

Trust and trustworthiness in nursing: an argument-based literature review

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Caring requires nurses to establish trusting relationships with patients and to be trustworthy professionals. This article provides insight into the conceptual understanding of trust and trustworthiness in nursing through an argument-based literature review of 17 articles published between 1980 and 2010. Trust is characterized as an attitude relying with confidence on someone. The importance of trust relationships is considered by addressing the imbalances of power in nurse–patient relationships as they increase the vulnerability and dependency of the truster. Trust is considered as a process, and time, reliance on others, risk and fragility are identified as basic attributes of trust. However, trustworthiness is inadequately explored in the nursing ethics literature. Nurse educators have a responsibility to ensure that nurses are equipped with the attitudes and knowledge that are needed to establish trusting nurse–patient relationships.

Key words: ethics, interpersonal communication, nurse–patient relationships, nursing practice, philosophy.

Trust is essential to human relationships and is critical to both human development and life itself (Govier 1992). According to Baier (1986), trust is allowing someone to take care of something about which the truster cares deeply. For Baier, the act of ‘caring for’ involves discretionary powers. She says, ‘when I trust another, I depend on her good will toward me. Where one depends on another’s good will, one is necessarily vulnerable to the limits of that good will, and gives others an opportunity to harm when one trusts, and shows confidence that they will not take it’ (Baier 1986, 235).

Despite the confidence in and reliance on the expected actions of the trustee, there is lack of certainty about what the trustee might do; he/she might carry out whatever is expected of him/her or violate the trust. Trusting always involves a certain amount of risk, and a willingness to risk abuse. Therefore, a trust-based relationship requires that the trustee be trustworthy. Thus, the goodwill of the trustee, argued by Kant to be an unconditional good (Johnson

2010), a rationally guided will that adds a moral dimension to one’s behaviour, and personality traits (such as reliability, sensitivity towards others, integrity and professional competence) are important.

Trust and trustworthiness are especially relevant to health-care, as vulnerable patients cannot meet their own needs and must rely on the good will of others. Typically, nurses are the ones interacting with these patients; thus, they are the healthcare team members most intimately involved in patients’ lives (Nortvedt 1998), and patients entrust their health to nurses with the expectation that they will receive good care. Hence, the practice of nursing includes a moral dimension that requires sensitivity and trustworthiness (Gastmans, Dierckx de Casterlé, and Schotmans 1998).

The importance of trust and trustworthiness has been emphasised in nursing literature in the context of the interpersonal relationship between nurse and patient (Carr 2001; Mok and Chiu 2004; Langley and Klopper 2005; Sacks and Nelson 2007; Berg and Danielson 2007; Eriksson and Nilsson 2008). However, trust is also a social phenomenon that can apply organisationally and professionally. For example, Gilbert (2005) argues that trust in organisations occurs

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through impersonal systems and that organisations earn it by managing costs, providing comfort, ensuring security and establishing systems to identify needs.

Professionally, trust has a normative meaning, because professions must direct their services towards meeting needs and resolving problems. Thus, professionals must be competent and trustworthy to meet their obligations. Brien (1998) suggests that trust is an ideal to which professionals must aspire, morally and prudentially, to fulfil their responsibilities. He maintains that professions must cultivate a culture of trust in order to attain the ideal of professionalism. Being a professional requires the promise to abide by professional norms and use one's professional capacities to meet the needs of others without being primarily self-interested. This promise can be fulfilled only if the client cooperates, which can only occur if the client and the professional trust each other. Professionals have power because they possess specialised knowledge and exercise control over its use, but trust is a means of overcoming the power asymmetry of professional relationships (Brien 1998).

Because trust is considered vital for both interpersonal and professional relationships, it has been studied extensively. Healthcare studies report that higher levels of patients' trust in healthcare professionals are associated with more willingness to seek medical treatment and greater adherence to treatment recommendations (Thom, Hall, and Pawlson 2004; Musa et al. 2009). Although the positive effects of trust have been acknowledged, researchers have not agreed on a uniform definition of trust. Lewis and Weigert (1985) state that trust is highly complex and multidimensional; thus, it deserves an effective conceptual understanding that serves as a theoretical framework for scientific purposes.

In the context of nursing, further theoretical elucidation of these concepts can contribute to clarification and might inform nursing practice and education with alternative points of view and wider conceptualisations. Greater conceptual understanding can increase nurses' awareness of the normative value of trust in nurse–patient relationships and of their professional moral obligations. Conceptualisation is also critical for empirical research in nursing practice to improve patient care through appropriate measurement of the effects and outcomes of trust and trustworthiness.

AIM

This study explores the understandings and uses of the concepts of trust and trustworthiness within the field of nursing by reviewing argument-based nursing ethics literature.

METHODS

We conducted an argument-based nursing ethics literature review inspired by the methods of McCullough, Coverdale, and Chervenak (2004). Since this methodology involves a critical appraisal of arguments based upon empirical as well as philosophical and normative claims, some terms in this paper require clarification.

