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While physicians are sometimes accused of being benignly ignorant about pharmacists, pharmacists can sometimes appear maliciously well informed about physicians' behaviours. The existence of this asymmetry can make true interprofessional collaboration challenging. We undertook this research to explore the roots of this observation and as a way of supporting more collaborative patient care.

Si l'on accuse parfois les médecins d'ignorance bienveillante au sujet des pharmaciens, ceux-ci peuvent parfois sembler terriblement bien informés sur les comportements des médecins. L'existence de cette asymétrie peut rendre une véritable collaboration interprofessionnelle difficile. Nous avons entrepris cette recherche afin d'étudier les causes de cette observation, et de favoriser l'offre de soins plus collaboratifs aux patients.

Trust in interprofessional collaboration: Perspectives of pharmacists and physicians

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ABSTRACT

Background: Trust is integral to effective interprofessional collaboration. There has been scant literature characterizing how trust between practitioners is formed, maintained or lost. The objective of this study was to characterize the cognitive model of trust that exists between pharmacists and family physicians working in collaborative primary care settings.

Methods: Pharmacists and family physicians who work collaboratively in primary care were participants in this study. Family health teams were excluded from this study because of the distinct nature of these settings. Through a snowball convenience sampling method, a total of 11 pharmacists and 8 family physicians were

recruited. A semistructured interview guide was used to guide discussion around trust, relationships and collaboration. Constant-comparative coding was used to identify themes emerging from these data.

Results: Pharmacists and family physicians demonstrate different cognitive models of trust in primary care collaboration. For pharmacists, trust appears to be conferred on physicians based on title, degree, status and positional authority. For family physicians, trust appears to be earned based on competency and performance. These differences may lead to interprofessional tension when expectations of reciprocal trust are not met.

Conclusions: Further work in characterizing how trust is developed in interprofessional relationships is needed to support effective team formation and functioning. *Can Pharm J (Ott)* 2016;149:236-245.

Trust (noun): Firm belief in the reliability, truth, ability or strength of someone or something, as in "good relationships are built on trust."

—Oxford English Dictionary

Background

Interpersonal life is lived on a foundation of trust: without it, our activities of daily living become both impossible and meaningless.¹ Philosophers have long speculated on the centrality of trust to all human relationships, particularly

those in which risk, danger or uncertainty exist.² Social scientists have defined a variety of frameworks to examine the subtleties associated with trust and the circumstantial nature of its application.³ Biologists have suggested that humans have a natural predisposition to trust and that the subjective feeling of trusting another can be altered pharmacologically (e.g., by the use of oxytocin).⁴ Like the air we breathe, trust is universally relied on but rarely discussed.

As with any type of human relationship, trust is implicit in the structure and function of health care teams.⁵ For example, a physician may rely on—or trust—the pharmacist who completed an

assessment prior to diagnosing or prescribing for a patient. Errors (intentional or accidental) may cause a breach in trust—and the relationship—that may inhibit or prevent collaborative relationships from forming. Biases and stereotypes (known as attribution errors) may inhibit or interfere with an individual's ability to work collegially with others.⁶

As interprofessional collaboration becomes more prevalent, a form of interdependency is required between health care workers.⁷ This interdependency manifests itself, for example, in the reliance that nurses place on physicians' trustworthiness to accurately diagnose and prescribe, which in turn is built on a pharmacist's trustworthiness to accurately and completely undertake a best possible medication history. Without trust in the professional skills and good character of colleagues, true collaboration is not possible.⁸

Anecdotally, there have been reports that this interdependency may not be as deep as it could (or should) be in order to fulfill the promise of interprofessional collaboration.⁹ In particular, it has been reported that within collaborative family practice environments, pharmacists' recommendations may be ignored, or opportunities for pharmacists to contribute to decision-making may be overlooked.⁹ The root causes of such behaviours are of course multifactorial and will involve issues of structure, hierarchy, compensation models and power relationships.¹⁰ Rarely, however, is the issue of "trust" itself named as a reason for noncollaborative relationships or as the root cause of interprofessional tension.

