Received: 23 November 2022 | Revised: 12 March 2023 | Accepted: 21 March 2023

DOI: 10.1111/1747-0080.12809

ORIGINAL RESEARCH

Nutrition & Dietetics Journal of Dietitians Australia WILEY

Understanding how healthcare providers build consumer trust in the Australian food system: A qualitative study

Heath Pillen PhD[1] | **Liz Withall BNutrDiet Hon**[1] | **Emma Tonkin PhD**[1] | **Paul R. Ward PhD**[2] | **Samantha B. Meyer PhD**[3] | **Julie Henderson PhD**[4] | **Dean McCullum MSc**[1] | **John Coveney PhD, AdvAPD**[4] | **Annabelle M. Wilson PhD, AdvAPD**[1]

[1]College of Medicine and Public Health, Flinders University, Bedford Park, Australia

[2]Torrens University Australia, Adelaide Campus, Australia

[3]School of Public Health Sciences, University of Waterloo, Waterloo, Canada

[4]College of Nursing and Health Sciences, Flinders University, Bedford Park, Australia

Correspondence
Annabelle M. Wilson, College of Medicine and Public Health, Level 2 Health Sciences Building, Registry Road, Bedford Park South Australia, GPO Box 2100, Adelaide, SA 5001, Australia.
Email: annabelle.wilson@flinders.edu.au

Funding information
Flinders Foundation; Flinders University

Open access publishing facilitated by Flinders University, as part of the Wiley - Flinders University agreement via the Council of Australian University Librarians.

Abstract

Aim: This study aimed to identify how dietitians and other healthcare providers work to build trust in food systems in the course of providing dietary education.

Methods: Qualitative semi-structured interviews were conducted with 15 purposefully sampled dietitians ($n = 5$), general practitioners ($n = 5$), and complementary and alternative medicine practitioners ($n = 5$) within metropolitan South Australia. Interview data were then interpreted using an inductive thematic analysis approach, involving the construction of themes representing trust-enhancing roles around which beliefs about professional roles, the 'patient', and food and health were clustered.

Results: Healthcare providers communicate beliefs regarding (dis)trust in food systems through: (i) responding to patient queries and concerns following a food incident or scare; (ii) helping patients to identify (un)trustworthy elements of food supply systems; and (iii) encouraging consumption of locally produced and minimally processed food. Importantly, the expression of these roles differed according to participant beliefs about food and health (medico-scientific versus alternative medicine) and their adoption of professional projects that sought to promote medico-scientific ways of thinking about health and diet or manage the failures of Western medicine.

Conclusion: The development and consolidation of trust-enhancing roles amongst healthcare providers likely requires disciplinary reflection on professional values and the processes by which practitioners apply these values to understanding food systems.

KEYWORDS

complementary and alternative medicine, food system, professional role, qualitative research, trust

1 | INTRODUCTION

Trust building is an important element of everyday dietary practice. In her study of dietitian and client understandings of trust, Cant[1] identifies how dietitians build trust through their association with expert systems and their enactment of professional values or virtues such as integrity, respect, empathy, and collaboration. Ultimately, the purpose of trust building is to facilitate *cooperation*,[2] that is, to encourage utilisation of healthcare services, to facilitate open and candid forms of communication between patient and provider, to improve adherence to therapies, and promote engagement with follow-up care.[3] While Cant's findings reveal how trust-building is used by dietitians to enhance the therapeutic provider-patient relationship and patient outcomes, it is important to recognise that patients are also navigating trust in relation to nutritional science[4] and the food system,[5,6] with demonstrable impact on consumer behaviour.[7] This observation raises the question of how dietitians, and other healthcare providers providing dietary education, work to build trust in these abstract systems, thus facilitating cooperation with dietary recommendations. Such activities might complement existing work undertaken by food system regulators, food industry, and the news media to enhance trust in the food supply before, during and after food incidents.[8]

Building trust in the food system is particularly important for dietitians, general medical practitioners (GPs), and complementary and alternative medicine practitioners, who will routinely recommend therapeutic diets to their patients and work to build the (health) literacies required for individuals to act on these recommendations.[9–12] Many of these literacies, including those related to reading food product labels, appropriately assessing the risk level of novel food technologies, and selecting appropriate fortified foods, rely on trust in the food system and food system actors.[13] In the context of a de-localised and globalised food supply where processes of food production become obscured from consumer view,[14] being able to trust food and systems of production may help smooth over the anxieties created when individuals are encouraged to consume unfamiliar foods with unfamiliar modes of production. Trust also becomes increasingly important where the risks facing the individual are relatively high.[15] Such risk is especially pronounced amongst patient groups who are likely to benefit most from consumption from a regulated food supply, including pregnant women and women of childbearing age (for mandatory food fortification programs),[16] those with or at risk of cardiovascular disease (for novel food technologies and foods featuring health claims),[17] or those requiring dietary elimination (for those with food allergies or intolerances).[18]

