Understanding the psychology of trust between patients and their community pharmacists

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Pharmacists have long claimed to be the "most trusted professional," but rarely have we bothered to find out what that means from a patient's perspective. This research was undertaken to better understand what patients think about trusting individual pharmacists and what factors help them to trust, or not, the profession as a whole. We hope it provides readers with insights into how each pharmacist is shaping public opinion and trust every time we interact with a patient.

Les pharmaciens ont longtemps affirmé être « les professionnels en qui la population a le plus confiance », mais ont rarement pris la peine de se demander ce que cela signifie pour le client. Cette étude a été effectuée pour mieux comprendre ce que les patients pensent de la confiance envers les pharmaciens et quels sont les facteurs qui les aident, ou pas, à faire confiance à la profession. Nous espérons que cette étude fournira aux lecteurs un aperçu de comment chaque pharmacien forme l'opinion publique et la confiance chaque fois qu'il interagit avec un patient.

ABSTRACT

Background: Pharmacists need patients to trust them in order to support best possible health outcomes. There has been little empirical work to test the widely stated claim that pharmacists are the "most trusted" health care professional. This study was undertaken to characterize the factors that shape public trust of individual pharmacists and the profession as a whole.

Methods: An exploratory qualitative study was undertaken. Semistructured interviews with 13 patients from 5 different community pharmacies were completed. Interview data were transcribed, coded and categorized to identify trust-enhancing and trust-diminishing factors influencing patients' perceptions of pharmacists.

Results: Four trust-diminishing factors were identified, including the business context within which community pharmacy is practised, lack of transparency regarding pharmacists' remuneration, lack of awareness of how pharmacists qualify and are regulated and inconsistent previous experiences with pharmacists. Four trust-enhancing factors were identified, including accessibility, affability, acknowledgement and respect.

Discussion: This study illustrates that trust-diminishing factors appear to be somewhat outside the day-to-day control of individual community pharmacists, while trust-enhancing factors are elements that pharmacists may have greater personal control over. Further research is required to better understand these factors and to develop a more generalizable understanding of how patients develop trust in their pharmacists. *Can Pharm J (Ott)* 2021;154:120-128.

Background

Trust is integral to delivery of safe and effective health care.[1] If the strength of trust patients place in their professionals is marginal or weak, they are less likely to listen to advice, act on guidance or even engage with the health care system at all.[2] Pharmacists are fond of noting that they are the "most trusted professional" by the public[3]; it is difficult to know for certain the enduring truth behind this oft-repeated statement.[4] A recent study from the United Kingdom noted that public trust in the advice provided by pharmacists was indeed quite high: 87% of public respondents said they trusted pharmacists "a fair amount" or "a great deal," but in comparison to other health care professionals, the strength of that trust was significantly weaker, with only 39% of respondents indicating they trusted pharmacists "a great deal."[5] Further, recent high-profile exposés involving mystery shoppers being given

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KNOWLEDGE INTO PRACTICE

- Trust between practitioner and patient is essential to successful outcomes in health care.
- While pharmacists frequently state they are the "most trusted" professional, there is little empirical evidence to help understand this claim.
- Based on this research, there are 4 trust-enhancing factors (accessibility, affability, acknowledgement and respect) and 4 trust-diminishing factors (the business context of community practice, lack of transparency regarding pharmacists' remuneration, lack of awareness of how pharmacists qualify and are regulated and inconsistent previous experiences with pharmacists).
- While some trust-diminishing factors may be somewhat outside the control of individual pharmacists, trust-enhancing factors appear to be amenable to control by pharmacists.

