Hospital Doctors' Trust Relations at Work: A Multi-Case Analysis

Abstract

In the organizational trust literature low trust and distrust are increasingly seen as two distinct but related concepts. We offer an in-depth analysis of how low domain-specific workplace trust and distrust transitions into high distrust among senior hospital doctors in the UK NHS. Our analysis - informed by psychological contract, trust, and distrust theory - draws on qualitative data from three related studies of doctors in 2015, 2020 and 2023. These data points allow for an examination of senior hospital doctors' experiences over time. Our findings indicate that an exogenous event in the form of COVID-19 created heightened expectations of doctors' being valued and being granted greater autonomy during the early stage of the pandemic. These heightened expectations led to increased trust in the short term but were ultimately interpreted as unfulfilled during the post-COVID-19 period, so turning longstanding feelings of psychological contract breach into violation, high pervasive distrust of the healthcare system itself, and widespread intentions to retire prematurely or scale down their work commitments.

Keywords: Doctors; Distrust; Management; Transition; Trust; Workplace

INTRODUCTION

Research on distrust dynamics is particularly important because it has significant negative consequences for individuals, groups, and organizations (Božič & Keston-Siebert, 2024; Sitkin & Bijlsma-Frankema, 2018; Six & Latusek, 2023). In this paper, we build on the research perspective that considers trust and distrust as conceptually distinct (Lewicki, McAllister & Bies, 1998; Bijlsma-Frankem, Sitkin & Weibel, 2015; Six & Latusek, 2023). Rather than being seen as two ends of a continuum, trust and distrust are sometimes pictured as being orthogonally related. Our starting point is to adopt the classic definition by Lewicki *et al.* (1998) of trust as confident positive expectations that make an actor willing to render oneself vulnerable and take risks. In contrast, distrust refers to confident negative expectations that lead an actor to be unwilling to render oneself vulnerable and instead engage in protective acts or refrain from certain actions (Lewicki *et al*., 1998; Six & Latusek, 2023). Confident positive expectations involve "a belief in, a propensity to attribute virtuous intentions to, and a willingness to act on the basis of another's conduct" (Lewicki *et al*., 1998, p. 439). Conversely, confident negative expectations involve "a fear of, a propensity to attribute sinister intentions to, and a desire to buffer oneself from the effects of another's conduct" (Lewicki *et al*., 1998, p. 439). Research suggests that trust and distrust exist along spectrums, ranging from weaker to stronger forms – weak/low trust to strong/high trust and weak/low distrust to strong/high distrust (Bijlsma-Frankema *et al*., 2015; Lewicki *et al*., 1998).

In their critical review of distrust research, Six and Latusek (2023) identified distinct facets and sequences involving trust and distrust, including pervasive distrust, domain-specific distrust, mistrust, domain-specific trust, and complete trust. Domain-specificity refers to trust or distrust that pertains to a specific aspect of a trusting or distrusting relationship. Pervasiveness refers to

situations where all aspects of the relationship are either fully trusted or fully distrusted (Lewicki *et al*., 1998; Sitkin & Bijlsma-Frankema, 2018; Six & Latusek, 2023). Central to our analysis is Lewicki *et al.*'s. (1998) proposition that trust and distrust can coexist in working relationships, which has received both theoretical and empirical support (Six & Latusek, 2023). Notably, Lewicki *et al*. observed that within working relationships, different levels of trust and distrust can coexist. They offered a framework of four cells, ranging from the simultaneous existence of low trust and low distrust to high trust and high distrust. However, Six & Latusek (2023, p. 16) call for future research to explore "when does a relationship between actors that is in one [trust/distrust] sequence move to the other [trust/distrust] sequence? How does this happen?" Our empirical study extends prior research on distrust by analysing how low forms of distrust/trust transitioned into high trust/low distrust and how this situation eventually transformed into working relationships characterised by high distrust.

Despite, as noted by Six & Latusek (2023), the lack of research explaining transitions between trust and distrust and vice versa, a few studies do shed light on how trust can turn into distrust (e.g., Bijlsma-Frankema *et al*., 2015; Sitkin & Roth, 1993). Central to these studies is the assumption that trust transforms into pervasive distrust through a punctuated shift involving a tipping point. This research suggests that trust only transforms into distrust when context-specific value incongruities between the trustor and trustee become generalised. Recent research by Hurmelinna-Laukkanen, Niemimaa, Rantakari, & Helander (2023) supports the notion of a tipping point and the role of value incongruence in the trust-distrust transition. Although this value-incongruence is helpful, much of what we currently know about the transition from trust to distrust is conceptual and requires empirical testing.

To address the need for empirical research we draw on a revelatory case (Yin, 2009) from the NHS in Scotland. Over time we were able to study low domain-specific distrust/trust transitioning to a relatively high trust/low distrust stage, but which subsequently evolved into a to high form of pervasive distrust. This revelatory case was a three-phase analysis of senior hospital doctors' experiences over an eight-year period in NHS Scotland in 2015, 2020, and 2023. The focus of the current paper is on the qualitative analysis of open-ended, often extensive, text data from each survey (n1=430; n2=190; n3=900). These text data was especially revealing in showing how trust transitioned into distrust between these senior doctors and their leaders in NHS Scotland. Our data and insights from the psychological contract literature (Conway & Briner, 2009; Rousseau, 1989) show how largely trustful relationships can transform into stronger forms of distrust when there is a previous history of low trust relationships within the organization. In the third phase we detected a transition from relationships characterised by relatively high trust during COVID-19 to relationships of stronger distrust post-COVID. Valuing and granting autonomy to many senior doctors during the pandemic triggered expectations among them that were rapidly interpreted as unfulfilled, which turned longstanding accounts of psychological contract breach into violation and perceptions of a lack of hope that matters would improve in the future. Such distrust manifested itself in widespread intentions to retire prematurely and/or scale down their work commitments, which have significant implications for the functioning of healthcare in the NHS in Scotland.

To our knowledge, this is one of the first empirical studies to investigate such transitioning in the context of employer-employee settings. We firstly contribute to the literature on distrust (Lewicki

et al., 1998; Sitkin & Bijlsma-Frankema, 2018; Six & Latusek, 2023) by showing how a persistent low domain specific trust and distrust creates the conditions for a tipping point, theorised by other distrust scholars (e.g., Bijlsma-Frankema *et al*., 2015; Six & Latusek, 2023), that triggers distrust. Secondly, we contribute to the distrust literature by showing that a distrust dynamic will be set in motion when: (a) there is a perceived commitment by employees that a previous situation of low trust relationships within the organization will be explicitly transformed, (b) when that commitment is perceived by employees to be both explicit and valued by them, and (c) the transition from trust to high distrust will be triggered by employees' perceptions of significant violation of the commitment to transform the situation.