Healthcare providers are well placed to support the development of trust in such heightened contexts of risk.[19] For GPs at least, this building of trust already occurs in relation to other healthcare providers and novel healthcare technologies.[20] For complementary and alternative medicine practitioners such as naturopaths, developing trust in 'nature' is thematic when discussing issues such as vaccination.[21] For dietitians, a trust building role can be inferred given how dietetic associations have taken up positions in support of the safety of food, specifically in relation to the irradiation of food,[22] consumption of functional foods,[23] and use of food and agricultural biotechnologies.[24] Despite this top-down endorsement of trust in the food system, little is known about how dietitians and other healthcare providers perceive their role in relation to building trust in food systems. In our study, we examine how a range of healthcare providers, including dietitians, GPs, and complementary and alternative medicine practitioners, perceive and enact the role of promoting trust in food systems. Furthermore, our research is interested in how (dis)trusting roles are shaped by the healthcare providers own trust in food systems and the standpoint from which they view food, health, and their professional role. Together, these findings will help identify roles that are likely to *build* or *erode* trust in food systems, while also identifying professional values or ideals that are likely to facilitate or inhibit the enactment of trust-enhancing roles.

2 | METHODS

Within our research, we adopted a social-constructionist perspective whereby beliefs about healthcare provider roles are taken as inseparable from the social and cultural lens through which matters of risk and trust are understood.[25] This enabled us to not only identify the variety of (dis)trust enhancing roles that healthcare providers perform, but also understand how these roles emerge from one's own trust in food systems, beliefs about health and food, and beliefs about the patient-provider relationship. To examine the construction of the trusting role, we performed qualitative semi-structured interviews with healthcare providers practicing within primary care settings and responsible for providing dietary advice to patients, reported in accordance with the Standards for Reporting Qualitative Research (SRQR).[26]

English-speaking dietitians, GPs, and complementary and alternative medicine practitioners practising within South Australia were recruited via purposive sampling. A total of 15 participants, 5 from each professional group,

were sought based on resources available for the research. These professional groups were chosen because of their role in providing dietary advice to patients, but also because of differences in their approach to matters of food and health,[27] forming standpoints that are expected to influence perceptions of the healthcare provider role and the relationship of healthcare providers with food systems. Practitioners were informed of the study through email distributed directly to primary care clinics within Greater Adelaide. Attempts were made to make the study broadly representative to the wider population by inviting health professionals working across different areas of relative socio-economic disadvantage (as per Socio-Economic Index for Areas measures)[28] to participate in the study. Following receipt of the study information, interested healthcare providers were responsible for contacting the researchers to seek out further study information and arrange interviews at their convenience. Ethical approval of the study was gained from the Flinders University Social and Behavioural Research Ethics Committee (Project Number 8228) and written informed consent was obtained from all participants prior to data collection.

Our exploratory study used semi-structured interviews guided by an interview schedule developed by the research team, including persons from mix of professional backgrounds that included dietitians (with research, clinical, and community dietetics experience), those with experience in the sociology of food and trust, and those with experience in government food regulation. The questions used sought to examine the interaction of beliefs about the professional role, beliefs about health (risks) and food, and trust in food (see Supporting Information). These questions functioned to establish a standpoint from which claims about the trusting role might be examined. After establishing this standpoint, we turned to questions examining how the healthcare provider role might differ in the period following a food incident, and how the healthcare provider role might look in comparison to other strategies for building trust in food systems.[8] The interview schedule was piloted with several healthcare providers to ensure clarity and appropriateness of the wording. The interviews took place at a time and location decided by participants, occurring between March and July 2019. Interviews were either conducted face-to-face, or via video/teleconference, with each interview lasting approximately 30–45 min. All interviews were performed by one of two researcher-dietitians, each with experience in performing qualitative research exploring trust in food systems. Following professional transcription of interview audio recordings, transcripts were crosschecked against audio files for accuracy and identifying details were omitted from the transcripts. Pseudonyms were used for all research participants. These transcripts were then imported into NVivo version 10 (QSR International) to assist with the organisation and analysis of interview data.

Our interpretation of participant data was informed by Braun and Clarke's[29] broad approach to thematic analysis, which we used to understand the trust-enhancing roles that healthcare practitioners enact and to identify how these practitioners justify and make sense of these roles. Drawing from an inductive approach to thematic analysis, a single author (a researcher-dietitian), familiar with the data through her role in data collection, coded the transcripts to identify (i) the actions taken by the practitioner and (ii) the implicit (according to the researcher) or explicit reasoning used to justify these actions. Together with a second and third author (both researcher-dietitians with experience in clinical and community dietetics), these codes were then used to construct themes representing trust-enhancing roles, around which certain beliefs were clustered. A coding matrix was then used to further explore the relationship between enacted roles and beliefs, supporting refinement of the coding structure and exploration of the relationships between codes. Throughout the analytical process, additional literature was sought to better understand the diversity of worldviews and motivations held by complementary and alternative medicine practitioners.[11,12,21,27] This was designed to increase sensitivity to and support a reflexive critique of issues and assumptions shaping our interpretation of the collected data.