An argument is 'a connected series of statements or propositions, some of which are intended to provide support, justification or evidence for the truth of another statement or proposition' (The Internet Encyclopedia of Philosophy 2010). Argumentation is a process of deductive or inductive reasoning. Frogel (2004) suggests that philosophy is the domain of argumentation.

Ethics is a branch of philosophy concerned with understanding what is 'good' in human interactions with others and the environment. Although philosophy approaches this through logical analysis, Frogel (2004) suggests that argumentation cannot proceed through logical reasoning only; it also requires the autonomous judgment of individuals (Frogel 2004). Normative ethics concern values and norms and seek to arrive at moral standards that regulate right conduct by appealing to general ethical theories, such as virtue ethics, teleological or deontological approaches, and values and principles. Arguments in normative ethics can be supported by facts derived from descriptive ethics (a branch of ethics), which is regarded as a form of empirical investigation into our behaviour and attitudes, but argumentative statements are also constructed through normative ethical claims.

McCullough, Coverdale, and Chervenak (2004) suggest that the literature of normative medical ethics is argument-based and uses ethical analysis and argumentation to explore the implications of the ethical conceptualisation of clinical practices and healthcare policies rather than their empirical descriptions. They propose an 'argument-based medical ethics formal tool' for critically appraising normative medical ethics literature. Although designed to evaluate articles' logical rigour, McCullough, Coverdale, and Chervenak (2007) and other investigators (Quaghebeur, Dierckx de Casterlé, and Gastmans 2009; Wernow and Gastmans 2010) used this tool in their systematic literature reviews.

We employed McCullough, Coverdale, and Chervenak (2004) method to review the arguments about trust and trustworthiness in the nursing ethics literature rather than obtaining data on the factual role of trust in nursing practice or describing nurses' attitudes towards trust. In this paper, 'argument-based literature review' refers to the systematic review of the philosophical arguments on trust and trustworthiness in the field of nursing.

This method comprises four steps: (i) identifying the focused questions; (ii) conducting a literature search to identify articles relevant to the focused ethics questions; (iii) assessing the adequacy of the articles' argument-based methods; and (iv) identifying the authors' conclusions and positions.

FOCUSED QUESTIONS

Examining the relevant literature led us to formulate the following questions:

- How are the concepts of trust and trustworthiness characterised and defined in the nursing ethics literature?
- What related terms are used to describe trust and trustworthiness?
- What is the relational/social context of trust and trustworthiness?
- What is the normative meaning of trust and trustworthiness?
- What are the critical antecedents, attributes, and consequences of trust and trustworthiness?

LITERATURE SEARCH

The electronic databases Academic Search Premier, Informaworld, CINAHL, Medline, Philosopher's Index, Psycinfo, Social Science Citation Index, Science Direct, ERIC (EBSCO), ERIC (OvidSP) and Scopus were searched using combinations of the keywords 'trust', 'trustworthiness', 'nurse', and 'nurse-patient relationship'. We also searched the reference lists of the identified articles to find additional relevant publications.

SEARCH OUTCOME

We only included articles in nursing ethics literature that addressed a focused question, reported ethical arguments on trust and trustworthiness clearly and were published in English between 1980 and 2010. We accepted the arguments in each article at face value, without in-depth analysis or critique. Editorials, case studies, opinions, nursing organisation position papers, codes of ethics, books and chapters, dissertations, and empirical studies were excluded.

Seventeen publications met our inclusion criteria. Included authors originated from the UK (7), the USA (7) and Canada (3). All studies were published in nursing journals, and 15 had a nurse as their primary author (see Table 1).

DATA ABSTRACTION AND SYNTHESIS

The data abstraction and synthesis process consisted of reading, comparing, categorising and inter-relating the data. The data abstraction process started with reading the articles thoroughly to identify recurring themes and arguments; then, the authors identified the data to be extracted through a series of discussions. A data abstraction form was then designed to reflect the study's focused ethics questions and was later revised to include definitions of trust, trustworthiness and related terms (such as trust and trustworthiness as relational phenomena, both interpersonally and impersonally, the normative conceptualisation of trust and trustworthiness, and trust as a process with antecedents, defining attributes and consequences). Passages in articles that explicitly addressed the subthemes identified in the data abstraction process were marked and transcribed on the form. Data were analysed by inter-relating them and were then integrated into subheadings appropriate to the subthemes. For the purpose of this article, the term 'truster' is one who places trust in someone or something, while the term 'trustee' is a person or an organisation being trusted.

RESULTS

Definition/characterisation

Thirteen authors give a clear definition of trust (Meize-Grochowski 1984; Washington 1990; Pask 1995; Johns 1996; Hams 1997; Peter and Morgan 2001; Hupcey et al. 2001; Peter and Watt-Watson 2002; Williams 2006; Sellman 2007; Bell and Duffy 2009; Crigger 2009; Carter 2009). Gilbert (1998), De Raeve (2002) and Tarlier (2004), however, provide general definitions. Sellman (2006) is the only author who defines trustworthiness clearly as a virtuous characteristic of a person or institution (see Table 1).

