available. The ongoing COVID-19 pandemic has surfaced the declining trust in both the public and private healthcare systems in India. It warrants the need to understand why public trust in healthcare institutions is deteriorating. Healthcare system in India has changed over the years. It has brought in, the concepts of commercialization and new managerialism. This has changed the relationships of providers and health managers which creates an impact on public trust in the healthcare system. Indian public healthcare system is highly under-resourced and yet is the only resort for a major section of the society, especially the poor. It is widely known to be inefficient in catering to the needs of the public. The private healthcare system on the other hand has grown exponentially and has proved to be highly overpriced.

Aim To draw a conceptualization of public trust in healthcare systems in the Indian context. I will be referring to the model of Public Trust in Healthcare given by Felix Gille (2017). In this model, the public sphere, where public trust is shaped by the discourse of shared experiences and perceptions about the healthcare systems, has been centralized.

Methods Qualitative Systemic Review

Current stage of work: Conceptual framework of the research has been completed and review of the articles is under progress.

Expected results Public sphere is cardinal in shaping public trust in healthcare systems. The process of consensus-building in the public sphere is constantly changing, making it dynamic. The communication channels- active, passive and feedback, shaping the public sphere are temporal. The internal changes in the healthcare systems also determine some aspects of trust.

38 WHO AND WHAT TO TRUST IN A CRISIS? A NARRATIVE EXPLORATION OF PERSONAL AND POPULATION HEALTH THREATS

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Background Healthcare crises demand decision-making under duress. Time-bound judgments, based on imperfect information, must be made while managing expectations of unpredictable outcomes. Trust is vital for all involved.

Experts characteristically use experience-based narratives to draw inferences. Paradoxically, during the Covid-19 pandemic, prevailing social mistrust of 'experts' switched to an urgent demand for expertise when much was unknown or unknowable. Professionals debated what constituted trustworthy evidence while public intolerance of ambiguity grew. Case studies, including auto-ethnography, combined with narrative analysis can be used to explore novel and complex situations with unclear boundaries between phenomenon and context.

Aims

1. Explore how different forms of uncertainty (expertise, limits of medical knowledge, and discerning which is which) impact on trust and decision-making in patient-professional relationships.
2. Compare dynamics of trust and knowledge mediation during Covid-19 with other health threats.

Methods This work (completion Feb 2021) takes a social constructionist approach, applying Labov's framework for narrative analysis to an auto-ethnographic account and purposively

selected stories of Covid-19, HIV/AIDS, cancer and dementia from public media sources. The author is a frontline clinician and qualitative researcher. She is critically considering her experiences and the stories as case studies exemplifying shifting meanings of trust.

Results Identified narrative structures provide insights into variable conceptualisations of trust. Elements (e.g. values, duties, expectations) and genres within individual stories illuminate how notions of safety and risk change according to perceived level and immediacy of threat, balanced against ability to identify trustworthy knowledge. Comparisons of how professionals and patients use life experience, personal networks and external evidence sources, and how different forms of uncertainty impact the building or breaking of trust, will be presented.

Conclusions In Covid-19, disruption to usual communication modes changed trust and relational care beyond that experienced in other personal or population health crises. Understanding this may improve future decision-making and communication.

Oral presentations

Theme: Conceptualising truth and trust in health related contexts and settings

Day 1: Thursday 18th March – 13.35-14.55

1 DO YOU WANT TO KNOW WHAT PUBLIC TRUST IN THE HEALTHCARE SYSTEM IS ABOUT?

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10.1136/bmjopen-2021-QHRN.39

Background Public trust is essential for the well-functioning of healthcare systems. Examples of healthcare activities that are heavily dependent on high levels of public trust are vaccination, organ donation, establishment of national health records or acceptance of measures against pandemics. Despite the frequent use of the term in the public sphere and societal interest to maintain high levels of public trust, we have only a limited understanding of what public trust as a concept actually is. This conceptual uncertainty of public trust in the healthcare system poses problems for health care governance and policy making.

Aim We aimed to answer: what is public trust in the healthcare system?

Methods We analysed three English NHS case studies: an analysis of online news with readership comments concerning the care.data initiative; a secondary analysis of interviews about participants' experiences and perceptions of biobanks; and an analysis of public focus groups about perceptions of the 100,000 Genomes Project. Further, we analysed existing conceptual work and trust theory.

Results This resulted in a full conceptual framework of public trust in the healthcare system. The framework constitutes of 16 conceptual, nine framing and two effect themes. Public trust builds on information equally relating to past experiences, present perceptions and future expectations. Public trust legitimises the actions of the healthcare system as well as encourages the public to participate in healthcare-related

activities. Further, levels of public trust are affected by spill-over effects from high or low levels of public trust in other parts of the government system. Last, many actors inside and outside the healthcare system influence public trust.