MISE EN PRATIQUE DES CONNAISSANCES

- La confiance entre le praticien et le patient est essentielle au résultat positif en matière de soin de santé.
- Alors que les pharmaciens soulignent fréquemment qu'ils sont les professionnels « en qui la population a le plus confiance », il y a peu de preuves empiriques pour soutenir cette affirmation.
- Selon la présente étude, les quatre facteurs qui améliorent la confiance sont l'accessibilité, l'amabilité, la reconnaissance et le respect. En revanche, les quatre facteurs qui la diminuent sont le contexte des affaires en pratique communautaire, le manque de transparence sur la rémunération des pharmaciens, le manque de sensibilisation sur la façon dont les pharmaciens se qualifient et sont réglementés, ainsi que les expériences précédentes contradictoires avec les pharmaciens.
- Certains facteurs qui diminuent la confiance sont hors du contrôle des pharmaciens, mais certains facteurs qui l'améliorent peuvent être contrôlés par les pharmaciens.

incorrect or harmful advice by a pharmacist seem to have further eroded public trust in the profession as a whole.[6]

Studies examining trust in other professions highlight an important complicating factor: individual patients or recipients of professional services may have high levels of trust in their personal care provider but still demonstrate low levels of trust in that profession as a whole or the health care system itself.[7,8] Such studies suggest that the psychological construction of trust is highly contingent—that is, trust is earned one patient at a time based on specific experiences and successes rather than automatically conferred upon professionals by virtue of their degree, qualification or job title.[7,9]

Few studies have examined the psychological construction (or "mental map") of trust between pharmacists and patients. Studies from other professions (notably medicine) have provided interesting methodological templates for examining this important issue,[10,11] but caution needs to be exercised in applying findings from these other professions directly to pharmacy. As noted by Allinson and Chaar,[12] pharmacy, unlike most other health professions, has an explicit corporate, for-profit structure and workplace that surrounds it, which directly influences the perception by patients of the pharmacist (whether or not pharmacists themselves are owners, are operators or directly profit from the business within which they work). Despite this physical context for the practice of the profession of pharmacy, pharmacists themselves generally recognize the importance of building trusting relationships with patients in order to support pharmaceutical care and health goals.[13] It is therefore important for the profession as a whole—and individual pharmacists—to better understand how psychological construction of trust in pharmacists occurs for patients and how pharmacists can practise to optimize trust building.

Research objective

The objective of this research was to identify and characterize factors associated with public trust in pharmacists in the context of community practice in Ontario, Canada, and to explore opportunities to enhance trust building between pharmacists and those they serve.

Methods

Trust is a complex psychological phenomenon that has more frequently been described philosophically than empirically. While it is clear that absence of trust between practitioners and patients leads to suboptimal health outcomes and negative clinical experiences for both, there is scant literature describing how trust is actually developed, nurtured, tested and sustained, particularly within a pharmacist-patient context. As a result, a qualitative exploratory research method was selected for this study to provide a starting point for future research in this area.

For convenience purposes, sites for this study were community pharmacies involved in the University of Toronto's experiential education program. Purposive sampling was used to identify a cohort of 5 community pharmacies, representing different geographical locations and business models (e.g., chains, independent, grocery). Designated managers or owners in these pharmacies who agreed to participate were informed of the study objective and asked to make recruitment

TABLE 1 Characteristics of community pharmacies used as recruitment sites ($n = 5$)

Characteristic	Pharmacy 1	Pharmacy 2	Pharmacy 3	Pharmacy 4	Pharmacy 5
Location	Suburb	Urban	Rural	Urban	Suburb
Type	Grocery	Independent	Chain	Chain	Grocery
No. of pharmacists (full-time equivalent)	2.75	1.75	2	4.5	4.25
No. of regulated techs (full-time equivalent)	1	0	1	2	1.5
Approximate daily prescription volume	450	250	300	800	800
Specialty services provided	Flu clinic	Compounding Flu clinic	CDE Flu clinic	CDE CAE Flu clinic	CDE Flu clinic
Approximate No. of med checks/month	5	5	15	20	20

CAE, Certified Asthma Educator; CDE, Certified Diabetes Educator.

flyers available to patients at the point of prescription pickup. Pharmacies were not asked to attempt to recruit or convince patients to participate in this research but to simply indicate availability of the recruitment flyer should individual patients be interested in discussing their experiences with pharmacists. In the recruitment flyer, interested patients were asked to contact a research assistant by email to learn more about this project. When contacted, the research assistant would provide general information by return email regarding the study remit and process, then seek permission to schedule a follow-up phone call, FaceTime appointment or Skype call to discuss further. During this conversation, full informed consent (pursuant to a research protocol approved by the University of Toronto Research Ethics Board) was sought from patients for participation in the study.