TRUST AND DISTRUST RELATIONS

One perspective in trust research considers trust and distrust as two ends of the same continuum, with distrust at one extreme and high trust at the other (e.g., Deutsch, 1958; Mayer, Davis, & Schoorman, 1995). Trust is commonly defined in terms of the trustor's willingness to be vulnerable and positive expectations (e.g., Mayer *et al*., 1995; Rousseau *et al*., 1998). In this context, low trust, mistrust, and distrust were often considered synonymous (Mayer *et al*., 1995), leading to a lack of differentiation between the antecedents and consequences of trust and distrust (see Six and Latusek, 2023). Similarly, high trust was associated with positive outcomes such as increased productivity and commitment, enhanced cooperation, greater employee and customer satisfaction, and improved societal functioning (Luhmann, 2017), while distrust was explicitly or implicitly linked to a lack of such outcomes. A second perspective challenges this view and demonstrates that trust is conceptually distinct from distrust (e.g., Bijlsma-Frankema *et al*. 2015; Lewicki *et al*., 1998; Sitkin an& d Roth, 1993; Sitkin & Bijlsma-Frankema, 2018; Dimoka, 2010; Kostisl*et al*.,

2022). This second perspective is becoming more accepted by trust researchers, receiving theoretical (Lewicki *et al*., 1998; Sitkin & Roth, 1993; Sitkin & Bijlsma-Frankema, 2018) and empirical support (e.g., Bijlsma-Frankema *et al*., 2015; Benamati, Serva & Fuller, 2010; Dimoka, 2010; Saunders, Dietz & Thornhill, 2014).

Within the second perspective, there are two distinct approaches to distrust. Some scholars argue trust and distrust cannot coexist (e.g., Sitkin & Roth, 1993), while others suggest they can coexist (e.g., Lewicki *et al*., 1998). The first group posits that the coexistence of trust and distrust is impossible because distrust is conceptualised as pervasive (Bijlsma-Frankema *et al*., 2015; Sitkin & Roth, 1993). This view implies that there are no domains of action free from distrust as distrust is seen as "an all-encompassing negative lens through which distrusted others are perceived" (Sitkin & Bijlsma-Frankema, 2018, p. 52). Consequently, there is no room for trust in its presence. In contrast, the second group of scholars (e.g., Lewicki *et al*., 1998; McKnight & Chervany, 2001; Saunders, Dietz & Thornhill, 2014) believes that while trust and distrust are conceptually distinct, they are domain-specific and thus independent of each other (i.e., they can coexist). They argue that ambivalence within working relationships is common, allowing for both trust and distrust to be simultaneously high or low in the same relationship. For instance, an individual might have confident negative expectations about another actor's ability in one domain while maintaining confident positive expectations in another domain of their relationship. Lewicki *et al*. (1998) proposed a model outlining four constellations of coexisting trust and distrust in working relationships: low trust/low distrust (cell 1), high trust/low distrust (cell 2), low trust/high distrust (cell 3), and high trust/high distrust (cell 4).

Although both views have received some theoretical or empirical support, their relative contributions to organizational trust research remain unsettled, especially over whether they apply to different contextual conditions and in addressing trust-distrust transitions.

Transitioning from Trust to Distrust

Distrust researchers theorised the transition between trust and distrust using 'punctuated threshold' models (e.g., Sitkin & Roth, 1993), illustrating that the transition is 'punctuated' once the tipping point or value incongruence threshold is reached (Sitkin & Bijlsma-Frankema, 2018). During the initial stage, there is a linear relationship between antecedents and trust, and a violation in one domain that reveals context-specific value incongruency does not extend to the other (Bijlsma-Frankema *et al*., 2015). However, once the tipping point is reached (i.e., context-specific value incongruencies accumulate over time), the parties enter the second stage characterised by nonlinear, disproportionate reactions to violations (Bijlsma-Frankema *et al*., 2015). In other words, the trustor transitions from low trust to distrust in a punctuated manner once a threshold of value incongruence is surpassed (Bijlsma-Frankema *et al*., 2015; Sitkin and Roth, 1993). For instance, in their case analysis of the emergence and development of intergroup distrust in a court of law (between judges and administrators), Bijlsma-Frankema *et al*. (2015) theorised that perceptions of core value incongruence triggered distrust between judges and administrators when a threshold level of value incongruence was exceeded. Importantly, the punctuated threshold models assume that the tipping point is reached when individual and context-specific value incongruities accumulate and reinforce each other. Nonetheless, most of what we know about transitioning from trust to distrust is conceptual. Bijlsma-Frankema *et al*. (2015) acknowledge that their study fails to test the transitioning from trust to distrust involving punctuated switch and vulnerability

threshold because they entered the research settings when distrust was already there. Hurmelinna-Laukkanen *et al*. (2023) examined how new technology deployment can unintentionally impact control and trust dynamics, revealing a pattern of distrust like that identified by Bijlsma-Frankema *et al*. (2015). They found that InfoSec experts in financial organizations initially had positive expectations about the new technology, but as they became more aware of privacy risks their perceptions turned negative. This growing concern, which differed from other groups in the organization, led to internal value conflicts and collective resistance. This resistance marked a tipping point, shifting their trust to distrust as they rejected the associated vulnerabilities.

PSYCHOLOGICAL CONTRACT THEORY

As we noted, much of the trust-distrust literature is framed in terms of frustrated expectations. An important analytical framework that helps explain such expectations in an employee-employer context is the psychological contract (Rousseau, 1989). Psychological contracts surround the unwritten expectations and obligations between employees and their employers (Robinson, 1996). They have been applied in many work contexts, including healthcare (Collins & Beauregard, 2020; Topa, Aranda-Carmena & De-Maria, 2022). Researchers have explored the consequences of unmet expectations and perceived breaches in contract, suggesting that such breaches can lead to reduced trust (Conway & Briner, 2009). A key element in the unmet expectations argument is that psychological contract breach is a subjective experience whereby employees perceive their employer has failed to fulfil promised (explicit and implicit) obligations (Rousseau, 1989). Fundamentally, there are two root causes of perceived psychological contract breach: reneging and incongruence (Robinson & Morrison, 2000). Reneging is failing to fulfil a known obligation,

whereas incongruence involves a disconnect between different actors' expectations resulting in misunderstandings and frustrations.

The psychological contract, in contrast to formal employment contracts, is not a one-time agreement; rather it evolves over time and is based on an employee's experiences within the organization (Knapp, Diehl & Dougan, 2020; Rousseau, Hansen, & Tomprou, 2018). Rousseau *et al*.'s (2018) dynamic model proposes that over time there are various disruptions to the employment exchange and, depending on their nature, these disruptions can induce positive and negative reactions (Rousseau *et al*., 2018). The longer an employment relationship lasts, the broader the array of expectations might be included in the contract (Robinson & Rousseau, 1994).

Trust is central to the psychological contract and has been studied as an antecedent, a correlate, and consequence (Guest & Clinton, 2011). Psychological contracts rely on reciprocal trust that the different parties involved will fulfil the agreement (Conway & Briner, 2009). In a longitudinal study, Robinson (1996) found that levels of trust influenced perceptions of whether a breach had occurred and the reactions to breach. An employee with previously low perceptions of trust in an employer is more likely to seek, find, and recall incidents of breach, even though there is no objective breach, because it is consistent with their low expectations. The reverse also applies - employees with high prior trust will be less likely to perceive a breach when one occurs (Robinson, 1996). Drawing on a large sample consisting of 3109 employees from across seven countries, Guest and Clinton (2011) found that perceptions of both trust and fairness of treatment were significantly associated with higher levels of satisfaction and organizational commitment and lower levels of work-related anxiety and intention to quit. The moderation analysis indicated that

trust had a significant, albeit modest, impact on the relationship between the content of the psychological contract (measured by the number of promises made) and job satisfaction, organizational commitment, and reduced intention to quit. Studies focused on the consequences of psychological contract breach have also confirmed that breaches are associated with lower trust (Topa *et al*., 2022).