Objective

The objective of this research was to characterize the construct (or cognitive model) of "trust" in interprofessional collaboration in primary care, from the perspective of community pharmacists and family physicians directly co-involved in patient care.

Methods

Community pharmacists and family physicians in Ontario working within primary care environments featuring regular periodic contact and communication between one another were the focus of this study. Inclusion criteria for this study were the following:

1. Licensure as a pharmacist or a physician in Ontario for at least 3 years. Pharmacists

KNOWLEDGE INTO PRACTICE

- Effective collaboration between pharmacists and physicians requires trust.
- Different cognitive models of trust produce different behavioural expectations.
- Misalignments between practitioners' cognitive models of trust may produce interprofessional tensions.
- For pharmacists, trust is conferred based on status, degree, title or positional authority, while for family physicians, trust is earned based on competence and performance.

must be working in community pharmacy practice a minimum of 20 hours/week. Physicians must be practising as family doctors for a minimum of 20 hours/week.

2. Active patient-facing practice involving care of and contact with patients for at least 20 hours/week.
3. Practising within a setting in which some form of communication and/or collaboration with the other health care professional (i.e., pharmacist or family physician) occurs regularly (i.e., written, verbal or other communication at least 5 times weekly).

Pharmacists working in family health teams were specifically excluded from this study, as the structure and organization of these teams are qualitatively different from more traditional community pharmacist–family physician relationships.¹¹ As a result, it was determined that family health team dynamics should be studied separately from this cohort.

This research was exploratory in nature; consequently, a qualitative research design was selected. A snowballing sampling technique was used in which community pharmacists who initially participated in this study were invited to nominate family physician colleagues who they thought might be interested in participating. Initial recruitment focused on community pharmacists and was undertaken through recruitment flyers and word of mouth. Upon expressing interest in this study, information was provided to community pharmacists, who then were required to complete informed consent to participate. Upon conclusion of the interview with the community pharmacist, the interviewer asked for nominations/recommendations for family

physicians who might be interested in participating in this study. These family physicians were then contacted directly and invited to participate. Upon expressing interest in the study, information was then provided to the family physician, who was then required to complete informed consent in order to participate. Upon conclusion of the interview with the family physician, the interviewer asked for nominations/recommendations for other family physicians who might be interested in participating in this study.

A semistructured telephone interview protocol was used to guide interactions with all participants (see Table 1 for sample questions and responses). To facilitate constant-comparative and iterative coding and data interpretation, one interviewer was used for all data gathering and 2 researchers independently reviewed all data and transcripts. Telephone interviews were audiotaped and verbatim transcripts produced. In addition, the interviewer maintained field notes. Transcripts and field notes were managed using NVivo v9. These data were then reviewed and coded by the 2 independent reviewers, who worked together to develop a consensus on themes and priorities emerging from the analysis. A third reviewer was available to address disagreements but was not used. Each independent reviewer used a constant-comparison method for his or her analysis, the objective of which was to determine recurring patterns and underlying meanings and themes within the words used by participants, even when the specific phrases, terms or words used by participants was different.¹² The focus of this coding approach was to generate themes that could be confirmed through subsequent interviews. Interviewing was undertaken until saturation of themes was achieved.

Participants who completed the interview received a small gift card to acknowledge their time and contribution. This study was reviewed and approved by the University of Toronto's Research Ethics Board.

Results and Discussion

Initially, based on recruitment flyers and word of mouth, 20 pharmacists expressed interest in learning more about this study; after a one-on-one information session, a total of 11 pharmacists agreed to participate and completed informed consent procedures. These 11 pharmacists nominated 23 family physicians

for participation in this study; in general, these were physicians who the pharmacists felt were collaborative, interprofessional and approachable. Of the 23 family physicians contacted, 11 responded that they were interested in learning more about this study. Following a one-on-one telephone-based information session, 8 family physicians agreed to participate in the interview and completed informed consent procedures. Demographics of study participants are presented in Table 2.