3 | RESULTS

A total of 15 healthcare providers participated in the research, including five dietitians, five GPs, three naturopaths, one chiropractor, and one Ayurvedic practitioner (Table 1). From the interview data, we identified three roles (themes) that healthcare providers thought might influence consumer trust in the food system. The first role involved responding to patient queries and concerns following a food incident or scare, identifying affected products and re-assuring the patient about the safety of alternative products and thus the integrity of food regulation systems. The second role involved helping patients to identify (un)trustworthy elements of food systems, with the purpose of minimising uncertainty and anxiety around food consumption where there is conflicting information. Finally, the third role involved developing patient skills to assist them to safely consume locally produced and minimally processed food given certain distrust in food systems.

In constructing these roles, participants were found to creatively draw upon cultural bodies of knowledge regarding food and health, their professional role, and the patient. These bodies of knowledge are illustrated within Figure 1. This figure implies that trust-enhancing roles emerge from

TABLE 1 Participant characteristics.

Participant (pseudonym) ($n = 15$)	Health profession (dietitian: $n = 5$; general practitioner: $n = 5$; complementary and alternative medicine practitioner: $n = 5$)	Sex (female: $n = 10$; male: $n = 5$)	SEIFA IRSAD ranking[a]—location of practice
Claire	Naturopath	Female	0–3
Bernice	Naturopath	Female	7–10
Summer	Naturopath	Female	4–6
Peter	Chiropractor	Male	0–3
Lisa	Dietitian	Female	7–10
Stacey	Dietitian	Female	7–10
Neil	General Practitioner	Male	7–10
Andrew	Dietitian	Male	4–6
Jennifer	Dietitian	Female	0–3
Ava	Dietitian	Female	4–6
John	General practitioner	Male	4–6
Lucy	General practitioner	Female	7–10
Linnea	General practitioner	Female	7–10
Leanne	Ayurvedic practitioner	Female	4–6
Leon	General practitioner	Male	7–10

[a]SEIFA IRSAD, Socioeconomic Indexes for Areas—Index of Relative Socioeconomic Advantage and Disadvantage, ranked by decile, where decile 1 contains the lowest 10% of scores for the most disadvantaged areas and quintile 10 contains the highest 10% of scores for the most advantaged areas. Taken from the Australian Bureau of Statistics. Socio-Economic Indexes for Areas 2016. 2022. https://www.abs.gov.au/websitedbs/censushome.nsf/home/seifa. Accessed March 1, 2023.

bodies of knowledge connected to membership within orthodox (GPs and dietitians) or alternative (complementary and alternative medicine practitioners) medicine. Each of these roles were observed as being embedded within broader professional projects of asserting medico-scientific understandings of food and health (GPs and dietitians) or seeking to reclaim traditional food knowledges that had been either overlooked, ignored, or suppressed by orthodox medicine (complementary and alternative medicine practitioners). Summarised in Table 2, the following sections elaborate on how these trust-moderating roles were shaped by participant beliefs about professional roles, the 'patient', and food and health.

In providing narratives about their trust building role, participants engaged in an epistemic contest over valid forms of knowledge about food and health, creating a schism between the accounts of complementary and alternative medicine practitioners and the accounts of GPs and dietitians. For the former group, there was a privileging of traditional or enduring cultural knowledges about the relationship between food and health, contributing to a distrust of foods produced using non-traditional means (characteristic of the dominant food system).

> ...nature will never alter and rules for health will never change; that's one thing that the multinationals can't get away from. (Peter – chiropractor)

Alternatively for the latter healthcare provider groups, there was a privileging of medico-scientific knowledge of food and health, which contributed to a trust in the safety (but not necessarily the health promoting quality) of foods created under scientific systems of production and regulation.

> [Trust in the food supply means] that the food they buy from the supermarket is going to be edible and safe for them to eat and that they're not going to get sick from eating it. Trusting that the claims that are made on nutrition information panels are accurate or that they've been tested for safety I guess. (Ava – dietitian)

This epistemic contest also shaped understandings of their own professional-therapeutic role and of the patient. Following a similar pattern of medico-scientific presupposition, GPs and dietitians went about the professional project of assisting patients to think about their health and diet in medico-scientific terms, drawing on terminology of the 'diet-disease relationship'. The intention of this was to help