Violation and Employee Distrust

The psychological contract literature draws a distinction between breach and violation, based on factors such as intensity and emotional reaction (Robinson & Morrison, 2000). A psychological contracts breach occurs when one party feels that key promises have been broken, or perceived obligations are unmet leading to feelings of dissatisfaction, frustration, and disappointment (Conway *et al.*, 2011). However, such breaches do not necessarily lead to a violation, which refers to intense negative emotional reactions resulting from one party feeling betrayed by the other's actions (Rousseau, 1995; Topa *et al*., 2022). Responses to perceived violations of psychological contracts were deeper and more intense responses, akin to anger and moral outrage (Rousseau, 1989).

A strong relationship has been found between violations and reduced trust (Henderson and O'Leary-Kelly, 2021). Research has linked violations to the generation of distrust, dissatisfaction, and a desire to leave an organization (Robinson & Rousseau, 1994). Thus, Rani, Arain, Kumar & Shaikh (2018) propose that psychological contract breaches could be an antecedent to distrust because a negative previous psychological contract breach is likely (when combined with an emotional response) to result in negative affect, for example, distrust. The link between

psychological contract breaches and distrust is further supported by the negative emotions surrounding the concepts (Piccoli & De Witte, 2015). Feelings of unfairness have been related to negative emotions such as doubt or anger (Harth & Regner, 2017), which are foundations of distrust. Moreover, when expectations are not met, this can lead to cynicism reflected in an expression of distrust (Andersson & Bateman, 1997). Tomlinson and Lewicki (2006) maintain that distrust is expected to increase based on the magnitude of its violation, the number of past violations, and the perceived intentionality behind those violations.

CONTEXT: NHS SCOTLAND AND SENIOR HOSPITAL DOCTORS

The UK National Health Service (NHS), a publicly funded healthcare system founded on the principles of providing universal, high-quality health care, is becoming an increasingly challenging environment with the rising cost of care, the expanding scope of treatments, and increased demand (Thomas & Chalkidou, 2016). In the decade prior to 2020 there was little growth in real terms in UK healthcare spending, despite an increasing demand for services due to population growth and an aging population (Gainsbury & Appleby, 2022). During this period, there was political support towards engaging clinicians, in particular senior doctors, in leadership roles (Veronesi, Kirkpatrick & Altanlar, 2015). However, research has observed the tensions and struggles encountered by doctors in their efforts to navigate their roles as both leaders and followers - highlighting the gap between the recognition of leadership importance and the struggle to grant leadership identities to medical leaders (Howieson, Bushfield & Martin, 2024).

NHS Scotland (NHSS) is one of the four regional healthcare systems making up the NHS. It has been described as a system in crisis (Mooney & Barnes, 2022), with COVID-19 putting further

pressures on the system. Moreover, the pandemic significantly impacted upon the physical and mental health of clinicians, leaving many exhausted and disillusioned (BMA, 2022). The findings from the 2023 British Social Attitudes Survey (Jefferies *et al*., 2024) reported the overall satisfaction rate with the NHS has declined to 24% from 70% in 2010. Additionally, 84% of respondents agreed that the NHS has a major or severe funding problem. These figures suggest that the public is losing faith in the NHS and radical change and reform will be needed to overcome the challenges facing NHS Scotland. This call for radical change has been echoed by senior clinicians on many occasions (BMA, 2022). It is against this backdrop that our studies with senior doctors took place.

METHODOLOGY

Multi-Case Design

We conducted a multi-case analysis of three sets of survey data collected - in 2015, 2020, and 2023 (see table 1 for overview of cases). Each survey sample was from the same population – consultants (senior hospital doctors) from all specialisms in NHS Scotland. Due to constraints on conducting research during COVID-19, data collection for case two was limited to one major NHSS Board, while for cases one and three data were gathered from across NHSS. Although this may be viewed as a limitation, it is important to note that the 2020 survey had a high response rate (56%) with most respondents answering either one or both free-text questions. Moreover, the study conducted in 2023 showed no significant differences between Boards in doctors' responses to the survey. So, in line with the advice on multiple case selection (see Yin, 2009; Eisenhardt & Graebner, 2007), it was anticipated that the broad context and antecedents influencing trust relations between doctors and managers would be similar across the cases. The selection of the

three cases based on time for comparative analysis was guided by our interest in the trust/distrust transition process. Moreover, the inclusion of the representative 2020 case allowed us to explore the role of a disruptive episode (COVID-19) within this process (Langley, 2021).

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The surveys had a core of shared questions (Likert items linked to variables such as work engagement, burnout, clinical team and organizational identification, and medical leadership), and all three included qualitative open response questions asking participants to elaborate and explain their responses. Case one, the 2015 survey was completed as part of a wider mixed-methods study into senior doctors' experiences of work. The survey included 53 structured questions, six demographic questions and one open text question asking for the respondents to tell us about their experience of working as a consultant in Scotland. Case two, the 2020 survey focused on medical engagement and professional identity in the case health authority. This survey contained 54 structured questions, four demographic questions and two open-text questions which asked for (a) comments on their experiences of work and (b) their reflections on and lessons from the first phase of COVID-19. Case three, the 2023 survey, again explored doctors' experiences of work but had a focus on intentions to retire. It included 73 structured questions, six demographic questions and two open-text questions asking for (a) explanations of their views and (b) potential solutions. Each online survey was distributed to the target population of consultants via an email containing a web link. The results provide cross-sectional data at three points in time from senior doctors in NHS Scotland.

The focus of the current paper is on qualitative analysis of the useable open-text responses from each survey (n1=430; n2=190; n3=900). Responses ranged from a few sentences to more substantial responses comprising of several lengthy paragraphs. Answers simply stating 'no' or similar, 'together with those mentioning survey design were removed from the samples cited. These unstructured questions gave large samples of senior doctors the opportunity to provide authentic feedback, give voice to their views, and explain the 'why' underpinning their responses, so helping us to gain a more nuanced understanding of their experiences (Allen, 2017). Together the open responses from the three surveys provide a substantial data set for qualitative analysis (totalling 115,805 words). Analysing the free-text responses we aimed to thoroughly understand the nature of the cases in question and to provide analytically generalizable findings which could inform theory surrounding trust and distrust within employee-manager-employer relations in professional contexts (Eisenhardt & Graebner, 2007; Yin, 2009). To ensure the validity and reliability of the research in addition to free text responses we also draw on secondary data sources of key contextual elements for each period (Yin, 2009; Flyvbjerg, 2006).

Data Analysis

The inductive within-case analysis completed directly following data collection identified trust dynamics as a second-order theme in each study. Consequently, the second wave of analysis involved embarking on iterative cross-case analysis, guided by Eisenhardt (1989) and Eisenhardt and Graebner (2007), to examine trust dynamics in depth. We analysed the data to identify any trust/distrust sequences and transitioning processes across our dataset. Our approach parallels Eisenhardt's (1989) methodology, wherein extensive construct tables were used to demonstrate that the data 'contains' the phenomenon we aimed to explain. First, we condensed the qualitative

data from each case into a comparator construct table focused on their experiences with senior leaders, clinical leaders, and the organization. We then coded the data from each case, focusing on instances of trust and distrust by using known antecedents of trust (ability, benevolence, and integrity) and distrust (value incongruency, disidentification, negative reciprocity and desire to exit) (Mayer *et al*., 1995; Sitkin & Bijlsma-Frankema, 2018). Each author analysed one case and then the remaining two authors reviewed the coding - discrepancies were discussed and a consensus reached. Evidence tables were produced to display key trust/distrust data for each case. We then drew insights from the psychological contract literature (Conway & Briner, 2009) to examine the senior doctors' experiences with the specific goal of uncovering the processes that led them from trust to distrust.