Selected example quotations (based on transcripts and field notes) from the semistructured telephone interviews are included in Table 1. Three major themes were identified: 1) pharmacists demonstrate implicit trust of physicians based on their professional status/degree/role, 2) physicians do not demonstrate implicit trust of pharmacists simply based on their status/degree/role and 3) differences in psychological construct of trust between pharmacists and physicians may produce or exacerbate interprofessional tensions.

Pharmacists' cognitive model of trust

Pharmacists in this study generally expressed satisfaction and pride in working within a collaborative care environment. For most, such an environment represented the pinnacle of pharmacy practice, allowing optimal leveraging of knowledge and skills. In their descriptions of the family physicians with whom they worked, pharmacists consistently emphasized specific characteristics that were important in determining the nature/direction of a collaborative relationship: "intelligent/knowledgeable," "busy" and "confident." When describing specific situations or scenarios involving physician colleagues, they very rarely used the physician's first name; instead, honorific titles such as "the doctor" or "Dr. XXX" were used in most descriptions.

In discussing the way in which trust was formed in their relationships with family physicians, pharmacists described a process that was characterized as "implicit." Externalities (such as positional authority, status in the health care hierarchy, academic qualification or professional designation) were given significant weighting in determining whether trust could be conferred. The simple fact that a family physician was an MD was (in and of itself) reason enough for most pharmacists in this study to determine that

TABLE 1 Interview guide and sample transcript excerpt responses

Question	Pharmacist response	Family physician response
How would you describe the [physicians/ pharmacists] you regularly work with?	<p>"Very smart—very intelligent. Knows his stuff cold, which can be a bit intimidating."</p> <p>"Until I started working with them . . . well, I think it's really hard to understand just how much pressure physicians are under. I don't think I'd ever want to do that job."</p> <p>"It's really great working with Dr. X. He's incredibly knowledgeable—I always feel like I'm learning something new."</p> <p>"A bit intimidating, honestly. When you're working with someone who—well, just so intelligent—makes me always wonder, or question if I'm doing or saying the right thing you know?"</p> <p>"Super confident, actually. I don't know how they do it but they never—I don't know—they never let you seem them sweat anything, right? Always really calm and professional."</p>	<p>"Very nice, helpful."</p> <p>"I don't know what I'd do without [name of pharmacist]! She's great with the details I'm not so good with. Would trust her with my mother!"</p> <p>"Having [name of pharmacist] in the building has made a huge difference in terms of how we manage our patients with diabetes."</p> <p>"A real asset. [Name of pharmacist] keeps me—all of us—on our toes."</p>
Before working with [the physician/ pharmacist], what was your general impression of members of that profession?	<p>"Cocky. A bit arrogant. Not really a team player."</p> <p>"Intimidating. Really hard to speak with because they are always too busy."</p> <p>"Top of the heap, I guess? You know, like the leader."</p> <p>"A ton of respect. I can't imagine a harder—or more important—job."</p>	<p>"To tell you the truth I wasn't really ever that impressed with pharmacists. They never really helped—just pointed out mistakes."</p> <p>"Fine. They do their jobs."</p> <p>"Not too much actually—my interactions were pretty limited."</p> <p>"Actually, the only time I ever talked to a pharmacist was when I made a mistake. Not the best way to build a relationship. . . ."</p>
How do you know you can trust [the physician/ pharmacist]?	<p>"Well, you just do, right? He's the doctor and—well, he's not god or anything—but still, you need to just trust their judgment or the whole thing falls apart."</p> <p>"Physicians as a whole are pretty reliable people and so you are—I don't know, raised to trust doctors?"</p> <p>"I haven't actually thought about it. I mean, if they're a doctor, well that's pretty tough so they must have proven themselves."</p>	<p>"I like to see how they respond to different situations, then I make up my mind about whether, how, to trust them."</p> <p>"It has to build over time, right? They have to prove themselves."</p> <p>"It can take a while. At the end of the day I have to make sure my patients get the best possible care, so you can't just trust anyone who walks in off the street."</p> <p>"You just know, after a while. You can tell if they're competent, committed, someone you want to rely on. You have to see them in action."</p>
When you disagree with [the physician's/ pharmacist's] opinion or recommendation, how do you manage the disagreement?	<p>"Well, you try to put forward your point of view, the evidence and then, of course it ultimately has to be up to the doctor."</p> <p>"I don't know that we actually ever disagree—maybe different ideas but we always try to discuss it and come to an agreement."</p>	<p>"Ultimately, it's my responsibility, so while I appreciate an opinion, I have to make the final decision."</p> <p>"It's not a democracy—as the physician I have to be the one to make the decision, so—well, everyone recognizes we don't need to always agree on everything."</p>

