LITTLE IS KNOWN ABOUT why the public trusts nurses and how this trust impacts nursing’s value. Nurses proudly cite their long-standing trusted status recognized in public opinion polls (Gallup, 2012). Nursing, however, has failed to capitalize on the economic impact of this designation by documenting trust as a professional asset. Karen A. Daley, former president of the American Nurses Association (ANA), discussed recent Gallup poll and stated, “This poll consistently shows that people connect with nurses and trust them to do the right thing” (RTT News, 2013, para. 2).

Trust, one of nursing’s intangible assets, impacts nurses’ ability to form meaningful relationships with patients and this connection positively impacts health outcomes. Nursing’s attributes related to nurse-patient trust include clinical competency, demonstrated compassion and goodwill, patient advocacy, patient vulnerability, and nurses’ moral duty (see Figure 1).

Nursing’s trusted status also impacts the patient’s perspective on the quality of the health care system. The Patient Protection and Affordable Care Act will change how the United States delivers health care. Health reform focuses on improving health care quality while also reducing resource costs. As health care moves from a fee-based, “a la carte” volume-driven industry, it will struggle to become a leaner, high-quality, low-cost, patient-centered system. Demonstrating efficiency and comparative effectiveness will require the collection and analysis of data that measures worth (Bensink et al., 2013). Trust is an enhancer of the patient experience; trust is a nurse-sensitive quality measure that is linked to overall patient satisfaction and patient trust in nursing impacts organizational satisfaction scores (Naylor et al., 2013). Trust will be explored in this article as one of nursing’s heftier-weighted assets, tipping the scale on nursing’s valuation, and compounding the value of its other intangible and tangible assets (see Figure 2).

Trust: Defining the Concept

There is limited nursing literature related to the worth and value that trust imparts to the profession (Sellman, 2007). For this article, many of the most important literature resources are decades old but offer relevant foundational knowledge. “Trust is highly complex and multidimensional” and the related concepts associated to trust require an understanding of those antecedents and outcomes that stimulate the response in a relationship that creates trust (Dinc & Gastmans, 2012, p. 224; Lewis & Weigert, 1985).

People want to be trusted; to be valued for what they contri-
but to be trusted by others (Marshall, 2000). Marshall presents trust as an important imperative in life, affecting human conduct in all kinds of settings and is based on biological need, psychological requirements, emotional well-being, feelings of self-respect, and foundational to a human relationship. Webster links trust in its definition to reliance on, a confidence placed in, a charge of duty, and a commitment for a person to act in another’s best interest (Marshall, 2000).

Sellman (2007) and Johns (1996) suggested literature related to trust focuses on a concept that is predominantly explored in the disciplines of psychology, sociology, and business (Johns, 1996). Trust involves a psychological choice (trust) of one person over another. In the domains of sociology and business, trust is associated with an aspect of benefits sought that result in forming a contractual relationship.

In one of the rare in-depth concept analysis of trust found in nursing literature, Johns (1996) identified nursing trust as stemming from two perspectives: (a) the nurse-patient relationship and (b) the organizational relationship. The author relayed trust as having developed from a process and/or outcome relationship (Johns, 1996). He identified four elements at the core of the concept: (a) the risk associated with trusting another, (b) the decision made by the truster to trust the trustee, (c) the willingness of the vulnerable to rely on another, and (d) the consequences or outcome. The author pointed out the need to view the outcome of trust “at a point in time...an important perspective for measuring trust, antecedents, consequences and their interrelationships” (p. 80). In the nurse-patient relationship, the first three steps of the process are more accelerated than in most relationships, with the patient entering the encounter with a negligible testing period.

Figure 1. Imperative Components of the Nurse-Patient Relationship

TRUST

Positive Results
Moral

Reliance
Goodwill

Compassion
Clinical Abilities

Patient Needs/Vulnerability

Figure 2. The Balance of Nursing’s Intangible and Tangible Assets

Intangible Assets

Trust
Intuition
Caring

Tangible Assets

Patient Outcomes
Revenue
Knowledge
Efficiencies

Nursing Value
Johns (1996) highlighted the organizational relationship that can affect trust in relation to the nursing profession. This is viewed from two perspectives in the literature, one noting the organization oversight of the nurse supports his or her status, while the second notes that nursing trust is bolstering the patient’s measurement of his or her care episode. In the first view, the patient’s physician and hospital are seen as authorities that oversee the level of nursing competence. The patient does not understand the nurse is a licensed practitioner with a scope of practice. Rather the public sees the physician and hospital as authoritative while the nursing role can be described as collaborative. The nurse, however, is clearly collaborating with the patient, forming an alliance in an effort to return the patient to optimum health but he or she is also making practitioner decisions supported by his or her license which is monitored by the state (de Raeve, 2002). The organization will be affected by mistrust of the nurse and this “hammers communication and reinforces negative assumptions” (Johns, 1996, p. 78). Trust in the nurse offers an economic worth to the organization.