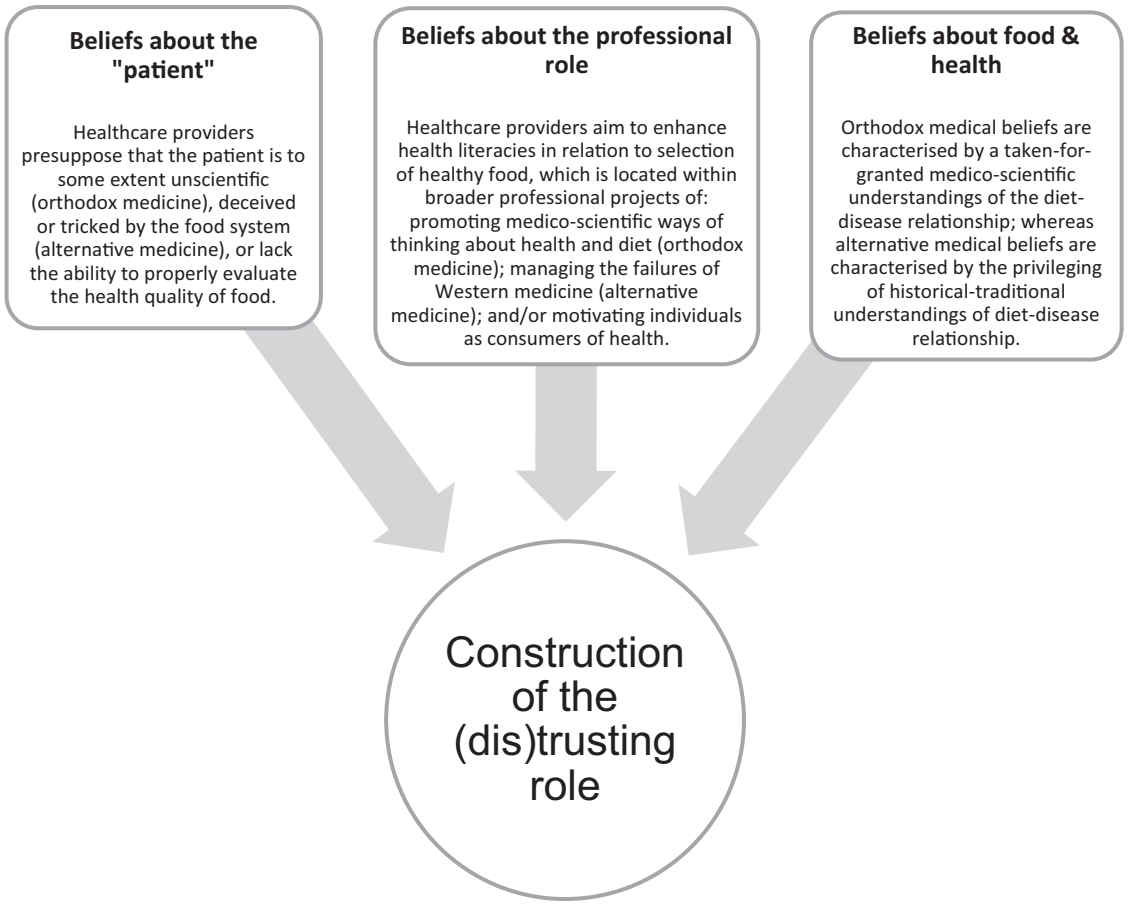

FIGURE 1 Stocks of knowledge used in the construction of trust-promoting roles amongst healthcare providers.

patients identify misinformation and reduce confusion around appropriate dietary behaviour.

> People get themselves into little echo chambers and to them – they start trusting people that are charismatic but probably don't warrant that trust. (Neil – GP)

> [My role is] myth busting about particular ingredients as being unsafe – GMO, wheat, gluten, sugar... (Lisa – dietitian)

Alternatively, complementary and alternative medicine practitioners adopted a professional role whereby they were tasked with managing the failures of 'Western medicine', which they did so by attempting to disrupt 'naïve' beliefs about food and health and the trust that individuals 'uncritically' place in formal systems of food production. As one naturopath asserted, 'there's a presumption that the food we are purchasing is safe and quality. That's not necessarily the case' (Claire – naturopath).

Therefore, it is possible to observe distinct patterns of thought that organise thinking in relation to the trust-enhancing role of healthcare providers. This means that for complementary and alternative medicine practitioners, any such role must be constructed in a way that is consistent with their trust in traditional knowledges about health, food production, and food consumption, and their distrust in (harmful) modes of food processing that Western medicine has somehow overlooked. For GPs and dietitians, promoting trust in formal (scientific) systems of food production and regulation is embedded within systems of trust in scientific knowledge and systems. The trust enhancing roles that appeared to relate to these professional ideals are now discussed in turn.

The first role involved helping patients to identify affected food products while re-assuring them about the safety of alternative products. According to GPs and dietitians within this research, a discussion of food systems and food safety was often initiated by patients following a publicised food incident or scare. As consumers, carriers and communicators of medico-scientific knowledge, these healthcare providers sought to resolve uncertainty regarding the patients' susceptibility to the threat by helping patients to identify precisely what food products were affected, drawing upon notifications published by food

TABLE 2 Theme and coding structure for the construction of trust-enhancing roles amongst general practitioners, dietitians, and complementary and alternative medicine practitioners.