(continued)

TABLE 1 (continued)

Question	Pharmacist response	Family physician response
	"I wouldn't call it a disagreement—like it's not a conflict. More that usually the doctor knows something I may not and when we discuss it and I get all the facts, then it might make more sense."	"I don't say this out of disrespect but with pharmacists—not just pharmacists, but nurses, all the other allied health—they don't have the whole picture. The big picture. That's what physicians have so we need to rely on that."
How much do you trust the work, the judgment, the opinions of the [physician/pharmacist]?	<p>"Well, of course you trust them, why wouldn't you? Sometimes they may not know the right answer, but that's not an issue of trust."</p> <p>"They're experts in their areas, right? And we—well, pharmacists know about drugs so they should trust us about that."</p> <p>"You don't have much of a choice but to trust them, do you? How can I second-guess a diagnosis or a lab test result?"</p>	<p>"If it's in their specific area of expertise and I know that and they've proven themselves before, of course I'd trust that."</p> <p>"It's not that you don't trust them—it's just that, well, I need to be responsible and make the decision so give me the information and let me do my job."</p> <p>"In my experience pharmacists are pretty accurate and detailed and can get you the information you want. Many of them do seem hard pressed though to actually ever make a decision—they just want to give you information."</p>
Have you experienced a situation where you feel your judgment or opinion wasn't trusted by [the physician/pharmacist]? How did that feel to you?	<p>"It's frustrating. You work hard, do the research, plan your approach. And then after 2 seconds the answer is no."</p> <p>"Makes you feel like—well, what's the point? It just seems unfair—I'm a well-qualified professional too. Are they even interested in what I have to say?"</p> <p>"I don't worry too much about it, or take it too personally."</p> <p>"It's sometimes easy to see why physicians get the bad reputation they have. You feel shut down, disrespected sometimes when you don't get the response you think you deserve."</p>	<p>"Um . . . no, I don't think so."</p> <p>"We haven't always agreed on everything but I don't think that has anything to do with trust."</p> <p>"I know [pharmacist name] doesn't always agree with my decisions and may get a bit upset but at the end of the day we all know it's each of us doing what we need to do for the sake of the patient."</p> <p>"Physicians are like this with other physicians too. I mean, who are the specialists I refer my patients to? People I know, have experience with, know they are competent—I would never refer my patient to a stranger just because that stranger had a certain background or degree or reputation. You need to know them as a person, as a specialist."</p>
How is trust developed between physicians and pharmacists?	<p>"One patient at a time. They need to see us prove ourselves to them before they can trust us."</p> <p>"I guess it takes time—though we seem to be more trusting of them than vice-versa."</p> <p>"When they know you are not out to get them, or prove them wrong, or step on their toes—that's when they will trust you."</p>	<p>"It has to be earned, that's what physicians are taught. It may make us look nasty or like bullies but we have to know—see with our own 2 eyes—what [the pharmacist] is capable of doing for us and our patients first."</p> <p>"I think there's—well, good will. An expectation that the pharmacist will do the best job he or she can. But that's different than trusting someone in a tough or complicated situation. Docs don't even do that with each other, why would we do that with a whole different profession?"</p>

trust in decision-making and judgment should be conferred. As noted by one participant:

Well, of course, why wouldn't you trust them? They're doctors, right, so they've proven themselves already.

Importantly, this implicit, conferred trust did not mean that there was blind faith in all decisions or in the accuracy of all prescriptions; instead, the trust conferred appeared to be focused on activities that were unique to medical practice and distinct from pharmacists' skill sets.

