants experienced a stage of shattered trust that was characterized by dissatisfaction with health care relationships, a measure of satisfaction was eventually attained and could be explained by the various configurations of the reconstructed trust in guarded alliance. None of these configurations, however, resembled the absolute trust of the initial naive stage. Indeed, patients and their families emphatically denied that blind faith was possible once insight into the inner dimensions of the health care world was achieved. Thus, movement through this process seemed to involve cognitive shifts that prevented a return to prior innocence. Because they were based upon more realistic expectations, all patterns of guarded alliance included numerous qualifiers and conditions that addressed the limitations inherent in health care relationships.

TRUST IN PATIENT'S COMPETENCE

Over the course of prolonged chronic illness, all of the patients and family members in our study developed numerous competencies with regard to illness management in the context of daily living. Further, many gained competence in

aspects of care that would normally fall within the professional domain of expertise. Universally, their goal was to live well with chronic illness. While some hoped for a cure or an effective treatment in the future, none expressed this as a priority for their current health care.

Within the context of illness management, all of the informants made major health care decisions. Such decisions often took the professional perspective into consideration and sometimes included deferring to the judgement of the health care professionals. In the stage of reconstructed trust, which we call 'guarded alliance', the degree of deference to the professional perspective varied with each relationship configuration. While many factors accounted for this variation, one of the most significant was the degree to which the professionals expressed trust in their clients' competence to make sound decisions with regard to their health.

The competence described by informants was not equivalent to independent decision-making or assuming total control of their own health care. Rather, it reflected their capacity to make, share or delegate decisions in such a way that their own best interests were protected. Since different circumstances demanded different ways of making decisions, it became clear that competence involved flexibility with decision-making. For example, in the event of an acute episode, the most competent decision was often to allow health care professionals to make decisions on their behalf. Obviously this sort of competence was more likely when the patient perceived that the health care professional trusted his or her judgement. One informant's complaint against his physician illustrates this point: 'Now if he had researched me better, he would have known that I am quite capable of knowing if I have shortness of breath. They won't take your word for it. It has to be tests, tests, tests'. Thus, trust from the health care professional played an important role in fostering patient competence.

The informants emphasized that trust from health care professionals was an especially meaningful and powerful component in shaping their illness experience. Being trusted by one's health care professional was described as an affirming and validating phenomenon, one which promoted self-esteem and fortified the

health care relationship. As one informant explained:

I overheard him [the internist] talking to a nurse, and he said, 'Look, you want to know about myasthenia, you ask her [referring to the patient]. You know, she knows more about it than I do.' I loved it! I loved it, you know! I have such confidence in them now that I know I can trust them!

Such meaningful trust was explained not as a generalized respect for others or a global attitude toward humankind, but rather as a specific belief held by a professional that this patient had skills and competencies with regard to illness management. One man articulated it this way:

I felt good because I was in control of myself a bit more. They trusted me to do these things too, and they even told me that only certain people get to be put on those things [home total parenteral nutrition]. You know, I started to appreciate that they really did think that I knew something about it.

It was precisely because these affirmations were context-specific and individualized that they held such meaning for the informants.

Informants explained that as their own competence developed over time, they came to expect acknowledgement and acceptance of that competence within their health care relationships. When this was not forthcoming, their dissatisfaction with health care relationships escalated. One informant expressed her frustration this way: 'I haven't been looked at as a human being in years. I'm a medical disaster. How did she [doctor] put it? A pathological nightmare!' At the opposite end of the spectrum, informants occasionally described difficulty in developing a sense of competence until encouraged to do so by a health care professional. This demonstration of trust was seen as an extraordinary act that served not only to enhance the informant's sense of personal competence but also to foster trust in the professional.

COMPETENCE GENERATING TRUST

Once informants felt competent and expected this competence to be recognized and acknowledged by their health care professionals, they were creative in bringing this about. Many engaged in 'doctor shopping', a process by which

they actively sought a physician who was comfortable with competent patients. For example, when interviewing potential health care providers, many informants described making their expectations regarding the health care relationship explicit. While some informants attempted to change existing health care relationships, others chose to search until they found an individual health care provider who already demonstrated the capacity to trust the competence of patients. As one informant said: 'I have no respect for the medical profession whatsoever, unless they've earned it from me'. A key source of information in this process was the informal network established among others with chronic illness.

Once they found a health care professional with the potential for such trust, informants used a variety of strategies to foster the development of that potential. One method for accomplishing this was to actively engage in providing the kind of information they perceived to be important. The context for trust was established by strategic accounts of their illness experience thus far and their knowledge base associated with disease and treatment.

Another method they described included demonstrating to the health care professional that they were informed and judicious users of the professional health care system. Many talked with pride about having 'figured out' the system after much trial and error. They learned, for example, under what circumstances it was acceptable to call for help, and in what manner that call should be made. By doing so, they believed that they had demonstrated to the health care professional their commitment to not abusing the relationship.