Actions taken to moderate trust in the food system (themes)	Justification for these actions	Beliefs informing these justifications (categories)	Beliefs informing these justifications (major codes)
Responding to patient queries and concerns following a food incident or scare, identifying affected products and re-assuring the patient about the safety of alternative products	Re-assure the patient about the integrity of food regulation systems	Beliefs about food and health	Food safety equates to food being free from microbial, chemical, and physical contaminants
		Beliefs about the professional role	Professionals must remain connected and aligned with scientific food organisations such as Food Standards Australia and New Zealand
		Beliefs about the 'patient'	Patients considered to be vulnerable to misinformation
Helping patients to identify (un)trustworthy elements of food systems	Minimise uncertainty and anxiety around food consumption where there is conflicting (mis)information	Beliefs about food and health	Dietary health involves meeting physiological needs in support of short and long-term health
		Beliefs about the professional role	The professions' role is to enhance dietary health literacies Professionals must encourage a critical approach to food systems rather than blind trust or dependence Professionals must take a lead role in using their scientific knowledge to bust dietary myths
		Beliefs about the 'patient'	Patients considered to be routinely deceived or duped by the food system Overall, patients lack the ability to properly evaluate the health quality of food
Developing patient skills to assist them to safely consume locally produced and minimally processed food	Responding to a certain degree of distrust in food systems	Beliefs about food and health	Food safety equates to food being organic, unprocessed, and free from pesticides Food processing introduces novel risks to health
		Beliefs about the professional role	Professionals have an ethical role of supporting food and environmental sustainability
		Beliefs about the 'patient'	Patients require support to re-acquire traditional food knowledges and practices

manufacturers, national food system regulators or state public health authorities. In doing this, the GP or dietitian sought to re-assure their patients about the overall integrity of the food system. Underwriting this

response was the presupposition that food-borne threats to health are largely microbial, a threat that is otherwise well managed within systems of food regulation.

> ...FSANZ [national food regulator] is on top of it and nothing will be sold if it's, you know, deemed unsafe. Anything you see on the shelves, if it's deemed unsafe it gets recalled straightaway. (Lisa – dietitian)

The same presupposition was not evident in accounts by complementary and alternative medicine practitioners, who perceived food-borne threats as being more related to the (poor) nutritional quality of extensively processed foods and harmful by-products of food processing. For these complementary and alternative medicine practitioners, food incidents were not necessarily isolated threats to health but rather formed part of a system of food production that is intrinsically pathogenic.

> To be honest I probably encourage it [not to trust food supply] because unless they are getting the foods that I've talked about [organic and unrefined foods] they probably have reason not to trust it. (Peter – chiropractor)

A second trust enhancing role involved helping patients to identify (un)trustworthy elements of food systems. Emerging from a concern with the vulnerability of patients to unscientific dietary 'myths' and inappropriate marketing claims, GPs and dietitians described a role in demarcating between trustworthy and untrustworthy elements within the food supply. For these healthcare providers, trustworthy elements included nutrition information panels (compared with health symbols and marketing claims) and systems for preventing or limiting the growth of microbial pathogens.

> I think I do generally have significant trust in producers and regulatory bodies but I don't have a lot of trust in marketers purely because I don't believe that their motives are necessarily ethical. I rarely trust what's written on the packet other than the nutrition information and that's usually what I'll get people to refer to when it comes to things like low cholesterol diets and carbohydrate counting and things like that. I tell them to ignore what's on the front of the pack and just go straight to that information. (John – GP)

For complementary and alternative medicine practitioners, there was a general antagonism towards formal food systems with no evidence (within interviews) of there being objects of trust to be found within such a system. Even food products that might be more favourably regarded, such as organic foods, were distrusted by way of their association with the formal food supply. Rather, trust was located in systems of food production and consumption outside of the regulated environment of the food supply.

> I don't have a huge level of faith, I guess, in food production currently...I basically go to as many local farmers' markets as I possibly can. I grow a lot of my own food and promote my clients do the same...Ultimately, yeah, I don't have a huge level of trust in necessarily what's being put in the food, if that kind of makes sense, and also too how our natural world in general is being treated to produce it. (Leanne – Ayurvedic practitioner)

Although being a definitive role of complementary and alternative medicine practitioners, GPs and dietitians also reported encouraging patients to consume locally produced and minimally processed foods, constituting a third trust-moderating role. For each of these groups, there was a convergence in the belief that food systems have introduced novel risks to health. For GPs and dietitians, it is the proliferation of energy-dense and nutrient-poor foods within food systems that have introduced risks for the development of obesity and chronic disease. For certain complementary and alternative medicine practitioners, this idea was supplemented by beliefs about how food systems function to generate novel 'toxins' through mass food processing practices while also disrupting traditional food knowledges and practices.