RESULTS

Our within case analysis of the 2015 data revealed that doctors felt significantly deprofessionalised through reduced autonomy and status. They also expressed low trust and low distrust in their NHS employers, senior leaders, and medical leaders, often associated with the increasingly complex institutional logics governing healthcare in Scotland. In the 2020 case, collected amidst the first phase of the global pandemic, we sensed an increase in trust towards clinical leaders, the senior leadership team, and NHS Scotland as a system. This increase in trust stemmed from senior doctors being granted greater autonomy over patient care, improved collaborative working, greater autonomy over how they organised their work, and greater recognition by the public, senior leaders, and other healthcare workers of their professionalism and contribution to a national emergency. It also represented a period of hope and optimism that lessons learnt during COVID-19 would be continued in the longer term. This hope was supported by a renewed sense of 'calling'

among doctors. The final 2023 case analysis provides a contemporary and reflective perspective among doctors. We observed a growing sense of confident negative expectations, frustration, and disillusionment among many doctors, which led to their disidentification with their employers and, in some cases, a reduced sense of calling, career orientation and burnout. Moreover, we now observed stronger distrust among doctors of their clinical leaders, senior managers, and the NHS system. In our cross-case analysis we became particularly interested in exploring and explaining the transitions from Phase 1: Low Trust/Low Distrust to Phase 2: High Trust/Low Distrust to Phase 3: High Distrust/ Low Trust. We present our results for each phase and then introduce our emergent theoretical framework - explaining the transition by drawing on psychological contract theory.

Phase 1: Low Trust/ Low Distrust

Our analysis of the 2015 phase one data suggested senior doctors felt low trust alongside low distrust in their senior managers, clinical leaders, and the organization (see table 2). This low trust/distrust dynamic reflects Lewicki *et al.*'s (1998) cell one and was characterised by feelings of mistrust and suspicion but lacking either confident positive or negative expectations (Six & Latusek, 2023). Such feelings among doctors were accompanied by widespread expressions of deprofessionalisation, often associated with perceived tensions between increasingly pervasive bureaucratic, financial, and political logics affecting their employers and their traditional medical professionalism.

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Some respondents believed most clinical leaders and senior managers were *well intentioned*, supportive and had a difficult job managing doctors with specialised expertise, diverse opinions and competing needs within the context of limited resources. However, a majority articulated concerns about the integrity of managers, which reflects domain-specific value differences between doctors focused on patient care and managers guided by financial objectives. These value differences signalled low distrust and/or low trust of managers motives. Respondents expressed frustrations surrounding the negative clinical consequences of government targets, often proposing there was too great an influence of political priorities on senior doctors' decisions leading to stagnation (see Q1, table 2). Others focused on the perceived dishonesty of clinical and non-clinical managers – arguing that they are only interested in *targets and money nothing else* (Q2). In table 2, Q3 echoes these sentiments noting that there is a disconnect across the system between clinical priorities and short-term political goals. The statement below highlights many doctors' beliefs about the consequences of targets:

> *"…unrealistic targets set by governments in constrained financial circumstances has led to a shift towards employing more non-clinical staff to come up with ways of meeting targets rather than employing more clinical staff to treat patients in order of clinical priority."*

This representative quote, along with those in the first section of Table 2, suggests that in the pre-COVID-19 period a dynamic characterised by low trust/ low distrust focused on a specific aspect of respondents work relationships with senior or clinical managers. In the above quote, domain specificity refers to issues surrounding the target culture. Other, integrity-related domains raised

included views concerning the over-regulation of the medical profession compared to a lack of regulation of managers.

Lack of benevolence was also a common theme in our analysis of case one. Frequent among these were beliefs concerning senior managers and clinical leaders' lack of care and compassion towards doctors and patients. For example, Q4 (Table 2) suggested that senior managers did not know their staff and were detached from doctor's daily work, which was interpreted by doctors as a lack of care. Q4 is fundamentally about a specific aspect of senior management, suggesting that there was no pervasive distrust in senior management because some respondents noted that there were "*some good managers*" and their comments point to specific domains of work relationships. Q5 noted feeling "*let down*" by medical managers. Several doctors commented on bullying behaviour, and with a minority proposing "*bullying culture*" existed in their organizations (Q6, Table 2). These beliefs led doctors to express their frustrations with the system and wariness of managers (e.g. feeling let down and having low expectations). However, negative beliefs were often accompanied by more positive observations about their wider working environment or by cautious optimistic suggestions about the future. Nonetheless, it was clear that these negative experiences had weakened the fundamental tenets of their trust relations with managers, resulting in low distrust/low trust in specific domains.

Several senior doctors in the study complained of micromanagement, claiming that managers did not trust their professional judgement:

> *"[The] constant mistrust and micromanagement demonstrated by over management of clinics, PA's, annual leave, etc., is depressing."*

The value conflicts mentioned previously, together with this perceived micromanagement and its consequences for autonomy, contributed to doctors' expressions of deprofessionalisation. Some respondents suggested that navigating these value differences would involve empowering doctors to take the lead and initiate change.

Nevertheless, despite the low trust dynamics between senior doctors and managers, doctors did voice their support for the principles of the NHS, expressed their pride in being part of the medical profession, and acknowledged that tough decisions have to be made (see Q6, Q7 and Q8). Notwithstanding, several respondents queried the ability of senior, mostly non-clinical, managers to manage effectively:

> *"The NHS now tends to be run be managers unqualified for the job or not qualified at all."*

> *"Managers vary dramatically in ability …because of often unreasonable demands on them we lose the most able to other organizations."*

The first quote draws attention to the beliefs about the high levels of competence between doctors, who regarded themselves as highly trained professionals, and the low levels of competence of non-medical managers who were seen to lack the skills and ability to manage. The second quote highlights the pressures that many non-clinical managers face concerning their legitimacy in the NHS face, suggesting these pressures lead some good managers to leave. Most comments related to ability were again domain specific. For instance, in Q7 (table 2) the distrust domain specificity surrounds senior manager's lack of understanding of frontline work and their inability to manage workload. Alternatively, Q9 suggests low domain specific trust as evidenced through their

confidence in the patient safety focus of NHS Scotland, but it also shows signs of low domain-specific distrust in relation to concerns about bureaucracy and the disconnect between manager's understanding and doctors' knowledge of clinical need. Others took a more critical view, with one respondent suggesting that:

> *"Underfunding has resulted in a failure to advance services into the 21st century resulting in big outcome gaps when compared to the rest of the developed world.*

To sum up, our phase 1 analysis shows that senior doctors considered their (mostly non-clinical) managers to lack benevolence, integrity, and, importantly, ability. However, we contend these perceptions, beliefs and expectations were attributed by doctors to be typically associated with specific aspect of their relationships with different types and characteristics of leaders in NHS Scotland. In other words, senior doctors' reduced trust/ low distrust was not generalised across all aspects of the relationships with their leaders. We propose that feeling "let down" in these domains represent minor breaches of the doctors' psychological contract, which developed over time and resulting in doctors increasingly lacking in trust and/or showing domain specific aspects of distrust. Despite this breached contract, we also observed some hope for the future and an acknowledgement that managers had a difficult job to do under increasingly difficult circumstances in a healthcare system under stress.