Inclusion criteria for this study were 1) minimum of 21 years of age; 2) sufficient verbal English-language skills to understand and provide informed consent and to engage with the researcher, based on the researcher's assessment and 3) a minimum of 6 conversations with any pharmacist about any topic related to health and/or medication use in the past 12-month period. There was no theoretical or methodological foundation for inclusion criterion 3 available in the literature, so this arbitrary number was established as a way to ensure a degree of interaction or familiarity with a pharmacist as a condition for participation. Exclusion criteria for this study were 1) any relative or friend who is or was a pharmacist and who may potentially influence the patient's sense of trust in the profession, 2) individuals who self-identified as having formally complained about or been involved in legal or disciplinary proceedings against a pharmacist in the last 10 years and 3) a current or retired health care professional (i.e., a registered or formerly registered member of a regulated health professional college) or a student currently enrolled in an educational program leading to potential registration with a regulated health professional college.

Upon completion of informed consent, the research associate scheduled an appointment to interview the participant. Interviews were scheduled by phone, Skype, FaceTime, Google-Hangouts or other technological options based on mutual convenience of participant and researcher. The researcher used a semistructured interview protocol (Appendix 1, available online at www.cpjournal.ca) to guide conversation. With the participant's permission, audio and/or video recording of the interview was undertaken and verbatim transcripts were produced. In addition, the research associate maintained field notes during the interviews to support data interpretation and analysis as required. All interviews were undertaken by the same research associate. As a semistructured protocol was used, this afforded significant flexibility for interviews to be individualized to each participant's unique perspectives, with the goal of eliciting individual stories and supporting individual participants in undertaking their own interpretation and meaning-making to enhance credibility of analysis. A nominal gift card was offered to participants in recognition of the time involved in participating in this study.

Analysis of transcript data was undertaken using an inductive thematic coding method described by Yin.[14] All transcripts were reviewed by 2 independent coders, who identified and characterized themes in interviews using participants' own words as supporting evidence for theme characterization. After coding of each transcript independently, coders met to confer and reconcile thematic descriptions and characteristics as part of the process of building and refining a coding dictionary. With subsequent transcript reviews, this coding dictionary was used to guide analysis while being subject to ongoing refinement based on consensus. A stable coding structure for this research was established when no or only minimal/editorial refinements

to the dictionary were required to achieve agreement among both coders. This was also defined as the point of thematic saturation for the study, the point at which no additional new information was emerging from subsequent interviews and the point at which data gathering was suspended. Following agreement upon the coding dictionary and completion of all transcript analyses, a secondary round of coding consolidation was undertaken in an attempt to rationalize established codes into the fewest meaningful categories possible without losing data integrity. In this second round of coding, both researchers consolidated themes independently, met to reconcile differences and worked until consensus to achieve the final thematic analysis presented in the findings and discussion section below.

Findings and discussion

A total of 11 community pharmacies were approached to participate in this research and 6 subsequently agreed. Five of these sites were selected, with 1 site being reserved as backup in the event that was needed. Designated managers in these sites were provided with information and opportunities to clarify their participation and responsibilities in this study. Of the 5 participating sites, there were no dropouts. See Table 1 for pharmacy characteristics of study sites involved in this research.

In the initial round of recruitment, 100 patient-oriented flyers were provided to each site; pharmacies were asked to indicate flyer availability to patients collecting prescriptions but to not press them to participate. In the event that patients had questions regarding the study, pharmacists were instructed to ask the patient to contact the research associate at the email address provided. In the event that recruitment was problematic, designated managers were invited to request additional flyers be sent to the pharmacy.