> Now, there are issues of pathogens and spoilage and all that sort of thing in the modern world, which is inescapable, but it doesn't change the ideal. Ideal is straight out of the ground, straight off the tree in its optimal condition, free of pesticides, fertilisers, chemical sprays, herbicides, all of that. (Peter – chiropractor)

These ideas about food risks meant that whereas GPs and dietitians favoured educative strategies designed to encourage patients to consume fewer processed foods (consistent with national dietary guidelines) with limited concern regarding the source (country of origin being one exception), the source did matter for complementary and alternative medicine practitioners, who encouraged participation in, and consumption from alternative

systems of food distribution such as farmers markets, farm-gate sales, and food-cooperatives.

> I talk to clients about trying to buy more local, particularly with fruit and vegetables, but – and more wholefoods and I think that that's – in my area that's probably – the trust issues become more in the processed foods and what's actually in it... (Claire – naturopath)

Therefore, while GPs, dietitians, and complementary and alternative medicine practitioners arrived at common ground in encouraging patients to consume locally produced and minimally processed food, their motivations for doing so differed according to their beliefs about the extent of health risks posed by the food system.

4 | DISCUSSION

This study aimed to identify how dietitians and other healthcare providers work to build trust in food systems in the course of providing dietary education. It did this by first identifying the roles that healthcare providers might take in building such trust, and second by examining how these roles are shaped by the standpoint from which healthcare providers view food, health, and their professional role. In brief, the three roles that were identified from the study of dietitians, GPs, and complementary and alternative medicine practitioners include: responding to patient queries and concerns following a food incident or scare; helping patients to identify (un) trustworthy elements of food systems; and, providing patients with the skills to safely consume locally produced and minimally processed food.

What our research has demonstrated is that these roles can be enacted in different ways, with the potential to either enhance or erode trust in the food system. Specifically, the research demonstrated that the propensity of healthcare providers to build trust in the food system is dependent on their own beliefs and values around food and health. These beliefs are likely to be shaped through professional socialisation[30] or professionalisation[31] given the relative uniformity of beliefs amongst orthodox versus alternative medical practitioners in our study. Professional socialisation here is taken to refer to the process by which members of a given profession internalise the values and norms of that profession, giving rise to a defined body of beliefs, attitudes, skills, and knowledge.[32] If we are to understand trust building roles amongst healthcare providers, then we must first recognise that these healthcare providers are members of professions that contain 'a body of knowledge, an inherent culture and a recognised role in serving society'.[33] Therefore, any attempt to persuade healthcare providers to enact trust-building roles is likely to require engagement with processes of professional socialisation, occurring prior to entry into a healthcare profession, during formal academic education, and through ongoing clinical or professional training.[31]

These findings are consistent with the pedagogical assertion that 'teaching about food systems is value-laden',[34] requiring educators to explicitly engage with values that underpin professional trust in food systems. While it may be tempting to assume that dietitians (and other healthcare providers) may be used instrumentally through education and training to enhance trust in food systems as credible members within the 'stakeholder network' of food system regulators,[35] a more critical, constructivist, or experiential pedagogical approach might provide a more authentic engagement with the beliefs and values that underpin trust in food systems,[34,36] while also attending to critiques of the disciplinary power present within dietetics education.[37] Regardless of pedagogical orientation, it is sufficient to conclude from the findings of our study that any examination of food systems should be accompanied by an explicit examination of professional values towards such systems.

In reflecting on the study findings, we (the researchers) recognise that the findings risk essentialising practitioners of orthodox and alternative medicine and portraying professional knowledges and identity as if they were static and intrinsic traits of each group of healthcare providers. Rather, we recognise that professional discourses and identities are likely to be shaped by a range of factors, extending beyond those examined in this research. In particular, we recognise that professional identity and role will be partially shaped through processes of patient-provider interaction[38]—with the role of the patient-client largely missing from our study. This reflection highlights study limitations in relation to sampling and the use of individual interviews. By drawing on a small sample of self-selected orthodox and alternative medicine practitioners, our study likely appealed to those practitioners for whom 'trust and food' was a salient topic, potentially polarising the sample and limiting exposure to diverse perspectives. Future qualitative research might address this limitation through the addition of maximum variation sampling,[39] which would seek to sample healthcare providers who are more or less orthodox/alternative in their approach. A larger sample size may also help to compensate for the effects of value polarisation within the sample, while also better representing the diversity of beliefs held by dietitians, GPs, and complementary and alternative medicine

practitioners. The use of interviews is also a limitation in that we were unable to observe how professional identity and role might be negotiated in interaction with different patient-clients. Although we attempted to offset this limitation by raising questions about the perceived role of trust for patient-clients and how they negotiate trust-building work within healthcare consultations, this approach is limited in its ability to examine how professional discourses are maintained or challenged through the course of clinical interaction and within different interactional contexts. Future qualitative research would benefit from the additional use of observation and patient-client interviews or surveys to identify how trusting roles are enacted within real-life or simulated consultative environments and the effect this has on patient-client trust.