TABLE 2 Participant demographics

Demographic characteristic	Pharmacists (<i>n</i> = 11)	Family physicians (<i>n</i> = 8)
Age, y (mean and range)	33.2 (27–62)	40.2 (31–59)
Years in practice (mean and range)	9.1 (2–40)	11.1 (7–31)
Self-reported estimate of frequency of contact with other professional, times/week (mean and range)	13 (5–25)	7 (5–10)
Frequent reasons for contact	<ul style="list-style-type: none"> • Prescription clarification • Management of prescription error • Recommendation for alternative due to supply shortage issues or lack of insurance coverage 	<ul style="list-style-type: none"> • Prescription clarification • Inventory/supply shortage management issues • Procedural/policy clarification (e.g., insurance coverage)
Frequent modes of contact	<ul style="list-style-type: none"> • Fax • Telephone • E-mail 	<ul style="list-style-type: none"> • Telephone • Fax
Sex, F/M	64%/36%	50%/50%

I don't know anything about diagnosis of—oh, let's say R(heumatoid) A(rthritis). So of course if the doctor says it's RA, then it's RA, who am I to question that?

However, when the issue of prescribing errors or medication management arose, the construct of trust moved more toward the actual outcome:

Well, it's my job, right? I'm supposed to make sure the doctor doesn't do anything that will harm the patient—or the doctor! I mean they're so busy, they can't know everything . . . this is my way of, you know, helping? I can keep my eye on the prescribing side so the doctor can manage everything else.

As illustrated by the excerpt above, the pharmacists in this study still demonstrated implicit, conferred trust in terms of physicians' motives, intentions and competencies and instead framed the notion of error as something understandable, to be expected and something that they could “help” with, rather than representing a breach of competency resulting in reduction in trust.

Of interest, when asked to describe the reverse situation (i.e., when a pharmacist's recommendation was not valued or trusted by the family physician), pharmacists framed this issue as one of lack of reciprocation:

I trust them to do their job—it's frustrating, okay, sometimes it feels almost like patronizing?—when you know they don't trust your recommendation just because they think, well, you're [air quotes] “just a pharmacist.”

This notion of a trust differential, one that is based on professional designation rather than demonstrated competency, was a source of frustration to most pharmacists in this study, particularly because (based on professional designation), pharmacists implicitly conferred trust on physicians, a trust that appeared unreciprocated and consequently made most participants feel underappreciated or undervalued.

Family physicians' cognitive model of trust

Family physicians in this study also generally expressed satisfaction with their relationships with pharmacists. In their descriptions of pharmacists, they emphasized several key attributes: “nice,” “available,” “helpful” and “keeps us on our toes.” When describing specific situations or scenarios involving pharmacist colleagues they knew, the pharmacist's first name was always used (i.e., no honorific title was ever used to describe the pharmacist). In their descriptions regarding how trusting relationships were formed, physicians indicated the need for evidence, a track record of success or some kind of proof that the

MISE EN PRATIQUE DES CONNAISSANCES

- Une collaboration efficace entre les pharmaciens et les médecins requiert de la confiance.
- Différents modèles cognitifs de confiance génèrent différentes attentes comportementales.
- Les écarts entre les modèles cognitifs de confiance des praticiens peuvent susciter des tensions interprofessionnelles.
- Pour les pharmaciens, la confiance est conférée d'après le statut, le degré, le titre ou l'autorité positionnelle, alors que pour les médecins de famille, la confiance se gagne en fonction de la compétence et du rendement.

pharmacist was indeed trustworthy. Physicians in this study never commented on the role of academic preparation, previous experience or job title as a reason for trusting; instead, there was a strong emphasis on demonstration of competency—and first-hand observation of success—as the vehicle by which trust would be earned (rather than simply conferred due to professional qualification, title or standing).

It's great to know the pharmacist has your back. You spend most of your time as a family doc . . . well, you know, the buck stops here, the buck stops with you, I mean me. So having someone to help you out, to keep an eye out, matters a lot. To be honest, there are lots of pharmacists I wouldn't ever say this about—a lot of them aren't very good—but XXXX is great.