Phase 2: High Trust and Low Distrust Triggered by COVID-19 Experience

The events of COVID-19 appeared to cause a break in the low trust/ low distrust dynamic. Our analysis of the 2020 case data allows us to theorise that the increased workloads and risk exposure caused by the COVID-19 pandemic led to a disruption of doctors established psychological

contracts. However, this was a disruption that many were willing to bear, especially at the outset because they experienced an initial period during the pandemic when they also sensed greater autonomy over patient care, how they organised their work, and greater recognition by the public, senior leaders and other healthcare workers of their professional worth. In this second phase respondents attested to their voices being heard and being trusted by managers to enact change (see Table 3, Q10). In response, many doctors believed this new phase showed high hopes for future form of reprofessionalisation. Importantly, doctors did not express cynical or sceptical views, which typifies a low distrust relationship (Lewicki *et al*., 1998). Accounts also reflected increased trust in their senior leadership team, clinical leaders, and the NHS system. The extract below (see also Q11) illustrates how doctors experienced greater trust and support from managers and the system enabling them to make effective changes for patients:

> *"During COVID-19 it was refreshing how quickly changes were facilitated and how efficiently things were done. The whole attitude in the hospital changed and there was a real 'can do' attitude. Clinicians and departments were able to come up with realistic solutions to potential problems and these were taken on board and acted upon, this was a stark contrast to the normal extremely slow pace of any changes within the NHS system and is a real positive to come out of an otherwise very stressful and serious situation."*

The above quote also attests to doctors sensing a 'can do attitude' and effective 'clinically led' change, which reflected positive views of the competence of the organization, its benevolence in enhancing collaborative working, and being listened to by senior managers. However, we found little direct mention of managers integrity during this phase, although we consider the references

to benevolent behaviours and the trust of managers in doctors during COVID-19 as good evidence that their values were more aligned during the crisis than in the previous phase.

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The clinically led nature of change was a feature of several participants accounts. This was accompanied by an increased sense of hope, confidence and optimism that the service would continue being clinically led in the future (Q12 and Q13, Table 3), so heralding the potential for the 'reprofessionalisation' and a renewed sense of 'calling' among doctors in contrast to the previous decade of deprofessionalisation most doctors claimed to have experienced.

> *"The crisis situation also enabled much more collegiate culture between different teams, so this positive effect of the COVID-19 experience needs to be encouraged beyond the pandemic."*

Positive beliefs concerning ability and benevolence of senior leaders, clinical leaders, and the system itself attested to increased levels of perceived trustworthiness (Mayer *et al*., 1995). The quote below emphasises these perceptions:

> *"It is possible to engage whole clinical teams and make rapid but appropriately managed changes to clinical practice. We must remember how the whole organization worked together, and senior management engaged with staff across all disciplines and take that forward into the future."*

In summary, our analysis of the phase 2 data indicates that during the initial stage of the COVID-19 pandemic, trust relations between many doctors and their employers improved markedly. Our comparisons of this period with data from phase 1, show improved trust was driven by heightened beliefs of senior management's ability, benevolence, and integrity. For example, before COVID-19 many doctors believed that senior managers were unable to make effective decisions and manage workflow properly; in contrast, during COVID-19 they were as effective leaders, able to minimise the effects of the bureaucratic logic. Thus, we suggest the crisis created a positive disruption (Rousseau *et al*., 2018) to doctors' psychological contracts. This disruption led them to develop a renewed sense of 'calling' and new/revised contract expectations concerning increased autonomy and collegial working to effect meaningful change going forward.

Phase 3: Emergence of High Distrust and Low Trust

The final 2023 case analysis unveils expressions of burnout and a growing sense of frustration among many doctors, which led to their disidentification from their employers and, in some cases, a reduced sense of calling and career orientation (see table 4). Doctors' accounts were littered with expressions of cynicism, scepticism, hopelessness, lack of confidence, and passivity toward managers, senior leaders, and the health system, all of which are typical of high distrust and low trust in working relationships (see Lewicki *et al*., 1998). Thus, we argue our data shows a transition from relatively high trust towards high distrust in leadership co-existing with low trust in their professional environment and in the NHS being able to function effectively to meet increased patient demand.

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Insert Table 4

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Respondents expressed frustration with (the return to) autocratic decision-making by senior leaders:

> *"Terrible culture in top level managers in NHS [Board] with autocratic decision making, ignoring the voice of physicians."*

The quote above shows how doctors believed they had lost their voice and autonomy, in contrast to the gains made during the pandemic. These beliefs were further emphasised by Q23 (Table 4). The reference to having to *"fight against moronic managerial decisions"* also sets out negative expectations concerning the 'ability' of senior leaders as it suggests that their decisions are illogical, not well thought through, and potentially harmful to patients. This perceived lack of 'ability' was common across multiple domains including the government, senior management, clinical leaders, the system and its facilities. Several respondents saw their previous faith in clinical leaders' abilities being challenged by their leader's recent behaviour (Table 4, Q24). Respondents suggested that the perceived lack of support from clinical leaders has led to a strong negative reaction with deep dissatisfaction and low morale across the clinical team – reflective of the notion of negative reciprocity discussed in the distrust literature (Sitkin & Bijlsma-Frankema, 2018). Moreover, further comments suggest that the NHS as a system was failing due to mismanagement and bureaucratic structures:

> *"I'm disgusted by the mismanagement of the NHS."*

> *"It is frustrating that the pace of change seems to have changed from being agile/dynamic to almost stationary!"*

The negative emotional response of 'disgust' in the first statement above aligns with feelings of disidentification. Alternatively, the second quote highlights doctors' frustration that the barriers, which had been removed during Covid-19 to facilitate clinical led change, had remerged to produce inactive and inefficient change. Moreover, after successful careers in the NHS many senior doctors alluded to their sense of disillusionment and disidentification with the organization, stating that they were no longer proud to work for the NHS, often expressing a desire to leave the organization:

> *"We were proud of the NHS when we qualified but are now waiting to see it implode and want to get out as soon as we can afford to do so."*

The above use of 'implode' reflects an emotional lack of hope and confident negative belief that the NHS is broken and is experiencing intense pressures due to insufficient resources and feelings of frustration, scepticism and burnout amongst doctors, nurses, and allied health professionals. Q25's assertion: "*I have little incentive to work in a failing system"* (Table 4) emphasises the dire state and all-encompassing nature of negative emotions surrounding their recent experiences of work. Several respondents also observed there was no strategic plan or vision for recovery and a lack of appetite for the radical change required to revitalise the NHS. Together these factors led most respondents lacking hope and expressing a desire to retire before their typical pension age, with several stating that they wanted to leave sooner rather than later. Desires to leave and/or reduce their work time were motivated by several factors –three important motives were (a) to avoid pension tax penalties, (b) to escape a failing system, and (c) to achieve greater work life

balance. Comments also revealed the development of high distrust in the government and in politicians to work in the interest of patients and clinicians.