Trust is generally characterised as a belief (Pask 1995) or an attitude bound to time and place (Meize-Grochowski 1984; Washington 1990), a confident reliance on someone or something (Meize-Grochowski 1984; Washington 1990; Johns 1996; Hams 1997; Carter 2009), a willingness to engage in a relationship while accepting one's consequent vulnerability (Johns 1996; Hams 1997; Peter and Watt-Watson 2002; Bell and Duffy 2009), and a complex process of internal mediation incorporating risk and vulnerability whenever a significant action or decision is encountered (Carter 2009).

Definitions of trust from Pask (1995), Peter and Morgan (2001), Peter and Watt-Watson (2002), and Sellman (2007)

Table 1 Articles included in the literature review (date order)

Reference	Trust as relational/social phenomenon			Trust as process		
	Country	Definition/characterization	Related terms	Interpersonal trust		Outcomes
				Antecedents	Attributes	
Meize-Grochowski R. (1984) USA		Trust is an attitude bound to time and space in which one relies with confidence on someone or something known	Faith Belief Hope	Nurse-patient relationship	Impersonal trust	A sharing of feelings between two persons Development of a therapeutic relationship Openness and honesty between two persons Increasing level of trust
Washington GT. (1990) USA		Trust is the reliance on the promise, written or verbal, of an individual		Nurse-patient relationship		Improve the public's perception of professional nursing Improving patient care
Pask EJ. (1995) UK		Trust is belief that our good will be taken care of. It involves the capacity to put our faith in the goodwill of others towards us, and to accept that not all can be known	Faith Belief	Nurse-patient relationship Nurse-physician relationship	Basic trust in ourselves Trust between members of health care team	Reducing patient anxiety Sense of control
Johns JL. (1996) USA		Trust is the willingness to place oneself in a relationship that establishes or increases vulnerability with reliance on someone or something to perform as expected		Nurse-patient relationship	Perception of risk Perception of competence Past experiences Expectation of positive consequences	Improving patient care and organizational effectiveness Realization of expected benefits and unanticipated results Stable, increasing or decreasing levels of trust

Table 1 Continued

Reference Country	Trust as relational/social phenomenon			Trust as process			
	Definition/characterization	Related terms	Interpersonal trust	Impersonal trust	Antecedents	Attributes	Outcomes
Hams SP. (1997) UK	Trust is a willingness to engage oneself in a relationship that has reliance on either person(s) or thing(s), with an expectation that vulnerability may arise from either the trustee's or truster's performance		Nurse-patient relationship		Perception of competence Past experiences Expectation of positive consequences	Vulnerability Reliability Reliance Performance and expectation Trustworthiness of the trustee Risk Time	Empowerment of patient and nurse Development of the traditional nurse's role Improving patient care Realization of expected benefits, Stable, increasing or decreasing levels of trust
Gilbert TP. (1998) UK	Trust is a mechanism within the power relations of caring	Mistrust Abuse Hope		Trust in institutional/professional network Positions of trust Mistrust	Basic trust in ourselves Choice and degree of control Interpersonal forms of trust are a prerequisite for more complex impersonal forms of trust	Time Competence Uncertainty Expectations Risk	
Peter E, Morgan KP (2001) Canada	Trust is the reliance on others' competence and willingness to look after, rather than harm, things one cares about that are entrusted to their care Trust is the reliance on another's goodwill		Nurse-nurse-physician relationship	Trust in institutional/professional network Conflicts of trust		Vulnerability Competence of trustee Goodwill of trustee Discretion of trustee	Improving organizational effectiveness
Hupcey JE, Penrod J, Morse JM.&Micham C. (2001) USA	Trust emerges from the identification of a need that cannot be met without the assistance of another and some assessment of the risk involved in relying on the other to meet this need	Faith Risk-taking			A need that cannot be met without the help of another Past experiences Perception of risk	Dependency Risk Expectations Limited focus to the behavior related to the need Testing of the trustworthiness	Evaluation of the congruence between expectations of the trusted person and actual behaviors