Despite these limitations, the research has contributed knowledge about how dietitians and other healthcare providers can work to build trust in food systems in three key ways. First, healthcare providers aligned with orthodox medicine are likely to already perform trust-enhancing roles, with these roles intersecting with the professional project of elevating scientific evidence and dispelling 'pseudoscience',[40] thus shaping a role whereby patients are encouraged to navigate relations of trust on scientific terms. Second, healthcare providers should seek to develop the ability of individuals to safely consume food from a variety of sources, while not undermining trust in the food supply either in relation to perceived adverse effects of food processing or the loss of nutritional value. And third, the development of trust-enhancing roles also requires supporting healthcare providers to develop personal trust in food systems. These findings suggest a need for further educational research to identify how trust-enhancing roles might be purposefully developed amongst healthcare providers, drawing from a reflexive examination of how professional values and beliefs are applied to food systems.

AUTHOR CONTRIBUTIONS

All authors provided important intellectual input, approved the submitted manuscript, and agreed to be accountable for its content. *Conceptualization and methodology*: ET, PRW, SBM, JH, DM, JC and AMW; *investigation*: LW; *data analysis*: LW, AMW, ET; *writing—original draft preparation*: HP; *writing—review and editing*: all authors; *project administration*: AMW; *funding acquisition*: AMW.

FUNDING INFORMATION

The study was funded by a Flinders Foundation Health Seed Research Grant.

CONFLICT OF INTEREST STATEMENT

The authors have no competing interests to declare.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

ETHICS STATEMENT

Ethical approval for the study was gained from the Flinders University Social and Behavioural Research Ethics Committee (Project Number 8228) and written informed consent was obtained from all participants prior to data collection.

ORCID

Heath Pillen https://orcid.org/0000-0002-0406-9406
Annabelle M. Wilson https://orcid.org/0000-0003-4308-8113

REFERENCES

1. Cant R. Constructions of competence within dietetics: trust, professionalism and communications with individual clients. *Nutr Diet*. 2009;66(2):113-118.
2. Earle TC, Siegrist M, Gutscher H, Gutscher H. *Trust in Risk Management: Uncertainty and Scepticism in the Public Mind*. Taylor & Francis Group; 2010.
3. Cook KS, Stepanikova I. The health care outcomes of trust. In: Brownlie J, Greene A, Howson A, eds. *Researching Trust and Health*. Routledge; 2008:194-214.
4. Penders B. Why public dismissal of nutrition science makes sense: post-truth, public accountability and dietary credibility. *Br Food J*. 2018;120(9):1953-1964.
5. Taylor AW, Coveney J, Ward PR, et al. Fruit and vegetable consumption—the influence of aspects associated with trust in food and safety and quality of food. *Public Health Nutr*. 2012;15(2):208-217.
6. Tonkin E, Wilson AM, Coveney J, Webb T, Meyer SB. Trust in and through labelling–a systematic review and critique. *Br Food J*. 2015;117(1):318-338.
7. Machado Nardi VA, Teixeira R, Ladeira WJ, de Oliveira SF. A meta-analytic review of food safety risk perception. *Food Control*. 2020;112:107089.
8. Wilson AM, Withall E, Coveney J, et al. A model for (re)building consumer trust in the food system. *Health Promot Int*. 2016;32(6):988-1000.
9. Berkman ND, Davis TC, McCormack L. Health literacy: what is it? *J Health Commun*. 2010;15(S2):9-19.
10. Crowley J, O'Connell S, Kavka A, Ball L, Nowson CA. Australian general practitioners' views regarding providing nutrition care: results of a national survey. *Public Health*. 2016;140:7-13.
11. Steel A, Schloss J, Leach M, Adams J. The naturopathic profession in Australia: a secondary analysis of the Practitioner Research and Collaboration Initiative (PRACI). *Complement Ther Clin Pract*. 2020;40:1-7.