Of the initial 5 × 100 flyers distributed, a total 36 potential participants contacted the research associate for more information. Of these 36, 16 agreed to be interviewed and were scheduled. Of these 16, 3 subsequently changed their mind or withdrew for other reasons; a total of 13 participants ultimately completed the interviews. Demographic characteristics of these participants are provided in Table 2. Importantly, these participants were not a demographically representative sample of pharmacy service recipients. Thematic analysis as outlined in the methods section revealed 2 broad categories, labelled as "trust-diminishing" and "trust-enhancing" factors:

1. Trust-diminishing factors

Four subthemes were identified that appear to diminish public trust in pharmacists. Importantly, all of these subthemes are connected to structural features of the community pharmacy business model that are subject to little influence by frontline pharmacists themselves. As such, these themes appear to represent an initial barrier to trust that individual pharmacists must first overcome prior to working with potential trust-enhancing factors.

a. Psychosocial cues associated with the business context of pharmacy practice

All participants in this study described community pharmacies as "businesses" rather than as "health care" centres. None of the participants framed this in a negative or pejorative manner but rather in a matter-of-fact, self-evident manner. In some cases, participants indicated the business nature of the pharmacy (e.g., availability of groceries or other consumer goods) was actually a positive feature of the practice model from a convenience perspective. Nonetheless, the psychosocial cues associated with the place of practice featured prominently in the way in which participants in this study framed issues of trust in pharmacists: similar to engaging with any employee of any other retail outlet, relationships with pharmacists begin from a perspective of "caveat emptor"—let the buyer beware:

> *I mean it's nothing against the pharmacist—but, well, if I was going to [large department store chain] to buy a sofa or something, you expect the salesperson is going to want to make the sale, right? I know they're not lying, but they have a job they need to do so you take what they say with a grain of salt. It's a bit like that with the pharmacist. (P4M50)*

> *Pharmacies are stores after all, stores that sell lots of things. There's nothing wrong with that—I mean I actually really like the variety of things, important things you need, that you can buy there. But it's a store and the staff that work in the store—yes, yes, the pharmacist—well then it's like you just have to expect it's like any other store and you need to be careful and not necessarily just automatically believe everything they're selling. (P5M60)*

Most participants in this study highlighted how the physical design of most pharmacies—emphasizing consumption and consumer goods over health care—had a direct influence on how much they trust the pharmacist.

> *I don't know, I guess I never thought of it before. I don't "trust" anyone in a store really—you ask questions they give answers, you have to sort of sift it for yourself, confirm it yourself, not just blindly accept things. And then—well in a drug store—I mean you're surrounded by all this stuff, right, so it just makes you feel, maybe it's all psychological I don't know, all these things for purchase—it's just like another store. Maybe that's unfair, I don't know. (P5F71)*

b. Opacity of how pharmacists are remunerated

All participants in this study noted they had little to no understanding of how much, when and why pharmacists got paid for their work and the clinical services and advice they provide. Some admitted to curiosity about this, particularly in

TABLE 2 Demographic characteristics of participants ($n = 13$)

Participant identifier*	Age, y†	Sex	No. of current prescriptions†	Medical conditions†	Highest level of education†
P1F56	56	Female	6	Arthritis Asthma	College
P1M70	70	Male	4	Hypertension Gout	Technical school
P2M66	66	Male	7	Hypertension BPH Arrythmia	High school
P2F37	37	Female	6	Contraception Diabetes Crohn disease	High school
P3F71	71	Female	4	Hypothyroid Hyperlipidemia	University
P3F60	60	Female	8	Hypertension Hyperlipidemia Depression Anxiety	University
P4F44	44	Female	4	Contraception Dermatitis URTI	College
P4M50	50	Male	6	Cancer Pain Side effects	University
P4M61	61	Male	7	Asthma Diabetes Hypertension	College
P5F29	29	Female	4	Contraception Hypothyroid Antibiotic	University
P5F71	71	Female	9	Did not disclose	High school
P5F72	72	Female	7	Depression Arthritis GI issues Macular Degeneration	College
P5M60	60	Male	4	Anxiety Pain control	College

URTI, upper respiratory tract infection; BPH, benign prostatic hypertrophy.
*Code to identify patient: P(n) refers to pharmacy from which individual was recruited (see Table 1).
†If disclosed by participant during interview.

the context of trying to determine how much to trust or value advice that was provided.