Informants further described selective information-giving as a means of fostering and maintaining trust. For example, it was important to withhold certain kinds of information, such as instances of non-compliance or alternative treatment that might engender disapproval from the health care professional. In addition, informants described the use of explicit and clear requests for assistance from their health care providers. In contrast to their earlier and more naive expectation that health care providers would know what was in the patient's best interests, they now assumed responsibility for making their needs known in an assertive and unequivocal manner.

One man explained it this way: 'I'm a car mechanic. Now a car mechanic is a good example, comparing a car to a human. If somebody brings a car to me, I would ask a person "What's happening to the car?"' Thus, although the physician didn't ask, the patient assumed responsibility for volunteering what he understood as essential information from his point of reference.

The final strategy by which informants used their newly acquired competence to foster trust involved efforts to reduce the status differential between themselves and their health care professionals. The informants described gift-giving, inquiring about the professional's health and family life, joking, expressing concern for the professional's working conditions, and rationalizing errors as strategies aimed at humanizing their health care encounters. These strategies stemmed from the shared belief that health care professionals would find it much easier to trust patients in whom they had a human interest. As one informant explained: 'The difference was that they came across as human, you know, like you weren't just a pay cheque'. In addition, informants employed a number of tactics to elevate their ability to communicate to a level more compatible with that of the professional. Such strategies included becoming familiar with medical libraries, consulting with other professionals and patients, media-watching to monitor current developments in treatment, and voracious reading. All of these tactics served the purpose of enabling fluent communication in the language of health professionals.

Thus the accounts emphasized the role patient competence played in enabling them to generate trust from their health care professionals. Informants clearly valued this trust and perceived it to be an important element of successful health care relationships.

Trust from the health care professional not only fostered satisfaction with health care relationships, it also promoted and maintained patient competence. This competence was nurtured in a number of ways. The feeling of being trusted fostered self-confidence and self-esteem through validation and affirmation. One example, in which an informant's complaints could not be objectively verified by the physician, illustrates the point. 'He knows there's something going on. Again, he says, he doesn't

know what, he says, but it's there. You know, he's sympathetic to the pain I go through.' This type of trust supported the informants' belief in their own ability to respond competently to the ongoing challenges of living with chronic illness.

Informants described competence in the face of chronic illness that was neither absolute nor permanent. They explained that the nature of chronic illness demanded continual adaptation that stressed their ability to maintain competence over time. Thus trust served to bolster their sense that they could continue to make the shifts required to demonstrate competence with regard to their illness management.

Clearly, from the perspective of the chronically ill person, trust is one of the most significant elements in health care relationships. It serves as a foundation for the kind of relationship that permits collaboration and cooperation with regard to illness management. According to our informants, when patients are trusted by their health care professionals, they are more able to trust in return. Thus the most satisfying health care relationships for the chronically ill patient are those characterized by reciprocal trust. In other words, trust from health care professionals fosters trust in health care professionals.

DISCUSSION AND IMPLICATIONS

According to the informants in our study, one of the most significant features of evolving health care relationships is the shift in patients' expectations of health care providers and the health care system. The process of relationship evolution takes patients from a stance of general naive trust into a position of specific reconstructed trust. This reconstructed trust accounts for limitations in both the system and the individual health care providers. Such trust is no longer characterized by blind faith in the humanity of the system; rather, it is analagous to a confident expectation as to what the health care professional can offer. This reconstructed trust permits patients to develop increasing confidence in their own competence with regard to illness management. In turn, they increasingly demand recognition and acknowledgement of that competence from their health care professionals.

This view of health care relationships represents a departure from the widely accepted model generated by Parsons (1951, 1979) as to the nature of the sick role in modern society. This model addressed the phenomenon of sickness in terms of the role expectations associated with it. Parsons proposed that, in exchange for certain exemptions from social obligation, the sick person has an obligation to seek competent help for his illness and to cooperate fully with that help (Lambert & Lambert 1985). This conceptualization has been interpreted by many to validate the expectation that patients will trust unilaterally in their health care relationships (Gallagher 1979, Illich 1975, Tagliacozzo & Mauksch 1979).

The idea of patients placing complete trust in them is a very appealing one to health care professionals (Lorber 1979). However, from the patient perspective, such trust is impossible to maintain in the context of chronic illness. The type of trust envisioned by Parsons (1951, 1979) seems dependent upon health care professionals fulfilling their role by curing the illness (Illich 1975). In the instance of acute illness, it is assumed that patients can best help themselves by surrendering to the curative ministrations of the health care providers. Both neophyte patients and their health care providers seem to assume that the same rules of the game will apply in the case of chronic illness. It seems clear that such a mind set leads to distress and dissatisfaction for patients.

Importance of reciprocal trust

The perspective described by our seasoned informants emphasizes the importance of reciprocal as opposed to unilateral trust in health care relationships. Further, it makes dramatically evident the inappropriateness of the expectation that patients place absolute trust in health care professionals. Reciprocal trust is perceived as having a significant impact on illness management and the achievement of wellness in chronic illness. It provides a foundation that continues to foster trust and competence over time.