**Primary Trust Extended to the Nurse**

There are varying levels of trust that one individual may extend to another based on past relationships and the expected reliability of each individual. An infant extends primary trust to its parents (Hertzberg, 1988; Lagnespetz, 1992). A nurse-patient relationship is also described as based on a primary trust. Nursing’s reputation and role results in the patient’s general lack of mistrust of his or her nurse when entering into a vulnerable situation even though there is no prior relationship with the individual (Hertzberg, 1988). Primary trust appears to be extended to the nurse by the patient unless the nurse does something to break or damage this covenant (Hertzberg, 1988; Lagnespetz, 1992). Although today’s community seems to be moving toward a more complicated time where public trust seems in short supply, nursing continues to maintain the public’s support. Since nursing has garnered this trusted status over decades, it appears this asset is strongly banked in the public’s mind. When the profession experiences an occasional error, inevitable with all humans, it is weathered. As one of nursing’s important assets, this trusted position should be valued highly and protected against erosion.

“People seem to trust nurses, their general position and function, even if this is not the same as trusting the individual nurse” (de Raeve, 2002, p. 158). Trust in a professional is different than the reliance on his or her skills as an individual (de Raeve, 2002). Nursing care is integral to the perception of quality of health care delivered and it is important to delineate nursing’s unique influence on the community’s perception of their overall medical and hospital care. Nursing care includes “direct care giving, surveillance and monitoring of health status, emotional support for patients and families, assistance with activities of daily living, interprofessional team collaboration and patient education” (McHugh & Stimpfel, 2012, p. 566). The nurse assumes the role of intermediary between all other clinicians and both the nurse’s independent actions and his or her responsibilities initiated by the physician order are evaluated when defining the quality of nursing care.

**Vulnerability: Needing a Nurse**

Baier (1986) points out that trust, in most life situations, occurs between two rational adults, each entering a relationship on equal positions. Trust evolves as each demonstrates attributes causing one to trust the other. When illness requires hospitalization, the patient is vulnerable; there is a fear related to his or her condition (Sellman, 2005). Patients seek protection and wish to regain an ability to flourish (Sellman, 2005). The relationship between the nurse and patient is a relationship of unequal power with the nurse controlling care delivery (Sellman, 2007). The patient trusts in nurses’ care, hoping to regain his or her health.

Patients “general willingness to trust is likely to reflect their experiences of previous trusted relationships; and her or his perception of the trustworthiness of any given nurse will depend upon how far the nurse meets whatever criteria the patient uses to judge the trustworthiness of others” (Sellman, 2007, p. 31). For nurses, the protection of the patient requires knowledge and clinical abilities related to the patient’s condition, his or her vulnerabilities, and uncovering patient-specific nuances (Sellman, 2005).

When in the hands of the stranger nurse, the patient generally responds with a feeling of hope versus critical wariness.

The quality of the current nursing graduates and the level of their commitment to the profession should be a goal of all nursing educators. Seeking applicant numbers to fill the demand for nurses and a limit of nursing faculty prepared for academia should not result in a system that acquiesces and allows educational shortcuts. Nursing’s trusted reputation should be safeguarded and data that supports nursing as trusted should be gathered.

**Clinical Knowledge and Reliance**

Trust involves a compilation of ideals that involve confidence and reliance of one person in another (Baier, 1986; de Raeve, 2002; Govier, 1992; Sellman, 2007). These two concepts are intertwined: in that reliance in another requires a confidence in that individual and confidence stimulates a belief in the reliability of their actions. There is significance in the “moral nature or moral implications of the judgments profes-
Compassion, Goodwill, and Advocacy

Compassion is noted as the nurse acts based on a strong desire to alleviate discomfort or suffering. Goodwill means a feeling of benevolence and kindness toward the patient. Advocacy involves supporting or recommending on behalf of the patients, seeking what the nurse believes the patient would want. Offering all three of these attributes toward the patient is grounded in the profession’s history. The human interpersonal approach to patient care was formally introduced in nursing education by Hildegard Peplau after WWII (Baier, 2012). Before her, Florence Nightingale described behaviors of the nurse as caring and trustworthy, focusing on ridding patients of “apprehension, uncertainty, waiting, expectation, and fear of surprise”; avoiding “thoughtlessness” (Nightingale, 1859, p. 38). In the early 1900s, the nurses at the Henry Street Settlement described compassion as fundamental, offering that “compassion was not sentiment, but making justice and doing works of mercy; ...compassion was not a favor to the poor, but something to which patient had a right, and for the nurse an opportunity; ...compassion was not an organized religion, but it was, for the nurse inventors, a way of life” (Baier, 2012, p. 53; Hamilton, 1994). The compassion or empathy, goodwill, and advocacy that a nurse embodies in his or her practice influences the trust the patient identifies with his or her care and core values (Staughair, 2012).