> *To me, well, it's like when you go to a bank to visit a financial advisor. You know they're smart, but you're always just a little bit suspicious unless you know how they're getting paid, right? Why are you recommending this product to me? Are you getting a cut? That's how it works at banks, so I have wondered about that with the pharmacy too. I think it would be better if everyone just*

knew how pharmacists got paid so it made it easier to believe what they are saying. (P2M66)

Unlike with other health professionals (such as doctors), unasked questions around the influence of remuneration on clinical service provision caused most participants in this study to be somewhat less trusting of pharmacists. Several participants compared this to their experience with other health professionals:

When you go to the doctor, I guess you think, well, they get paid exactly the same no matter what they do or what they recommend and I think that's good, it makes you believe them more. But say when you go to a dentist and they suggest some procedure, well, it makes you wonder, even if you have insurance to pay for it—is this something I really need or do they just want the money? I wonder that with pharmacists sometimes too when they ask you about things like reviewing your drugs with you. (P1M70)

While no participants stated or implied there were any issues or concerns regarding financial improprieties that tainted their view of pharmacists, the lack of transparency in understanding how pharmacists are remunerated emerged as a structural barrier to trust enablement for the profession as a whole.

c. Lack of knowledge of academic and regulatory requirements for the profession

I never thought of it—I mean, do pharmacists go to university or is it a college diploma program? (P2M66)

No participants in this study correctly described the academic pathway, degree structure and regulatory requirements necessary for professional practice. When, as part of the interview process, these issues were explained by the interviewer, all participants expressed surprise:

Wow, you should really tell everyone about this. I mean if more people knew how hard it is to become a pharmacist—and yes, of course, now that I think about it that makes sense—that you have all these exams, with the actors and all that . . . I think, well I certainly have a new level of respect for my pharmacist after this. (P2M66)

Only 3 participants in this study were vaguely aware that pharmacists are regulated health professionals governed by a provincial college providing oversite activities and enforcing standards of practice. Once again, this information was seen as positive and, if more widely known, may enhance trustworthiness of the profession.

d. Lack of awareness of scope of practice and minimal expectations regarding competencies

Participants in this study all reported highly inconsistent experiences with different pharmacists over their lifetimes; most had experienced a "great" pharmacist, and all had experienced "lousy" pharmacists. This wide variability in personal experiences with pharmacists resulted in lack of certainty as to what they should reasonably expect a "competent" pharmacist to be and to do for them:

I guess I just hope they can answer my question or tell me they can't. The truth is most of the time, all I hear is "You need to ask your doctor about that," so it makes me think, what's the point in even bothering to ask them? I mean they're very nice people and very smart, I'm sure, but still, what's the point? (P2F37)

Several participants described how public education or awareness campaigns around what services pharmacists can provide alerted them to the broad array of competencies pharmacists possess and actually caused them to be more direct in asking for specific services:

I saw—I don't remember where, maybe it was an ad?—anyway, I learned that pharmacists could actually refill my prescriptions without me having to go back to the doctor, make that appointment, you know, it's such a pain. Anyway, I asked about this—it was strange, the pharmacist seemed reluctant, seemed to really want me to go back to the doctor's office. I had to be a bit insistent and finally the pharmacist gave me the prescriptions I needed, but it was a bit of work for me. Still it was good—much easier for me—so I would definitely be insistent again. (P1F56)

Overall, participants in this study described relatively low expectations of community pharmacists with respect to clinical competencies and seemed unsurprised by the frequency with which they were advised to see their doctor instead. Indeed, when the pharmacist provided independent care, service or advice—for example, independently assessing and then renewing a prescription as permitted under scope of practice—this was seen as surprising, positive and going "above and beyond the call of duty."