Table 1 Continued

Reference Country	Trust as relational/social phenomenon			Trust as process		
	Definition/characterization	Related terms	Interpersonal trust	Impersonal trust	Antecedents	Attributes
de Raeve L. (2002) UK	Patient's trust in the nurse is initially one of confidence in the institution and its representatives, rather than in the person of the nurse per se		Nurse-patient relationship	Trust in institutional/professional network	General trust Confidence in network of structures	Time Reliance
Peter E. Watt-Watson J. (2002) Canada	The act of trusting entails relying on others to be dutiful, caring, and good, resulting in the dependency and vulnerability of the other		Nurse-patient relationship	Trust in institutional/professional network Conflicts of trust	Perception of competence Evaluation of the moral character	Reliance Dependency Vulnerability
Tarlier DS. (2004) Canada	Trust, while founded on personal morals, is also related in a fundamental way to professional qualifications, skills, and competence		Nurse-patient relationship	Trust in institutional/professional network	Acceptance of others, sincerity, and genuineness Confidence in nurses' identifiable affiliation	Competence
Sellman D. (2006) UK	Trustworthiness as a virtue requires nurses to cultivate certain character dispositions, as well as to develop effective task performance	Hope Friendship		Trust in institutional/professional network Conflicts of trust Institutional trustworthiness	Confidence in network of structures Institutional trustworthiness	Competence Trustworthiness Goodwill Vulnerability
Williams LL. (2006) USA	Organizational trust is the positive expectations individuals have about the intent and behaviors of multiple organizational members based on organizational roles, relationships, experiences, and interdependencies			Organizational trust	Willingness to open ourselves Sense of justice	Risk Vulnerability Fragility Competence and honesty Concern for employees Reliability
						Increasing level of trust Trustworthiness of nursing as an institution Enhancing human flourishing

Table 1 Continued

Reference Country	Trust as relational/social phenomenon			Trust as process		
	Definition/characterization	Related terms	Interpersonal trust		Antecedents	Attributes
			Interpersonal trust	Impersonal trust		
Sellman D. (2007) UK	Trust is reliance on the others' good will	Belief Hope Faith Distrust	Nurse-patient relationship		Choice and degree of control	Reliance Goodwill Vulnerability Dependency The discretion of the trustee
Bell L. Duffy A. (2009) UK	Trust is the optimistic acceptance of a vulnerable situation, following careful assessment, in which the trustor believes that the trustee has his best interests as paramount		Nurse-patient relationship		A need that cannot be met without the help of another Perception of risk Perception of competence Past experiences	Competence Goodwill Fragility Vulnerability Risk Increasing level of trust Improving organizational effectiveness Potentially benefits patients
Grigger NJ. (2009) USA	Trust in refers to a relationship, situation, person or role in which one has confidence	Trust to	Nurse-patient relationship		Beliefs about person Past experiences	Reflexivity Goodwill
Carter MA. (2009) USA	Trust can be characterized as reliance on others' competence and willingness to look after the things that one cares about, which are entrusted to their care, rather than to harm them		Nurse-patient relationship		Perception of consistency in the words and actions of others General confidence in nursing	Vulnerability Dependency Confidence Reliance Goodwill Discretion Risk Fragility Morally response to the needs of patients

were similar because they were based on Baier's (1986, 259) definition: 'a "reliance on others" competence and willingness to look after (good will), rather than harm'.

Related terms

The most commonly used terms to describe trust that do not include its defining attributes are 'faith' (Meize-Grochowski 1984; Pask 1995; Hupcey et al. 2001; Sellman 2007), 'belief' (Meize-Grochowski 1984; Pask 1995), 'hope' (Meize-Grochowski 1984; Gilbert 1998; Sellman 2006, 2007), and 'mistrust' or 'distrust' (Gilbert 1998; Sellman 2007).

Pask (1995) describes faith as a capacity involved in trust. Meize-Grochowski (1984) states that faith implies confidence and reliance but, unlike trust, does not need to be based on experience.

Pask (1995) and Sellman (2007) refer to belief in describing trust (i.e. the truster's belief in the goodwill of the trustee). Meize-Grochowski (1984) distinguishes between belief and trust: 'belief does not suggest confidence or reliability the way trust does'.

Hope is similar to trust but is less fragile (Meize-Grochowski 1984). Gilbert (1998) states that hope emerges when there is no choice, whereas trust and mistrust require choice and are marked by a degree of control.

Mistrust and distrust are interchangeable. Sellman (2007, 33) uses distrust to clarify trust (or distrust) 'as a mean between trusting too much and trusting (or distrusting) too little'. For Gilbert (1998), mistrust is the functional equivalent of trust.

Sellman (2007) maintains that trust is closely related to ideas such as belief, hope, faith, confidence and reliance and that the goodwill of the trustee makes the difference. He also identifies friendship as a potential exemplar of a trusting relationship but cautions that patient-nurse relationships are essentially different, as they 'do not share common origins with friendship and patients do not freely choose to enter into relationships with individual nurses' (Sellman 2006, 106).

Trust and trustworthiness as a relational and social phenomenon

Trust thrives in human relationships and occurs both on interpersonal levels (interpersonal trust) and within organisations (impersonal trust).

INTERPERSONAL TRUST

Most authors describe trust within the context of nurse-patient relationships (Meize-Grochowski 1984; Washington

1990; Pask 1995; Johns 1996; Hams 1997; Peter and Watt-Watson 2002; De Raeve 2002; Tarlier 2004; Sellman 2007; Bell and Duffy 2009; Crigger 2009; Carter 2009). Washington (1990), for instance, stresses the importance of trust in the critical area of health-care, where patients can be completely dependent on nurses.