Previous experiences with pharmacists who weren't "very good" appeared as a common theme among family physicians in this study. Of interest, no pharmacists in this study ever brought up the issue of working with physicians who were "not very good."

A lot of times, I don't even know what (pharmacists) actually do. But with XXX, it's different. She really knows her stuff and it's really helpful to me. When I was in school, or residency, I guess, the pharmacists in the hospital, yeah, they were great, a lot like XXX, really helpful, knowledgeable, always there. Until XXX, I don't think I'd seen that as a family doctor, though.

Physicians seldom framed this as an issue of trust, noting this was not only part of their

professional socialization and culture but similar to the way in which physicians relate to one another.

I hope that doesn't make me sound . . . I don't know arrogant? I mean it's just the way we're trained, we don't just trust any random person with our patients. I don't care if it's a nurse, or another doctor or a pharmacist. . . . We're taught, it's our socialization maybe, this is my patient, I'm responsible, you have to prove to me I can trust you with my patient.

The notion that a pharmacist may be considered "any random person" was not explored in further detail in this interview.

As illustrated by the excerpts above, the cognitive model of trust for family physicians in this study appears to emphasize evidence and value, with trust being "earned" rather than being "conferred" automatically due to professional designation, academic qualification or any other externality. Previous exposure to pharmacists with widely different skills may also adversely influence family physicians' general opinions of pharmacy as a profession.

Implications of differing cognitive models of trust on primary care collaboration

Pharmacists appeared to recognize they have a different cognitive model of trust than physicians, although this recognition did not necessarily mitigate frustration or negative feelings. Pharmacists indicated they entered interprofessional collaborative relationships ready, willing and able to collaborate, trusting physician colleagues implicitly and expecting the same in return. When this implicit trust was not returned—and worse, when it became apparent that for physicians, trust must be earned and is not simply conferred—this produced a range of emotional responses ranging from frustration to aggravation to resentment. Pharmacists noted that, while intellectually, they understood the need to continue to engage, to work diligently to "earn" this trust, the emotional response to this reality led them at times to feel (as noted by one pharmacist in this research) "it wasn't actually worth the effort." The fundamental asymmetry in expectations of the relationship seemed "unfair" to some pharmacists and posed a short-term threat to the development of a long-term interpersonal or professional relationship.

Pharmacists noted that the onus appeared to be on them to make the psychological accommodation to accept the physician model of trust rather than finding any sort of compromise.

The emotional experience of offering implicit/conferred trust to a physician and receiving only earned trust in return created a variety of tensions for pharmacists in the short term. Physicians in this study appeared unaware of this experience, while pharmacists in this study recognized it and noted that, with time, this trust was eventually earned and the relationship evolved into a collegial, collaborative and rewarding experience. For most pharmacists, this experience reinforced the hierarchical nature of health professionals' practice. Importantly, one physician in this study noted that this behaviour was not really an interprofessional issue: physicians "trust" other physicians in a similar earned manner, as evidenced by the referral patterns of family physicians to specialists.

These findings raise important issues with respect to the ideal of interprofessional collaboration in health care. Historically, such collaboration has been assumed to be an unquestioned benefit. In creating interprofessional collaboration in primary care, governments and policy makers have emphasized structural and financial incentives to move family physicians into more collaborative practice settings. The psychological facets of collaboration have been generally overlooked; there has been an implicit assumption that well-intentioned, clever people (such as pharmacists and family physicians) could simply figure out how to work with one another in a collaborative setting. The literature has been generally silent on the issue of psychological readiness for collaboration between pharmacists and family physicians. Instead, much of this literature has focused on tools, structures, incentives and processes, rather than the underlying interpersonal dynamics that govern interactions between human beings.