Conclusion Future research needs to translate this conceptual framework into policy guidelines, as well as to validate the conceptual framework for healthcare systems other than the British NHS.

2 CONCEPTUALISING TRUST IN VIDEO CONSULTATIONS

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10.1136/bmjopen-2021-QHRN.40

Background Trust is recognised as an essential component of the patient-clinician relationship and high-quality care. With the turn to video consultations, patients and clinicians have raised concerns that it is harder to build and maintain trust. However, there is no research on how trust influences, and is influenced by, the video-mediated context.

Methods To investigate how trust matters for video consultations, we conducted a qualitative, in-depth study of the clinician-patient interaction in 37 video-recorded video consultations, drawn from 4 clinical settings (heart failure, diabetes, antenatal diabetes and cancer). We made detailed transcriptions and used Conversation Analysis to do a fine-grained analysis of the interaction, guided by the question ‘how does trust play out in the video-mediated consultation and how does technology influence this?’ Analysis of data occurred in parallel with development of theory.

Findings Our data support a new theorisation of trust in the video consultation, which can be conceptualised on three levels. First, trust *in the technology itself*: that it will function as expected (e.g., that both parties will be able to see and hear each other adequately). Second, trust that the *other party will be able to use technology effectively* to achieve the goals of the consultation (e.g., that the patient will be able to perform an examination). And third, the traditional *trust of the therapeutic alliance* (in which patients and clinicians build and maintain a working relationship), which may be supported or impeded by technology.

Discussion If video consultations are to become the ‘new normal’ for healthcare encounters, it is crucial that patients and clinicians are able to a) trust the technology, b) trust one another’s capability to use the technology, and c) use the technology to build and maintain a therapeutic relationship. Further research should explore how to optimise these different kinds of trust.

3 TRUTH AND TRUST IN CONSENT TO SURGERY

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10.1136/bmjopen-2021-QHRN.41

Truth and trust are at the centre of valid consent to surgery, with honest accounts and agreements by patients and surgeons. Yet social scientists’ study of consent is complicated by their uneasy relationships with truth. Ethnographies can involve researchers’ deceptions. Positivist truth claims rest on the findings being precisely replicable, which is not possible with unpredictable free agents in complex

social contexts. Interpretivists’ views of contingent truths can be relativist.

Critical realism helps to resolve these problems by combining the strengths of positivism and interpretivism within a larger framework. Like positivism, critical realism accepts that there is true reality, independent of our fallible thinking about it. Critical realists agree with interpretivists that there can be countless interpretations of reality, but not that these alter or construct reality itself. Critical realism understands everything at three levels.

The *empirical* level involves our experiencing, thinking and talking about reality. People may misinform, deliberately or in ignorance, leading to scepticism about whether truth exists.

The *actual* level involves existing things, people and events, offering stronger grounds for establishing truths. Yet appearances can be deceptive.

The third level is of *real* causal mechanisms, usually unseen by normal vision and only known in their effects, gravity for instance. Doctors’ diagnoses rely beyond symptoms on causes, such as viruses or heart lesions. Social causal mechanisms include class, gender, (in)justice and trust.

Our research about consent, in two London children’s heart surgery centres, illustrates the value of examining these three levels. Families and practitioners all held slightly differing viewpoints (the empirical level of interpretivism). These differing views all related to children’s heart lesions and planned surgery (the actual positivist level). Valid consent also involves unseen voluntariness, courage and trust (the real causal motivating level). The three interacting levels are central to consent to surgery, and to social research.

Day 2: Friday 19th March – 14.50-15.50

4 THE BUILDING OF EPISTEMIC TRUST: AN ADOPTIVE FAMILY’S EXPERIENCE OF MENTALIZATION BASED-THERAPY

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Background Recently, theorists have posited the development of epistemic trust - the trust in others as reliable sources of information - as an essential aspect of the therapeutic relationship and a mechanism of therapeutic change. Epistemic trust is likely to be disrupted in adoptive children and families and Mentalization Based Treatment (MBT) aims to explicitly promote its development.

Aim This study aims to investigate how epistemic mistrust is addressed and how epistemic trust is established within the MBT framework.

Methods This single-case, exploratory study reports data from in-depth interviews with one adoptive family, which were analyzed qualitatively using Interpretative Phenomenological Analysis.

Results Two superordinate themes are reported: *pre-therapy factors contributing to epistemic mistrust* and *factors contributing to the development of epistemic trust*. The findings highlight two critical elements in establishing epistemic trust: the use of certain clinical skills that help build a secure base within therapy and the possibility of trust being transferred from and to other professionals/systems beyond therapy.