The notion of reciprocity in health care relationships has been addressed in the literature on advocacy (Kohnke 1982, MacElveen-Hoehn 1983), negotiated models of health care

(Donabedian 1977, Kleinman *et al.* 1978, Lazare *et al.* 1976, Rogers & Barnard 1979, Williamson 1981), and participative decision-making (Kassirer 1983, Storch 1982). From each of these perspectives, theorists have recommended major changes in the manner in which health care relationships are conducted. In spite of considerable attention to such proposed changes in the recent professional literature, shifts in health care attitudes are not yet apparent from the perspective of chronically ill patients.

There are several possible reasons why the shift in practice is so painfully slow. One explanation may lie in the depth with which contrary belief systems are embedded in the values of the health care professions. Medical paternalism is perhaps one of the strongest themes in this regard. Even in its more modern incarnations, paternalism includes beliefs that patients are more likely to choose immediate gratification over long-term benefit, that formal decision-making is unfamiliar to most patients, and that physicians are more likely to be capable of objectivity with regard to decisions about care than are their patients (Weiss 1985). The extent of these beliefs is such that '... physicians may even interpret the patient's unwillingness to accept their professional opinion as clear evidence of irrationality and may use this assessment as a reason for closing out further discussion' (Kassirer 1983).

Paternalistic beliefs have been supported, to some extent, by research indicating that patients do not truly wish to participate in medical decision-making (Sherlock 1986, Strull *et al.* 1984). However, according to our informants, control of decisions is not the salient issue. Instead, patients interpret competence as the ability to appropriately make, share or delegate decisions regarding illness management on an intelligent basis. This never seems to imply a stance of absolute personal control, rather it represents skill at choosing the best decision-making method in each particular instance. Thus the conclusion that patients' disinclination to conduct medical decision-making reflects the need for absolute trust (Sherlock 1986) seems premature and myopic.

Another explanation for the resistance of the health care professions to incorporate reciprocity in relationships with patients may be found in the analysis of balance of power. Social

distance between patients and providers has served as a mechanism for preserving health care authority. Reciprocity in relationships therefore poses a threat to the power and status afforded the professionals (Pritchard 1983). Further, it engenders a fear that familiarity might breed excessive demands on the part of the patients (Lazare *et al.* 1976). Thus the notion of reciprocity challenges the accepted social order by magnifying the insecurity of health care professionals who feel that the need for their service is greater than anything they are capable of providing.

In view of the extent and scope of resistances to reciprocity in health care, it is not surprising that reciprocal trust is difficult to establish. The non-specific recommendations that abound in the literature on advocacy and negotiative models of care are of little assistance in this regard. For example, exhortations to adopt attitudes of generalized good will as the foundation for effective health care relationships may result in the paradoxical effect of diminishing trust because they are devoid of meaning for patients. Further, the traditional approach of promoting and maintaining unilateral trust is clearly counterproductive, for there is nothing that can reinstate naive trust once it is lost. Rather than focus all of their energies on fruitless efforts to rebuild absolute trust, health care professionals need to develop the ability '... to visualize and understand the social context in which both they and their patients function' (Corey *et al.* 1979).

Conflicting social processes

As Illich (1975) and Anderson & Helm (1979) argue, health care relationships are inherently conflicting social processes. Our traditional approaches have failed to recognize that this aspect of professional-patient relationships depended upon one party convincing the other of the advantage of trusting. Instead, the process of relationship evolution represents a complex and dynamic interchange of expectation clarification and trust negotiation between the two parties. Because the human component of health care is an important determinant of illness outcome (Moos & Tsu 1977), professionals are obliged to address health care relationships as

significant social processes rather than mere inconsequential niceties.

Clearly, there are significant advantages to both patients and professionals when reciprocity, and in particular reciprocal trust, is incorporated in health care relationships. In order for this to occur, professionals must broaden their focus towards encompassing illness experience rather than simply attending to diseases and disease process. For some, this will require the development of new attitudes towards the phenomenon of trust in health care relationships; for others, a heightened awareness of the powerful role reciprocal trust plays in terms of patients' perceptions and satisfaction with care will provide sufficient impetus towards new behaviours. Health care professionals cannot afford to promote naive trust at the expense of patient competence and reconstructed trust. Therefore, it is imperative to develop the particular skills of listening with intent, curbing preconceptions, soliciting the patient perspective, and validating conclusions. With these skills, professionals can identify the specific competencies of their patients to manage the particular problems associated with the chronic illness. In addition, we in the health care professions must work towards identifying and understanding the discrepancies between the perspectives of our patients and ourselves so that the trauma of shattered expectations may be reduced.

Conclusion

It is evident that trust is fundamental to successful, effective health care relationships. However, our traditional approach to this phenomenon has been simplistic and naive. Health care professionals have much to learn from those we serve. Our patients can teach us how to engage in reciprocal trust in order that we may make a meaningful contribution towards their efforts to live well with chronic illness.

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