2. Trust-enhancing factors

Participants in this study described pharmacist-specific behaviours (as opposed to structural barriers) that enhanced trustworthiness of both individual pharmacists and the profession as a whole.

a) Accessibility

All participants clearly and enthusiastically highlighted the importance of accessibility to constructing a trusting relationship with a pharmacist or any health care professional. Most participants noted that their pharmacist was generally more easily accessible than their physician, and this ease of access translated into enhanced faith in and belief in that individual's skills and competencies.

> *The pharmacy I go to now, the pharmacist, he's great. If I phone or if I come by, he always seems to have time to see me. Even if I don't have a specific question, even just a smile and hello. That really inspires confidence, like he's not afraid or hiding from me. Yes, that makes me trust him so much more. (P3F60)*

Compared to other health care professionals, the relative accessibility of most pharmacists was seen as a distinct and important trust-enhancing factor:

> *I really like that I can just call or go see [pharmacist's name]. With my doctor you have to go through a receptionist, then sometimes a nurse, then who knows who else and they sometimes forget or lose the message. It's really irritating and it just makes you wonder how good they are if they can't even get their act together around a simple message. I think pharmacists do this so much better than doctors. (P4F44)*

b) Affability

Strong communication skills, a friendly demeanour and simple interpersonal chemistry emerged frequently in these interviews as crucial to establishing and maintaining trust.

> *What I love about [pharmacist's name]—his smile! He gets this twinkle in his eye. I've never seen him not smile and that goes so far in my mind to tell me what kind of a person he is. I feel that if you like someone, well then, you'll listen to them, you'll trust them. I've had other [health care professionals], mainly doctors and they were just so impersonal. Makes it really hard to connect with them. (P3F71)*

Affability emerged as an important trustworthiness factor for pharmacists, particularly within the context of communicating around medication errors:

> *Here's where it really paid off. The pharmacy once gave me the wrong pills—I don't know, some mixup. If I didn't know them and like them, I would have been pretty upset. As it was, I noticed that they gave me something different than I usually get . . . so I called, I spoke to them and because they knew me, they apologized, fixed everything, it was fine. But that's only because you know I knew them, I liked them so it was not problem. (P4M50)*

c) Acknowledgement

Most participants in this study highlighted the importance of acknowledgement—the experience of feeling both listened to and heard—as a foundation for trust with pharmacists and other health care professionals.

> *I would say, in general, in my experience, I think pharmacists are usually better at this than doctors. Pharmacists, they actually do seem to try to listen to you, to what you are saying, better than most doctors do. That's really helpful, really important. (P3F71)*

Acknowledgement of the lived experience of health, wellness and illness was an important cornerstone to the establishment of trust and involved use of active listening, reflective statements and empathy.

> *I mean, it's easy to tell when someone is really, actually, listening to you and hearing what you are saying. Sometimes, it's just lip service and you know it immediately and then it's like, okay why am I bothering with this person. What I like about this pharmacist I see now, she actually looks at me when we talk, she doesn't get distracted or try to put me off. She is so reassuring, the way she describes things, I know she's actually understood what I'm trying to say. (P3F60)*

A particularly important element of acknowledgement for most participants in this study related to the clarity and quality of explanations and not simply providing a formulaic or one-size-fits-all answer to an individual's unique concerns or questions.

> *One thing that drives me crazy—and this happens all the time—is when I'm trying to understand something and you don't get a clear answer. For instance, a few months ago, one of my drugs wasn't available, they were short. [Pharmacist's name], she explained it to me, so well, so clearly, so I could understand why. That's important. Don't just tell me "oh we don't have your medicine." If you explain to me why, then I understand and I know you're actually trying to help me and I trust that you'll be able to fix the problem eventually for me. (P4M50)*

d) Respect

> *I've been going to drug stores for I don't know how long and one thing that's really good now are those little rooms they*

have, so if you need to have a private conversation—well, it was always very strange, I didn't like it, when you'd have all these other people around, in the store, in the line, hearing what you're asking or talking about. This is so much better to have this privacy. (P3F71)