12. Lee MK, Amorin-Woods L, Cascioli V, Adams J. The use of nutritional guidance within chiropractic patient management: a survey of 333 chiropractors from the ACORN practice-based research network. *Chiropr Man Ther*. 2018;26(7):1-9.
13. Tonkin E, Meyer SB, Coveney J, Webb T, Wilson AM. The process of making trust related judgements through interaction with food labelling. *Food Policy*. 2016;63:1-11.
14. Meyer SB, Coveney J, Henderson J, Ward PR, Taylor AW. Reconnecting Australian consumers and producers: identifying problems of distrust. *Food Policy*. 2012;37(6):634-640.
15. Ward P. Trust: what is it and why do we need it? In: Jacobsen MH, ed. *Emotions, Everyday Life and Sociology*. Taylor & Francis Group; 2018:13-26.
16. Brown RD, Langshaw MR, Uhr EJ, Gibson JN, Joshua DE. The impact of mandatory fortification of flour with folic acid on the blood folate levels of an Australian population. *Med J Aust*. 2011;194(2):65-67.
17. Al-Sheraji SH, Ismail A, Manap MY, Mustafa S, Yusof RM, Hassan FA. Prebiotics as functional foods: a review. *J Funct Foods*. 2013;5(4):1542-1553.
18. Barnett J, Leftwich J, Muncer K, et al. How do peanut and nut-allergic consumers use information on the packaging to avoid allergens? *Allergy*. 2011;66(7):969-978.
19. Ward PR. Improving access to, use of, and outcomes from public health programs: the importance of building and maintaining trust with patients/clients. *Front Public Health*. 2017;5(22):1-7.
20. Wilk AS, Platt JE. Measuring physicians' trust: a scoping review with implications for public policy. *Soc Sci Med*. 2016;165:75-81.
21. Malo B, Meyer SB, Filice E, et al. "If I'm a naturopath, It's because I trust nature above everything else": Canadian naturopaths' construction of vaccination as a risk object. *SSM – Qual Res Health*. 2023;3(100203):1-10.
22. Wood OB, Bruhn CM. Position of the American Dietetic Association: food irradiation. *J Am Diet Assoc*. 2000;100(2):246-253.
23. Bloch A, Thomson CA. Position of the American Dietetic Association: phytochemicals and functional foods. *J Am Diet Assoc*. 1995;95(4):493-496.
24. Bruhn C. Position of the American Dietetic Association: agricultural and food biotechnology. *J Am Diet Assoc*. 2006;106(2):285-293.
25. Lupton D. Sociology and risk. In: Mythen G, Walklate S, eds. *Beyond the Risk Society: Critical Reflections on Risk and Human Security*. Open University Press; 2006:11-24.
26. O'Brien BC, Harris IB, Beckman TJ, Reed DA, Cook DA. Standards for reporting qualitative research: a synthesis of recommendations. *Acad Med*. 2014;89(9):1245-1251.
27. Wiese M, Oster C, Pincombe J. Understanding the emerging relationship between complementary medicine and mainstream health care: a review of the literature. *Health*. 2010;14(3):326-342.
28. Australian Bureau of Statistics. *Socio-Economic Indexes for Areas 2016*. 2022. Accessed March 1, 2023. https://www.abs.gov.au/websitedbs/censushome.nsf/home/seifa
29. Braun V, Clarke V. Thematic analysis. In: Cooper H, ed. *APA Handbook of Research Methods in Psychology: Vol 2 Research Designs: Quantitative, Qualitative, Neuropsychological, and Biological*. American Psychological Association; 2012.
30. Cornelissen J, Van Wyk A. Professional socialisation: an influence on professional development and role definition. *S Afr J High*. 2007;21(7):826-841.
31. MacLellan D, Lordly D, Gingras J. Professional socialization in dietetics: a review of the literature. *Can J Diet Pract Res*. 2011;72(1):37-42.
32. Ajjawi R, Higgs J. Learning to reason: a journey of professional socialisation. *Adv Health Sci Educ*. 2008;13(2):133-150.
33. Higgs J. Professional socialisation. In: Loftus S, Gerzina T, Higgs J, Smith M, Duffy E, eds. *Educating Health Professionals: Becoming a University Teacher*. Brill; 2013:83-92.
34. Ng E, Cole DC. From tensions to transformation: teaching food systems in a graduate dietetics course. *Can Food Stud*. 2021;8(4):82-97.
35. Charlebois S, Summan A. A risk communication model for food regulatory agencies in modern society. *Trends Food Sci Technol*. 2015;45(1):153-165.
36. Carlsson L, Callaghan E, Broman G. How can dietitians leverage change for sustainable food systems in Canada? *Can J Diet Pract Res*. 2019;80(4):164-171.
37. Bessey M, Brady J. "God forbid you bring a cupcake": theorizing biopedagogies as professional socialization in dietetics education. In: Brown H, Ellis-Ordway N, eds. *Weight Bias in Health Education: Critical Perspectives for Pedagogy and Practice*. Routledge; 2021:51-62.
38. Sarangi S. Reconfiguring self/identity/status/role: the case of professional role performance in healthcare encounters. *J Appl Linguistics Prof Pract*. 2010;7(1):75-95.
39. Bryman A. *Social Research Methods*. 5th ed. Oxford University Press; 2016.
40. Neale EP, Tapsell LC. Perspective: the evidence-based framework in nutrition and dietetics: implementation, challenges, and future directions. *Adv Nutr*. 2019;10(1):1-8.

SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

How to cite this article: Pillen H, Withall L, Tonkin E, et al. Understanding how healthcare providers build consumer trust in the Australian food system: A qualitative study. *Nutrition & Dietetics*. 2023;1-10. doi:10.1111/1747-0080.12809