Pask (1995) and Peter and Morgan (2001) emphasise the importance of trust among members of healthcare teams. Peter and Morgan (2001, 3) state that 'health care professionals are dependent on one another for clinical judgments, observations, and the completion of delegated acts, physical safety and an emotionally secure work environment'.

Tarlier (2004, 238) invokes trust in both nurses and institutions by indicating the 'dynamic, two-way aspect of trust, in that patients trust nurses in part because of nurses' identifiable disciplinary affiliation, and in part because a particular nurse "earns" the trust of a particular patient by demonstrating a trustworthy moral character'.

IMPERSONAL TRUST

Trust in nursing's institutional and professional networks is often emphasised (Gilbert 1998; Peter and Morgan 2001; Peter and Watt-Watson 2002; De Raeve 2002; Tarlier 2004; Sellman 2006). Drawing on social theory, Gilbert (1998) argues that the trust structured within nurse-patient relationships is an impersonal form, established through the systems in which professionals (e.g. nurses) are embedded. He believes trust to be a mechanism of power within caring relationships that serves to manage complexity and enable resources to be claimed and distributed. De Raeve (2002), Sellman (2006) and Carter (2009) consider confidence in nursing as the basis of our trust in nurses because institutions regulate practices and endorse the trustworthiness of professional activities. Peter and Morgan (2001) and Peter and Watt-Watson (2002) draw attention to conflicts in trust relationships within the broader trust network. They argue that power imbalances, financial constraints, organisational politics and restrictive policies may lead to difficulties. Finally, Williams (2006) refers to organisational trust when he mentions the web of relationships formed by a nurse and other nurses, physicians and managers, all of whom influence organisational trust.

Trust and trustworthiness as a normative concept

Normative ethics concern the values and norms used to determine the rightness of actions and character traits. Trust and trustworthiness have normative aspects, which prescribe certain attitudes and actions for the trustee.

GENERAL NORMATIVE MEANING

Only Gilbert (1998) discusses trust as a mechanism within the power relationships of caring rather than as a normative notion. The other authors agree that trust has a normative meaning.

Carter (2009, 404) notes that trust invokes an intrinsic normative value. To her, 'trust is even more fundamental than duties of beneficence, veracity, and non-maleficence, because without trust, nobody would have a reason to take on these duties in the first place'.

TRUSTER

The consensus in the nursing ethics literature is that power imbalances in nurse–patient relationships contribute to trusters' vulnerability (Johns 1996; Peter and Morgan 2001; Peter and Watt-Watson 2002; De Raeve 2002; Carter 2009) and their reliance on others' goodwill not to harm them (Washington 1990; Pask 1995; Johns 1996; Hams 1997; Peter and Morgan 2001; Peter and Watt-Watson 2002; Sellman 2006, 2007). Carter (2009) addresses the inherent asymmetry in nurse–patient relationships, the unequal distribution of power and patient vulnerability when she describes building trust with patients as a moral and healing art. Agreeing with Carter (2009), De Raeve (2002) refers to the connection between vulnerability and the potential for exploitation in trusting relationships when she states that 'the concern about exploitation is going to be more, rather than less, of an issue in relationships of unequal power, as nurse–patient relationships inevitably are'. Sellman argues that 'the general expectation is that nurses will choose not to exploit the vulnerability'; however, he implies the drawback of trusting unwisely and emphasises the need to assess the other's dispositional stance towards people. According to Aristotle's view on virtue, Sellman (2007, 33) suggests that 'willingness to trust can be seen as a virtue located at a mean between an excess and a deficiency' of trust (or distrust).

TRUSTEES

Moral Commitment of Trustees. Trustees are expected to act for the truster's well-being and avoid doing harm (Pask 1995; Hams 1997; Peter and Morgan 2001; Peter and Watt-Watson 2002; De Raeve 2002; Sellman 2006, 2007; Carter 2009). Thus, the moral commitment of trustees manifests itself in goodwill and the obligation to do no harm as a moral minimum.

De Raeve (2002), Tarlier (2004), Sellman (2006) and Carter (2009) emphasise the importance of nurses' moral commitment by addressing the power imbalances in the

nurse–patient relationship. Sellman (2007) states, 'for the trusting patient, a trustworthy nurse is a moral imperative, especially where the recipient of nursing care has a diminished or compromised capacity to make an assessment of the trustworthiness of others' (Sellman 2006; 111). De Raeve (2002, 161) suggests, 'the depth and nature of the trust patients place in the healthcare system and its representatives to look after their best interests, warrants both morally and conceptually a response that needs to be honoured by an attempt to care about and not just for the patient'. For de Raeve, caring about patients requires nurses' active moral commitment to treat patients with generosity, charity and compassion. Carter (2009, 396) argues that, beyond honesty and compliance with ethical standards, nurses must commit to helping individuals achieve health-related goals in ways that also sustain their own values, rights, and responsibilities. Similarly, Tarlier (2004) implies the importance of moral commitment when describing nurses' trustworthiness as a disciplinary promise to their patients. Crigger (2009) views the nurse–patient relationship as fiduciary. For her, nurses are obliged to be loyal because patients trust their specialised knowledge and advice as facilitators of healthcare decision-making.