This study has revealed an interesting discrepancy between community pharmacists and family physicians in the cognitive or mental maps governing trust. As human beings, we recognize that the somewhat amorphous concept of "trust" underlies much of our day-to-day life. Without trust, interpersonal, family, employment and virtually all other kinds of relationships simply cannot function—or if they do function, they do so in such a laborious and inefficient manner as to become worthless. The complex, high-stakes nature of primary care is an environment where

trust must also undergird relationships. If "trust" means different things to different professionals, how is this negotiated and how does it affect the quality and extent of collaboration and teamwork? If pharmacists and family physicians are entering collaborative health care team settings with very different and unarticulated mental models of what trust is and how it is developed, there is a strong likelihood of misunderstanding, hurt feelings and resentments. In general, well-intentioned human beings treat others the way they expect to be treated in return. As the pharmacists in this study noted, the lack of reciprocated implicit/conferred trust can in the short term heighten interprofessional tension and, at its worst, can undermine formation of collaborative relationships.

There is no "right" way to form interprofessional relationships; as with interpersonal relationships, interprofessional relationships are a function of many different factors starting with simple chemistry. If, however, pharmacists' expectations regarding a fundamental principle such as what "trust" means are not reciprocated, this can lead to internalized resentment, disengagement and frustration. Conversely (and similarly), if physicians' behaviours are labeled as "wrong," "arrogant" or "intimidating," when this is simply their mental model for trust, this can lead to dismissiveness, disengagement and disinterest in further collaboration. There is no one or right way to trust: instead, it is important that those who are collaborating understand and respect the different ways in which trust is conceptualized and defined by individuals with different professional backgrounds and experiences (Box 1).

It is important to consider the generalizability of these findings to other contexts or jurisdictions. As Sztompka has noted,³ there are unique and important cultural and local factors that are important in understanding trust. Interestingly, there is virtually no published literature that has attempted to characterize trust (as a psychological construct) within interprofessional relationships in primary care or health care generally, despite an abundance of casual or off-handed references to the centrality of trust to effective care provision. There appears to be a tacit assumption that health care professionals have both a common understanding and agreed upon operational definition of what trust actually means and looks like in daily practice. This research provides a useful initial contribution to this literature and does not purport to generalizability beyond its local context and culture.

Box 1 Tips for pharmacists to help develop trusting relationships

- Understanding the cognitive model of “trust” for physicians can help you manage expectations for pharmacist-physician collaboration.
- Trust will take time to develop: learning to be patient and allow an interpersonal, rather than interprofessional, relationship to form first is necessary.
- Physicians need to know pharmacists by name, not just by role or location, in order to trust them.
- Do not interpret disagreement with your suggestions as disrespect for your professional autonomy or expertise.
- When the trust you freely confer to physicians isn’t immediately reciprocated, don’t disconnect and assume it will never happen. Continue to offer your skills and knowledge and allow trust to develop with your successes.

The number of participants was relatively small (although saturation of themes was achieved), and the snowballing technique used to identify participants means these participants were not representative of the general population of pharmacists and physicians. For convenience purposes, participants were all from the greater Toronto area and therefore not necessarily representative of either Ontario or Canada. While independent double coding of transcripts was used to enhance analytical rigour, no member checking (or verification) with participants themselves was possible because of logistical constraints. The snowballing sampling method used in this research is likely to have resulted in recruitment of participants (particularly physicians) who had already established trusting interpersonal relationships with pharmacists. Methods for recruiting participants who did not have such relationships and examining the issue of trust from the perspective of those practitioners is an important next step in this research project.

Replication of this method in other contexts and jurisdictions would provide a useful way of validating these themes and building the literature in this area. Use of alternative research

techniques that blend more observational/ethnographic methods with reflective/interviewing methods could further enhance the rigour of this work, although the logistics associated with such research would be challenging. The importance of trust as a foundation for collaboration, while somewhat self-evident and clear, requires further examination to understand how it is operationalized at the interpersonal and interprofessional level to support and enhance organizational development and quality improvement.

Conclusions

Interprofessional relationships, like interpersonal ones, are complex and subject to considerable ebbs and flows. Much of the interprofessional literature conceptualizes interprofessional relationships in somewhat bloodless terms, not recognizing the nuances and contradictions that are inherent any time human beings interact with one another. This study has highlighted the different ways in which pharmacists and family physicians may conceive of trust and the implications of these differences for collaboration and teamwork. ■

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