Value incongruencies (an important antecedent of distrust) were prevalent in comments relating to managers and the organization. In phase 1 such value differences tended to be less common and limited to fewer domains – such as the suggestion that managers were focused only on money while doctors where focused on patient care. However, by phase 3 we found a significant gap in values had emerged, encompassing multiple domains and various aspects of the organization:

> *"The values of the NHS are no longer those of myself and I suspect a large minority of doctors."*

> *"Coming into the organization from outside, I was struck by how arrogance, laziness, and aggression are rewarded by status and financial gain within NHS [Board], while hard work, compliance and collaboration are not. I think we're in such a deep hole that I can't really see a way out."*

Our analysis suggests doctors were feeling disenfranchised, significantly more so than pre-COVID-19. We found evidence that doctors perceived a lack of integrity and benevolence amongst their managers and the wider NHS culture. Several of the comments referred to systemic bullying and toxic culture (Table 4 - Q17, Q19 and Q20), which was affecting the mental health of doctors (Q20) and harming patient care (Q18). It was suggested that doctors were not being listened to and if they raised concerns, they were accused of being difficult and overly emotional. The word

duplicitous in Q17 evidences a belief that managers were dishonest and two-faced – pretending to care but not following this through with actions: This is further illustrated in the following quote:

> *Just had enough listening to the same lies and reading fiction in the form of clinical strategies that no health board had ever achieved.*

Such evidence leads us to conclude that this more generalised value incongruency and deception represented psychological contract violations, which are reflected in the respondents deep emotional responses to the situation including a reduction in hope and a desire to leave the organization. Q21 and Q22 reflect doctors' disappointment that past effort and dedication (especially during COVID-19) was not being valued by their employers The data suggested distrust had emerged due to a lack of transparency around decisions and a sense that promises made during COVID-19 have been broken (lack of integrity). Moreover, a lack of benevolence and support from clinical and senior leaders had resulted in a lack of hope and, in some cases, reduced sense of 'calling' amongst doctors.

The phase 3 data stand in marked contrast with the phase 2 data. We observed a transition from high trust/low distrust working relationships during the early stages of the pandemic towards high distrust and low trust due to perceived and pervasive contract violations, which appear to be heightened given the increase in doctors trust and psychological contract expectations built during the pandemic. We found evidence that COVID-19 had made the 'promise' that things would not return to a pre-COVID-19 situation of deprofessionalisation more explicit, and that doctors attached a great deal to this promise, which made the sense of injustice more acute leading some doctors to take a more active approach to quitting the system. Our data suggested a lack of hope

for the future, scepticism, cynicism and disidentification with the organization and the NHS system.

DISCUSSION

This paper addresses the question posed by Six and Latusek (2023: 16) in their critical review of the distrust literature: "When does a relationship between actors that is in one [trust/distrust] sequence move to the other [trust/distrust] sequence? How does this happen?" Additionally, it builds on and extends distrust research that considers trust and distrust as conceptually distinct, exploring whether they are mutually exclusive or can coexist (e.g., Lewicki *et al*., 1998; Bijlsma-Frankema *et al*., 2015; Six & Latusek, 2023). Our study shows how low trust/distrust in working relationships can evolve into high trust/low distrust, and conversely, how a state of high trust/low distrust can shift to high distrust/low trust.

Previous research presented two contradictory views on distrust as a concept distinct from trust. Some researchers argued that distrust and trust cannot coexist, while others suggested they are independent concepts that can coexist in working relationships. The former group typically based their argument on the pervasiveness of distrust, while the latter built on the assumption of multifaceted relationships and ambivalence. Our analysis supports the notion that trust and distrust are conceptually distinct but, importantly, that they can coexist. This is an important contribution, since the debate concerning the coexistence of trust and distrust remains unresolved (see Sitkin & Bijlsma-Frankema, 2018; Six & Latusek, 2023). Our data show, in most cases, that distrust was domain-specific rather than pervasive, which would preclude the simultaneous existence of distrust and trust. The distrust identified in this study related to different facets of working

relationships involving integrity, values, and benevolence, further supporting the trust-distrust coexistence argument. This aligns with research that considers trust and distrust as distinct but independent constructs and contradicts research that primarily views distrust as resulting from generalised value incongruence (e.g., Bijlsma-Frankema *et al*., 2015).

The primary contribution of this study lies in its implications for the trust to distrust transition literature in workplace settings. To our knowledge, this is one of the first empirical studies to investigate this transitioning in the context of employer-employee settings. We believe our data shows how workplace trust can transform into distrust. We argue distrust involves the trustor's unwillingness to be vulnerable and in not only attributing pervasive negative perceptions and expectations regarding key individuals or social groups such as leaders to their organizations (e.g., Lewicki and Tomlinson, 2003), but also to the sector or ecosystem in which these leaders and organizations are embedded. Figure 1 sets out our emergent theoretical framework. Using the lens of psychological contracting (Conway & Briner; 2009; Rousseau *et al*., 2018) and drawing on prior distrust research (e.g., Lewicki *et al*., 1998; Bijlsma-Frankema *et al*., 2015) we showed how and why low distrust/trust transitioned in relatively high trust working relationships that in turn transitioned into high distrust.

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Insert Figure 1 here
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We found that during the early stages of COVID-19, doctors interpreted the increased autonomy and public prestige they enjoyed as evidence of a hopeful future and that their sense of a gradual

trajectory of deprofessionalisation (including feelings of a lack of autonomy and declining prestige) prior to COVID-19 might have 'turned a corner'. Much of the commentary in the case conducted in 2020 expressed positive emotions, opinions, and attitudes towards the leadership and organization of the crisis, and, indeed, their own role in fulfilling their 'called' moral and social motivations in a grand scale. This aligns with Lewicki *et al.* (1998) who characterised high trust work relationships as hope, confidence, and initiative. It was also clear that doctors attached a great deal of value to this 'promise' of increased autonomy and prestige, and their freedom to live out their calling. Our data, however, showed that in the latter stages of the pandemic and during its aftermath senior doctors quickly sensed a return to their previous feelings of deprofessionalisation, exacerbated by increased resourcing problems and a grave sense of injustice over pension taxation regulations that 'punished' doctors for remaining at work up to and beyond retirement age. Much of the data from the 2023 study pointed to high distrust being a feature of the relationships between doctors, their leaders, organizations, and ultimately generalised to the Scottish NHS system and government. We also identified cynicism and scepticism typical for high distrust work relationships (Lewicki *et al*., 1998). Many doctors were keen to action the distrust brought about by violated promises by quitting the system, either 'quietly' by stepping down work commitments, or by retiring prematurely before their due date of retirement. So, to answer our research question, we show how a disruptive event such as COVID-19 may have triggered a process that gave rise to perceptions of new psychological contract promises in the eyes of doctors, but which were subsequently violated by a return to 'business as usual'.

Three propositions follow from our findings, which extend existing literature on workplace trust and distrust. The first is that a distrust dynamic will be set in motion when: (a) there is a reasonable

expectation among employees that a previous situation of low trust relationships within the organization will be explicitly transformed, and (b) the expectation concerning transformation is perceived by employees to be both explicit and valued by them. The second is that the transition from low trust to distrust will be triggered by employees' perceptions of significant violation of transforming the situation. This proposition closely mirrors the theoretical argument of a 'punctuated threshold of values' made by Bijlsma-Frankema *et al*. (2015) which proposed that once the accumulation of context-specific value incongruencies reaches the threshold, low trust transitions into distrust in a punctuated manner. However, Bijlsma-Frankema *et al*., (2015) could only offer speculation and some retrospective data on the tipping point concept and called for further research. Our cross-case analysis, drawing on data at three points in time provides such evidence. The data gathered during COVID-19 suggests that the nature of a 'tipping point' that can alter the state of workplace trust-distrust relations in an abrupt, punctuated way may lie in employees' perceptions of the nature of 'promise' of a revised psychological contract and employees' responses to perceived breach or violation. Previous research by Conway and Briner (2002) highlighted to several characteristics of perceived promises that impact on employee's responses to breach or violation. Three of these are relevant in defining the nature of a tipping point. Firstly, the greater the degree of explicitness of a perceived promise the more likely will be the sense of injustice among employees. Secondly, the greater that attribution of personal responsibility to organizational leaders for breach or violation, the more intense will be employees' reactions. Thirdly, the higher the degree of value an employee attaches to a specific aspect of the psychological contract, the more likely it will provoke a significant violation and negative, emotional response. Our third proposition surrounds who doctor's blame for the violation and

proposes that the transition from trust to distrust will be expediated when employees blame their situation on the whole system rather than on localised organizational factors.