Seemingly small but important concrete markers of respect were identified as very important to establishing trust and to enhancing the pharmacist's credibility as a health care professional rather than simply a merchant. In particular, participants in this study highlighted the importance of privacy and confidentiality in transforming their impression of pharmacies from places of business to places of health care. The offer to move to a private counselling area emerged frequently as an important point at which participants in this study suddenly viewed their pharmacist in a different light—less as a shopkeeper and more as a care provider. This shift was described in terms of respect afforded to the patient being reciprocated as respect for the pharmacist's professionalism in return. Other markers of respect included honesty in communication and use of medical terminology at an appropriate level for patient understanding.

One thing that is so important—why I would say I actually trust my pharmacist sometimes more than my doctor—I don't get the sense the pharmacist is trying to talk over my head with a lot of medical words I don't understand. I can see that she is really trying to be clear and straightforward and respect me, even if I'm not a scientist or a doctor. That kind of respect for seniors like me, it's important. (P5F72)

The trust-enhancing factors identified above were important counterpoints to the trust-diminishing factors identified previously and reflect an important tension within pharmacy practice between things pharmacists themselves can do to enhance trust and structural/systemic issues across the profession that appear less amenable to individual control or management. Data from this study highlight the importance of confirmation bias in pharmacist-patient interactions: participants in this study described a preexisting series of beliefs regarding pharmacists, their roles, their competencies and their skill set. With relatively minimal effort, pharmacists who were accessible, affable, respectful and empathetic were able to challenge these preexisting beliefs and reframe expectations, thereby earning the trust of the patient. This suggests that trust in individual pharmacists is built one interaction and one patient-practitioner relationship at a time, but that over time, it is less clear whether these individual trusting relationships help build a broader public trust in pharmacy as a profession given the tenacity of the trust-diminishing factors described previously. Importantly, and perhaps disappointingly for some pharmacists, data from this study suggest pharmacists should not expect to be implicitly or automatically trusted by patients simply because of their title or degree. Instead, trust will need to be *earned* through positive individual interactions.

Another intriguing finding of this study is the absence of comments by participants regarding technical perfection. Several participants recounted stories of how pharmacists they trusted made dispensing or other errors, and when these pharmacists "handled" the error professionally and efficiently, it actually enhanced their trust in the pharmacist.

Exploratory qualitative research such as this can be useful in signposting future lines of inquiry; it cannot answer questions categorically or make definitive claims. Strengths of this research include the independent double-coding of all transcripts to establish themes and the inductive analytical method used to refine and confirm them. Limitations of this research include the sampling method—as a convenience-purposive sampling method was used, research participants were not demographically representative of pharmacy users, and this limits transferability of findings. Further, the inclusion criteria of a minimum of 6 interactions with pharmacists excluded individuals with less or more episodic contact with pharmacists. While interviews were undertaken to the point of thematic saturation, there were a relatively small number of participants, which further limits generalizability. Nonetheless, as a first step in better understanding how patients psychologically construct "trust" in pharmacists, this research provides a starting point for further exploration of an issue of central importance to the profession and to pharmacists as individuals. In the future, the profession may consider additional research examining this issue in greater depth. A combination of qualitative (e.g., focus groups with patients, observational/ethnographic research) and quantitative research (e.g., surveys) focused on understanding the nature and evolution of trust in pharmacy-patient relationships can help practitioners and the profession as a whole better understand their value and importance to the health care system, as well as help prioritize advocacy, government relations and public outreach programming aimed at enhancing societal understanding of pharmacists and pharmacy practice.

Conclusions

For many years, pharmacists have been fond of saying they are the most trusted of all professionals. The psychology of trust is complex, yet it is essential to the practice of any profession. This research has identified potential barriers and enablers to trust within pharmacy related to structural features of the profession and personal behaviours of pharmacists. Further work in better understanding how to build trusting relationships between pharmacists and their patients is required to optimize health care outcomes. ■

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