There is an applied nurse-patient relationship with an extended goodwill from the initial encounter and this impacts the patient’s acceptance of the nurse’s ministrations. The nurse performs technical procedures that involve injecting and insertion of catheters and tubes into the body, and other treatment therapies that create discomfort, but in addition nurses massage, bathe, dress, and hold the hands of both the patient and family support members (de Raeve, 2002). A social and physical access is extended by the patient to the nurse, forming a technical and personal relationship between them. Nurses’ physical and social access extends far beyond other providers (de Raeve, 2002). Experiences such as assisting the parent who first tries to feed or swaddle his or her newborn, holding the hand of the patient on the surgical table, or sitting at the bedside when the patient takes his or her last breath are the memories a nurse cherishes and are the most personally and professionally rewarding.

The nurse commitment to the patient, the intimate nature of the care, and the nurse-patient relationship demonstrates a connection that is best described as the nurse caring for and caring about [not necessarily equal to liking] the patient. But it is questioned “good nursing in any environment of sustained care requires some degree of ‘caring about’ patients for ‘caring for’ to take place” (de Raeve, 1996, p. 21). Beyond the aspect of licensure and standards is the belief a nurse acts in a patient’s best interest.

Moral Duty

Health care is linked to the moral aspects of health services. Unlike business or sociology, nursing’s connection with a patient is more of a covenant than a contract (de Raeve, 2002). A nurse acting carelessly is viewed as negligent and morally harmful. Even if the intention was not to create harm, failure to follow standards of practice seems reprehensible when examined by the public. “In healthcare the moral and the technical seem to fuse” (de Raeve, 2002, p. 154). It would be an exhausting undertaking to describe all of the morally binding principles of the nurse to the patient. It is accurate, however, to state there is a given expectation and duty related to each patient. As a professional, the nurse claims to embody certain values based on the range and nature of the judgment related to care delivery (de Raeve, 1996).
Linking nursing value to money stimulates a moral dialogue. What motivates the nurse to nurse? In today’s health care environment, all providers are vying for limited health care dollars. This drive for money affects trust. In general, decisions made when money is amassed create a degree of skepticism related to provider motivations and resulting decisions. This erodes trust. Prescribing a high number of profitable high-cost procedures impacting provider profits causes distrust. This distrust is heightened when health care resources are perceived as being rationed based on financial goals or greed. Staff nurses are removed from these profits and experience a distance from the money that may impact positively the patient’s trust (Rutherford, 2007; Rutherford, 2010). Nurses are expected to resist those influences related to fiduciary relationships, maintaining the trust and primary responsibility to the person receiving his or her care. Nursing’s distance from the money allows the profession’s members to remain free of the conflict of interests that may cloud choices (Milton, 2012). This distance from money and its relationship to nursing’s trusted status should be studied.

**Nurse-Driven Data and Measuring Trust**

Although nurses speak of nurse-led outcomes that impact patient survival, decrease patient re-admissions, improve health outcomes, reduce costs, and improve overall patient satisfaction, “what is well known to registered nurses...has not often been recognized outside of nursing” (ANA, 2012, p. 1). In addition, the “protective function of nursing is essential for human flourishing” (Sellman, 2005, p. 9). Trust, therefore, has value to organizations seeking to prevent and/or reduce health care spending, striving for high patient satisfaction scores to attract patients and payers, and encouraging providers to motivate patients toward healthy choices.

Literature highlights the RN’s role as integral to patient satisfaction, the quality of care, interdisciplinary communication related to care delivery, and the efficient use of health care resources (ANA, 2012). As health care struggles to reduce costs, the nurse’s trusted voice becomes all the more essential. Trust within a business and transparency/honesty with stakeholders are linked to improved efficiencies and lower cost of doing business (Paine, 2009).