Trustworthiness of Trustees. The trustee's central moral commitment ('goodwill' and 'do no harm') manifests itself in trustworthiness and related virtues. Accordingly, trustee actions are motivated by goodwill and reflect the virtues and dispositions that enable their care of the valued things entrusted by the truster. Sellman (2006, 114) describes trustworthiness as a virtue requiring 'nurses to cultivate certain character dispositions, as well as to develop effective task performance'. Other authors also relate trustworthiness to certain character traits, including generosity, charity, compassion (De Raeve 2002), discretion, patience, honesty, reliability (Peter and Watt-Watson 2002), and compliance with ethical standards (Carter 2009), respect (Tarlier 2004), and fidelity (Crigger 2009). However, they do not provide a clear description of trustworthiness.

Trustworthiness of Institutions. Nurses work within systems guided by policies, goals and monitoring mechanisms. They comprise a network of complex relationships among government, insurers, universities, researchers, professional regulatory bodies, managers, and healthcare professionals. Trust among an institution, its employees and clients may influence employees' motivation and competence as well as the quality and use of their services. Therefore, fostering trusting relationships and enhancing institutional trustworthiness are considered important.

Many authors address the concept of trust within institutional and organisational contexts (Gilbert 1998; Peter and Morgan 2001; Peter and Watt-Watson 2002; De Raeve 2002; Tarlier 2004; Williams 2006; Sellman 2006). Peter and Morgan (2001) and Peter and Watt-Watson (2002) refer to the network of trust in which organisational and government policies influence clinicians' ability to establish trusting relationships with patients, while Williams (2006) emphasises the sense of justice required for organisational trust. However, only Sellman (2006, 113), in referring to the UK's non-profit motive system, mentions the concept of institutional trustworthiness: 'A virtuous institution is one in which individuals are encouraged to cultivate virtues and to act in virtuous ways'.

Trust and trustworthiness as a process

The nursing ethics literature considers trust a process arising from our capacity to trust ourselves and extend trust to others within historical and social contexts. Trust has antecedents in order to thrive, attributes distinguishing it from related concepts, and certain outcomes.

ANTECEDENTS

The term 'antecedent' refers to the preconditions for trust. The capacity to trust during infancy is considered essential to the development of an identity and the ability to build trust with others (Washington 1990; Pask 1995; Gilbert 1998). As the individual develops, trust is first extended to others within the primary care group and then to people outside of this institution (Gilbert 1998).

Trust requires a need that cannot be met unaided (Hupcey et al. 2001; Bell and Duffy 2009). Past experiences (Meize-Grochowski 1984; Johns 1996; Hams 1997; Hupcey et al. 2001; Bell and Duffy 2009; Crigger 2009) and the expectation of positive consequences influence the development of trust (Johns 1996; Hams 1997). Eventually, a perception of risk emerges as trust develops because of the possibility of disappointment or others' inappropriate behaviour (Johns 1996; Hupcey et al. 2001; Bell and Duffy 2009). However, Gilbert (1998) and Sellman (2007) argue that trust and mistrust require choice and thus imply a degree of control.

Certain factors are considered important in the development of a trusting relationship. These include the truster's beliefs about the trustee (Bell and Duffy 2009), the consistency of someone's behaviour (Meize-Grochowski 1984; Carter 2009), an evaluation of the trustee's moral character and perceptions of competence (Hupcey et al. 2001), whereby individuals are trusted or not depending on their knowledge and specific competencies.

Institutionally, trust in any professional is considered to flow from an initial confidence in the structural network. De Raeve (2002) argues that patients initially have a general trust in nurses, stemming from their confidence in the hospital, the GP, or the healthcare institution's wise selection and dismissal of incompetent nurses. Similarly, Carter (2009) refers to generalised confidence in the functional capacity of nursing as a helping profession, and Tarlier (2004) refers to confidence in nurses' identifiable affiliation by stating that trust is related to professional qualifications, skills and competences. According to Gilbert (1998), however, the development of interpersonal trust is a prerequisite for more complex forms of (impersonal) trust. Williams (2006) asserts that a pervasive sense of institutional justice is essential for the foundation of trust and for building and sustaining a nurse leaders' trustworthiness. Finally, Sellman (2006, 113) refers to institutional trustworthiness as an antecedent when suggesting that, institutions 'determine the extent to which the virtues can flourish within any given practice'.