We also contribute to the psychological contract literature that argues prior levels of trust are important in explaining employees' perceptions of whether a breach or violation of psychological contract has occurred. Robinson (1996) found that employees with low prior trust were more likely to look for, find, and remember incidents of breach, even in the absence of an objective breach, because it was consistent with their low prior trust. In line with this finding, we argue our data suggest that doctors' distrust in the 2023 study was contingent on their low prior trust pre-COVID-19. Our data from 2015 on doctors' low trust, amplified by the dashed hope of reprofessionalisation during the early part of COVID, suggest that low prior trust was a pre-condition for the distrust that followed? Thus, we argue that once low trust is established, it creates the conditions for a tipping point that trigger persistent distrust. This persistence could result from new or additional breaches of the psychological contract and negative attribution processes such as the cognitive consistency bias, selective attention, and selective interpretation (Jones, 1996). We can speculate from the data that had the situation during the period leading up to COVID-19 been characterised as high trust - which for a minority of doctors it was - there would have been positive attribution of the actions taken by leaders. An alternative explanation of our data is also possible, whereby the accumulation of multiple breaches further sustains or exacerbates low trust. Distrust emerged when the final breach occurred following the hope of reprofessionalisation during COVID. However, the return to business as usual following the hope generated during COVID-19 was the proverbial 'last straw that broke the camel's back'. This could lead to a switch from low trust to distrust, as outlined in Bijlsma-Frankema et al's. (2015) work. The key point here is that this last breach was

preceded by positive expectations and trust, rather than a series of breaches leading to low trust. It often feels more painful or traumatic to transition from a positive to a negative situation, or to realise that one's optimism and belief in a better outcome were unfounded.

To conclude, our cross-case analysis has allowed us to look at trust relations between senior doctors and managers at a system over three data points and to explore the impact of a global disruptive event in creating positive expectations and heightening trust and the subsequent distrust following the perceived violation of these expectations. Future research would benefit from exploring trust-distrust and distrust-trust transitions longitudinally with a different cohort of doctors, such as trainees to assess the influence of generational differences, which are believed to be influential in shaping meaningful careers and trust relations (Campbell, Twenge and Campbell, 2017). Moreover, it would be useful to examine how more localised disruptive events such as a major hospital scandal, can impact upon employee-manager trust relations. Our research also provides some support for the possibility that distrust can develop more abruptly and quickly than previous distrust research has suggested. Though, we were unable to fully examine the speed and timing required for the transition from trust to distrust so this could be a valuable focus for future research. Lastly, much of our discussion has been positioned from the unitarist view that conceptualises distrust as dysfunctional with negative implications (Siebert *et al*., 2016). From a pluralist or radical pluralist perspective, however, distrust among doctors is not necessarily bad and may be a natural consequence of legitimately differing interests. It is essential when public services and systems are not working as intended that senior professionals can question and express their opinions to foster change. Thus, an alternative study might examine the different frames of

reference and values of doctors entering employment as trainees and how these are influenced by their lived experience as they transition towards consultant or senior doctor status.

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Table 1: Description of Cases

Case name	Wider societal and NHS systems context	Inner context and trigger for research	Survey sample	Free text data
#1: Case 1: 2015 Study of Scottish Consultants' Experience of Work	Changing institutional logics with medical professionalism being challenged by bureaucratic and political-democratic logics since 1990s in Scotland. Increasing challenge to doctors' autonomy, status, and voice associated with the introduction of job planning, performance targets, patient safety regulations, introduction of medical leadership, elimination of 'bonuses' for performance.	Research into the experience of work among consultants employed in NHS Scotland, commissioned by the BMA (Scotland) Consultants Committee to assess 'deprofessionalisation' among senior doctors in Scotland.	1058 senior doctors	430 responses from 430 senior doctors
#2: 2020 Study of Medical Engagement among Consultants in a Large Scottish Health Board	Continued institutional logics shifts with medical professionalism being challenged by bureaucratic and political-democratic logics since 1990s in Scotland. Emphasis on medical leadership and medical engagement, and on creating a new sense of medical professionalism. Study conducted during first phase of COVID-19 in 2020 when the Health Board was under great strain.	Research into levels of 'medical engagement' among just over 500 consultants in a large Scottish Health Board commissioned to assess the success of a clinically led, managerially enabled strategy, and levels of consultant engagement with their jobs, clinical teams, and their employers.	266 senior doctors	220 responses from 190 senior doctors
#3: 2023 Study of Scottish Consultants' Intentions to Retire	Following COVID, there was evidence of senior doctors increasingly retiring before normal pension age and/or scaling down their work commitment. There was also increasing evidence of shortages among key specialties in medicine, both of which were causing severe resourcing problems. Pension taxation legislation limited the amount that doctors could take on retirement without paying what they regarded as punitive taxation.	Research into consultants' intentions to retire and/or scale down work commitments in NHS Scotland, funded by the NHS employers in Scotland, the BMA (Scotland) Consultants Committee, and the Academy of Medical Royal Colleges and Faculties in Scotland.	1698 senior doctors	1530 responses from 900 senior doctors

Table 2: Summary of Evidence on Low Trust Before COVID-19 for Case #1

Underlying Processes (Trust Dimensions)	**Relational Level**	**Illustrative Quotations from Senior Doctors Responses**	**Selected supporting quotations from secondary data**	**Impact on Psychological Contract**
Lack of Integrity	Between Doctors and Senior Leaders	*Senior medical managers are more influenced by political expediency than clinical need, and important decisions are constantly being ducked to avoid political embarrassment. (Q1)*	*Whilst targets had initially delivered some real improvements, they are now creating*	Breach due to value incongruence

	Between Doctors and Clinical Leaders	*I feel that medical managers are constrained by political targets and meeting these with limited resources in undoubtedly difficult. They tend to isolate themselves, often geographically, from the clinical realities - a fuller appreciation of these would make their decisions more uncomfortable. The clinician is left to get on with working around the ever-increasing obstacles to providing good quality patient care. (Q2)*	*an unsustainable culture and can often skew clinical priorities, waste resources, and focus energy on too many of the wrong things. (Fyffe, RCNS, 2016 Commissioned Sustainability Option Articles)*	Disconnect between expectations
	Between Doctors and NHS Scotland System	*My health board seems to prioritise targets over patient care. This is not individual managers' fault but comes from the target driven nature of NHS Scotland's management. (Q3)*		
Lack of Benevolence	Between Doctors and Senior Leaders	*Senior management don't visit except as an organised posse. Senior management don't know their staff and never tell people when they're doing a good job. […] There are some good managers, and they stand out like a beacon amongst the rest." (Q4)*	*Two in five doctors say bullying and harassment are problems in their workplace It is not just an issue about individual relationships. It also reflects pressures in the system, poor working environments, top-down 'command and control' leadership, and a culture (BMA Bullying & Harassment Review)*	Detached management, lack of mutual trust and reneging on promises
	Between Doctors and Clinical Leaders	*"[I have] strong feelings of being "let down" by Medical Managers in recent years, the lack of support for professionalism and the central interests of the patients we care for" (Q5)*		
	Between Doctors and NHS Scotland System	*I very much enjoy my clinical job […], I greatly value NHS principles and feel privileged to support patients […] I am frustrated by the recurrent circle of organizational changes […], poor working relationship between managers + consultants […] and persistent "bullying" culture despite public statements to the contrary. (Q6)*		
Lack of Ability	Between Doctors and Senior Leaders	*I have enjoyed my work here overall. The most frustrating aspect of the current workload is the inability of senior management to sort out the flow and capacity issues in the hospital. Senior management staff appear to have no proper understanding of our work practice. (Q7)*	*Workforce shortages going into the pandemic were acute, doctors were overworked, and capacity was limited.* *(BMA COVID-19Review 2).*	Frustrations and disappointment developed over time
	Between Doctors and Clinical Leaders	*Many of the problems we have stem from our managers' inability to manage the medical staff […]. Despite this, I sense a change so may feel better in the next year or so. (Q8)*		
	Between Doctors and NHS Scotland System	*NHS Scotland is probably one of the best healthcare systems in the world mainly because patient safety is priority […]. However, there are considerable issues around too much bureaucracy […] I feel there is a disconnect between realities of the job and perception of managers. (Q9)*		