The quality of nurses within an organization offers a measurable value to hospitals and impacts patient satisfaction. There is a positive relationship between hospital’s employing and supporting a higher percentage of caring and trusted nurses and the hospital’s satisfaction scores (ANA, 2012; Naylor et al., 2013). Nurse-sensitive indicators collected by the National Quality Forum and Interdisciplinary Nursing Quality Research Initiative program link nursing and quality findings and provide insight into nursing’s value. The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey indicates that four of the seven measured scores are strongly associated with nursing’s actions (McHugh & Stimpfel, 2012). HCAHPS impact hospital payment. The Centers for Medicare & Medicaid Services Value-based Purchasing Program care measures indicate the impact nursing care has on the quality of care delivery and health outcomes (McHugh & Stimpfel, 2012; Naylor et al., 2013). Today, the health care industry has a plethora of quality measures and nursing has been active in collecting data for over a decade. ANA’s National Database of Nursing Quality Indicators offer standards for nursing leadership and interdisciplinary interaction. The Hospital Compare website reports or ranks hospitals based on treatments that offer the best outcomes. This information is available for all to access. Nurse-reported quality measures associated with patient outcomes are noted to impact mortality, failure to rescue, and patients’ reports of the care experiences (McHugh & Stimpfel, 2012). Nursing plays a pivotal role in the volume-to-value transition the United States is undertaking and the profession should remain focused on demonstrating what they do.

Although the reputation of being trusted is hotly pursued in business circles for its intrinsic value, nursing has not marketed its trusted status as a value driver for the profession nor leveraged this asset to the health care industry. Trust has a measurable impact on the health of an organization and saves costs related to litigation, legislation, and lost revenue resulting from bad relations. It cultivates future relationships with consumers and stakeholders who support organizational goals (Paine, 2007). When exploring the need for accounting for this complex asset in the profession’s valuation, it is important to remember “patients attest to the importance of trust in their nurses”... and “measurement of this trust is significant to include in the assessment of nursing care quality” (Radwin & Cabral, 2010, p. 688). “Trust in healthcare professionals is associated with more willingness to seek medical treatment and adherence to treatment recommendations” and nurses, as trusted providers in the facilities, impact patient care outcomes (Dinc & Gastmans, 2012, p. 224; Thom, Hall, & Pawlson, 2004).

**Measuring Nursing Trust**

When Radwin and Cabral (2010) explored the literature (1982 to 2008) seeking instruments available to distinctively measure trust in nurses, only two measures were found that measured trust related to nurses. These two studies informed the development of the Trust in Nurses Scale, developed and assessed on patient-
centered nursing care (Radwin 2000; Radwin, Washko, Suchy, & Tyman, 2005; Radwin & Cabral, 2010). The Trust in Nurses Scale offered reliable and valid data when studying the concept of nursing trust (Radwin & Cabral, 2010). This model has been tested on diverse patient groups experiencing hospital and ambulatory cancer care and should be explored to collect data related to trust and its value characteristics for nurses. Each item in the scale addresses nurse activities or patient feelings. How often were nurses there when needed and how often did nurses act in the respondent’s/patient’s best interest are included as variables. Trust is measured using a global item, asking how much the respondent trusted the nurse using a scale from 1 to 10; 1 indicating no trust and 10 indicating trusting the nurse as much as possible. Radwin and Cabral (2010) concluded the study by attesting to the importance of trust in the patient-nurse relationship and measurement of trust as important to support nursing care quality.

There is an economic value for nursing to embrace and document patient trust. Qualitative research seeks the assessment of the patient’s perspective of trust related to experiences with the nurse. The willingness of the patient to cooperate and/or pay for services rendered is at the “core of cost-benefit analysis” (Rutherford, 2007, p. 16). Metrics can be used to examine observed behavior from theoretical behavior that would be expected in the absence of adherence to cooperation. Health care economics focuses on choices related to access, quality, and costs. Trust allocated to nurses from patients can be linked closely to higher quality and lower cost in health care. Access to health care is affected when the nursing investment is not adequate.

Conclusion

There is a positive linkage between nurse-patient trust and over-all patient satisfaction in the hospital experience. Today’s health care system is challenged to document its value. Nursing has the ability to influence its value and worth by highlighting its trusted status. Trust is a value driver for the nursing profession and data focused on its impact is worth compiling.

Linking trust to the fabric of nursing and investing in its measurement will become essential to nursing’s valuation and the resulting investment in nursing. Trust, identified in nursing’s core value, should be fostered by nurse educators as they prepare the next generation of nurses. Nurse administrators should connect the trust a patient has for his or her nurse to greater patient cooperation and increased honest transparent communication between providers and the patient.

Banking trust as a valuable nursing asset will substantiate nursing’s marketing and support its worth. Nursing’s trustworthiness is an intangible asset that warrants protection, as trust once lost is hard to recapture.

REFERENCES


continued on page 327
The Value of Trust

continued from page 288