DEFINING ATTRIBUTES

Trust's attributes are the characteristics associated with the concept of trust. Time has often been mentioned as a defining attribute of trust (Meize-Grochowski 1984; Pask 1995; Johns 1996; Hams 1997; Gilbert 1998; De Raeve 2002). For example, Meize-Grochowski (1984, 567) states, 'trust occurs in the present; however, the elements of past and future are occurring simultaneously within the act of trust', while Gilbert (1998) invokes time when he says that the capacity for trust flows from a developmental process. Johns (1996) refers to the dynamic and developmental nature of trusting relationships by drawing attention to the way trust levels may increase or decrease over time. Similarly, Pask (1995), Hams (1997), and De Raeve (2002) maintain that trusting relationships may be influenced by time.

Trust involves risk, because by trusting, individuals become dependent and vulnerable while expecting that the trustee will take care of the valued things entrusted to them. However, the person being trusted may not be fully committed to the relationship or have the necessary competencies. The outcome may violate expectations, and the truster might be betrayed (Washington 1990; Pask 1995; Johns 1996; Hams 1997; Gilbert 1998; Hupcey et al. 2001; Bell and Duffy 2009; Carter 2009).

Trust is fragile, and it is not easily regained once compromised (Williams 2006; Bell and Duffy 2009; Carter 2009). Meize-Grochowski (1984, 567) states that 'should one have a negative experience with someone or something in whom or which one trusts, then that trust will be broken or destroyed'.

Implicit in her view is the connection between the risks in trusting relationships and their fragility.

The most cited defining attributes of trust with regard to the truster are vulnerability (Johns 1996; Hams 1997; Peter and Morgan 2001; Peter and Watt-Watson 2002; Sellman 2007) and dependency (Meize-Grochowski 1984; Hupcey et al. 2001; Peter and Watt-Watson 2002; Sellman 2007). Bell and Duffy (2009) suggest an intimate connection between trust and vulnerability, while Carter (2009) observes that vulnerability is part of trusting because trust can be betrayed. Sellman (2007, 34) refers to 'the direct relationship between dependency and vulnerability on the one hand and the truster's willingness to trust on the other hand'.

Another truster-related attribute is trusters' confidence. Washington (1990, 419) suggests that 'trust involves a degree of confidence in what is communicated by the person or object'.

Goodwill is considered by several authors as an essential feature of trust, as it enables one to distinguish between the trustworthy and those only pretending to be (Peter and Morgan 2001; Sellman 2006, 2007; Bell and Duffy 2009). However, goodwill towards the trusting person is insufficient to warrant trust. Crigger (2009) states that the nurse-patient relationship is fiduciary and that loyalty and fidelity go beyond goodwill. Carter (2009, 398) argues that 'even assuming that caregivers are motivated by goodwill, something more is required for others to trust them'. For her, 'trust demands more than good will; it requires others to use their judgment and discretionary powers for moral reasons that are not simply self-serving'.

Trustees must not only possess goodwill but must also show discretion in meeting trust's demands (Peter and Morgan 2001; Carter 2009; Sellman 2007).

Other characteristics related to the trustee are reliability (Meize-Grochowski 1984; Washington 1990; Johns 1996; Hams 1997; Williams 2006) and competence (Peter and Morgan 2001; Tarlier 2004; Sellman 2006). Tarlier (2004) and Peter and Morgan (2001) suggest that trust, while founded on morals, is also fundamentally related to professional qualifications such as competence. Sellman (2006, 114) invokes competency as one of trustworthiness' qualities when he states that being a trustworthy nurse requires that attention 'be given to developing knowledge and understanding of both the cognitive and emotional domains of practice'.

OUTCOMES/CONSEQUENCES

The positive or negative consequences of trusting relationships depend on the truster's expectations and the trustee's intentions and actions. Several authors consider stable or

decreasing trust levels as an outcome of a trust relationship (Johns 1996; Hams 1997; Sellman 2006; Bell and Duffy 2009). Meize-Grochowski (1984, 571) suggests that the sharing of feelings, honesty, the development of a therapeutic relationship and the reinforcement of trust in someone or something between two people are important factors in the improvement of a trusting relationship.

Trust is an important element in improving patient care (Washington 1990; Johns 1996; Hams 1997). For example, Washington (1990) suggests that trust between nurses and patients can assist in the collection of accurate information necessary for correct nursing diagnoses. Organisationally, trust between nurses and their colleagues and other health-care professionals is considered necessary for effective team functioning (Peter and Morgan 2001), work restructuring (Johns 1996) and organisational effectiveness (Bell and Duffy 2009).

Carter (2009) argues that trust helps nurses respond morally to the needs of patients and is thus a vital dimension of clinical practice. Pask (1995) also views patient trust as necessary to nurses' ability to reduce patient anxiety and assist patients in regaining a sense of control. According to Hams (1997), a trusting relationship helps empower patients, while Sellman (2006) argues that enhancing patients' ability to flourish is the contribution nurses make through their trust relationship. Trusting relationships can improve the public's perception of professional nursing (Washington 1990), and trustworthiness adds to the general perception of the trustworthiness of nursing as an institution (Sellman 2006).