Table 3: Summary of Evidence on Improved Trust During COVID-19 for Case #2

Underlying Processes (Trust Dimensions)	**Relational Level**	**Illustrative Quotations from Senior Doctors Responses**	**Selected supporting quotations from secondary data**	**Impact on Psychological Contract**
Display of Integrity / Being trusted	By senior managers	*There was real freedom to innovate at pace and at a grass roots level - something we have never been able to do in the past. We were trusted to get on and sort out problems at a clinical level. (Q10)*	The impact by the end of the first wave was positive as there was a lot of focus on wellbeing *(BMA COVID-19 Review 2)*	Renewed reciprocal trust
Display of Benevolence	Between Doctors and Senior Leaders	*Supportive and encouraging employers are key for an efficient working department. I am blessed to be working in a good department in NHS where the head of department has been very considerate and helpful during COVID-19 times. (Q11)*	*In May 2020, 65% of respondents to our COVID-19 tracker survey agreed that*	Perceptions of being treated fairly resulted in greater

	Between Doctors and Clinical Leaders	*Reactivity, flexibility, kindness, colleagues (from all roles in the organization) support of each other was impressively demonstrated over the last few weeks. I hope it persists once the threat has gone. (Q12)*	*there was a greater sense of teamworking, 45% agreed they felt more valued as a doctor, and 47% agreed they felt less burdened by bureaucracy. (BMA COVID-19 Review 2)*	organizational commitment and expectations of autonomy and collegiate working going forward
	Between Doctors and NHS Scotland System	*When disaster strikes it's humbling how well everyone in the system works together. I would love us not to go back to the hundreds of steps needed to effect change. (Q13)*		
Display of Ability	Between Doctors and Senior Leaders	*I think that our organization and particularly our AMD for surgery, did a superb job at the beginning of the pandemic, with redeployment of staff and organizing surgery etc. We were kept well informed. (Q14)*	*'It may seem strange, but I enjoyed some of the aspects of the pandemic - leading the practice to change the ways we delivered care to our patients so that it was safe but also accessible …using well-established change methods was the good bit and helped staff morale and our patients felt supported and cared for.' (GP contractor/principal, England) (BMA COVID-19 Review 2)*	Expectations around clinically led decision making, mutual respect with managers, and potential for meaningful organizational change
	Between Doctors and Clinical Leaders	*By allowing clinicians some time to be resourceful we achieved so much, so quickly. (Q15)*		
	Between Doctors and NHS Scotland System	*NHS [Board] can pull together in the right direction when it needs to and quickly. Initial response to the threat of COVID-19 was excellent. This was definitely influenced by having core clinical staff at the centre of decision making. (Q16)*		

Table 4: Summary of Evidence on Emerging Distrust After COVID-19 for Case #3

Underlying Processes (Trust Dimensions)	**Relational Level**	**Illustrative Quotations from Senior Doctors Responses**	**Selected supporting quotations from secondary data**	**Impact on Psychological Contract**
Lack of Integrity	Between Doctors and Senior Leaders	*I have seen duplicitous behaviour by managers, bullying and a lack of integrity in both senior medical and managerial staff. Their concern for staff is little more than window dressing. (Q17)*	*Bullying and harassment in the Scottish National Health Service is a pressing issue that demands immediate attention… These harmful practices not only impact the well-being of doctors but can also jeopardise patient safety and the overall effectiveness of healthcare delivery (BMA Scotland's Race Equality Forum, Oct 2023)*	Value Incongruence - Violation Emotional Response – feeling betrayed and lied to
	Between Doctors and Clinical Leaders	*Are you wanting to know whether senior clinical or non-clinical managers have pushed through changes that have undoubtably harmed patient care? The answer is yes. Have I experience of managers using less than honourable behaviour in the process? Sadly, the answer to that is also yes. (Q18)*		
	Between Doctors and NHS Scotland System	*Toxic environment created by my current employer. (Q19)*		
Lack of Benevolence	Between Doctors and Senior Leaders	*I've raised concerns about the mental health of colleagues, but managers would prefer to address these when the doctor is completely broken and unable to function. … There needs to be an investigation of the bullying culture at [Board] amongst senior management. (Q20)*	*Working conditions need to make doctors want to stay, not push them out of the door, but too frequently they are uncaring, uncomfortable and unsafe (BMA Medical Attrition Report 2024)*	Violation Disidentification from the organization / Broken Promises Disillusioned
	Between Doctors and Clinical Leaders	*I have never felt so disempowered or undervalued by an organisation. The impression that I am given by clinical managers is that I am simply a resource available to do the work that the organisation wants me to deliver, regardless of my interests or specialist skills. My opinion is not sought about organisational challenges: rather, rules, processes and procedures are imposed 'from on high'. Every day, in some way, I am reminded how little I mean to the organization. (Q21)*		

	Between Doctors and NHS Scotland System	*Staff are the most demotivated I have ever seen them, at all levels and in all staff groups. Still seems to be little recognition from higher management that if they look after the staff, the staff will look after the patients. (Q22)*		
Lack of Ability	Between Doctors and Senior Leaders	*Every day is a fight against moronic managerial decisions but at the end of the day the doctors carry the responsibility and blame. (Q23)*	*The service is not financially sustainable, and NHS boards face a blackhole of over £500m by 2025-26," (Christie, BMJ, 2024)* *Our survey results show us that more than four in ten doctors are actively researching leaving our NHS – which would leave massive gaps in an already stretched workforce and seriously threaten quality of care. The health service is already on its knees (BMA Scotland, March 2023).*	Violation – Lack of faith / dismayed / negative emotional response / desire to leave the organisation.
	Between Doctors and Clinical Leaders	*I had great faith in our clinical leadership over the past several years and at the beginning of the COVID-19crisis. However, as we emerge from COVID-19 I am really dismayed at the behaviour of our AMD for surgery who has failed to listen to the concerns of the clinical lead for surgical HDU. (Q24)*		
	Between Doctors and NHS Scotland System	*Things are thoroughly depressing currently. I have little incentive to work in a failing system. Whilst I have no desire to watch the world burn, I will be leaving the profession as soon as it is financially viable for me to do so. (Q25)*		

Figure 1: Doctors Trust Dynamics Over Time – Trust/Distrust Transitions