DISCUSSION

Methodological discussion

This study has some limitations. First, though we assessed the relevance of articles, some did not include a clear definition of trust and trustworthiness.

Second, our study's articles have an Anglo-Saxon origin, which may have biased the findings of our study. Analysing articles in other languages would have provided more arguments and a more global understanding of trust and trustworthiness in nursing.

Despite these methodological limitations, the strengths of our study should be highlighted. We included only those articles that directly address the concept of trust and trustworthiness in the nursing ethics literature and offered philosophical-ethical arguments. In addition, a systematic data abstraction method enabled a reliable description and comparison of the articles' main concepts.

Discussion of the main results

One of the clearest results of this review is the characterisation of trust as interpersonal. This finding is supported by the empirical nursing literature, which identifies trust as an essential element of all nurse–patient relationships (Carr 2001; Mok and Chiu 2004; Langley and Klopfer 2005; Sacks and Nelson 2007; Berg and Danielson 2007; Eriksson and Nilsson 2008). The importance of trust relationships in nursing is reflected in trust's normative conceptualisation, which most authors conceive by addressing the power imbalances in the nurse–patient relationships that increase the truster's vulnerability and dependency and require the trustee's moral commitment. The trustee is expected to have goodwill towards the trusters and act on behalf of their well-being while doing no harm. Two inter-related aspects of this conceptualisation, a willingness to accept vulnerability to another party and positive expectations regarding their intentions and behaviour, have been extensively confirmed in the philosophical literature on trust (Baier 1986; Mayer, Davis, and Schoorman 1995; Robinson 1996; Rousseau et al. 1998; Lewicki, Tomlinson, and Gillespie 2006).

In the philosophical literature, the normative value of trustworthiness rather than trust is emphasised. Hardin (1996) argues that, without trustworthiness, trust has no normative value. Similarly, Hieronymi (2008, 213) suggests, 'the reasons for which one trusts a particular person on a particular occasion concern not the value of trust itself, but rather the trustworthiness of the person in question in the matter at hand'. Strikingly, Sellman (2006) is the only author who describes trustworthiness as a virtue, requiring nurses to cultivate certain dispositions and competencies. Other authors relate trustworthiness to certain trustee character traits, including generosity, compassion, patience, honesty, reliability, loyalty and fidelity, but without exploring the concept of trustworthiness as such. Some similarities between these findings and the empirical nursing literature emerge. Rather than providing a clear description of trustworthiness, discussions refer to certain qualities of nurses, such as honesty (Hupcey and Miller 2006), competence, respectfulness, reliability, and trustworthiness (Lynn-McHale and Deatrck 2000; Rchaidia et al. 2009). However, the concept has been inadequately explored in both argument-based and empirical nursing ethics literature, which may represent a major scholarly gap.

The concept of trustworthiness, considered a virtue predisposing one to act appropriately, is influenced by many factors. Six (2007) identifies its potential limits by suggesting that no one is perfectly competent and that distrust is

sometimes legitimate. He argues that 'what is acceptable behaviour is not a matter of black and white, but of many shades of grey' and that this may cause disagreements concerning the meaning of virtues like trustworthiness (Six 2007, 297). Six's (2007) argument should be understood in the context of the following practical considerations. First, human actions are context-dependent: many personal factors, such as nurses' beliefs and cultural values, influence their characters and behaviour. Furthermore, nurses work within healthcare institutions comprising multiple individuals and groups. Power imbalances, organisational policies and financial constraints influence a nurse's ability to cultivate trustworthy dispositions and attitudes. Second, good character is a necessary but insufficient element of trustworthiness, because good intentions and motivations do not guarantee good outcomes. Finally, trust emerges within human relationships where truster and trustee interact and influence each other's intentions and actions. The nature of the relationship and the ability of patients to understand nurses' cognitive and technical competencies can therefore influence their perception of trustworthiness. Disagreements between nurses and between nurses and patients concerning the meaning of trustworthiness and the nature of appropriate behaviour may still occur.

Also notable in our study is the characterisation of trust as a process marked by time. The empirical nursing literature also treats trust as a dynamic process (Thompson, Hupcey, and Clark 2003) consisting of varying levels evolving over time and based on mutual intention, reciprocity and expectations (Lynn-McHale and Deatrck 2000). Trust is also considered a state of mutuality that is dynamic, volatile, capable of rupture and subject to renegotiation throughout its lifetime (Carr 2001). This view is supported by Khodyakov (2007, 126), who points out that 'the decision to trust another person is made in the present and is affected by the partner's reputation, which represents the past, and by the expectation of possible tangible and/or nonmaterial rewards, which represent the future'.

In this review, reliance on others, risk and fragility are identified as basic attributes of trust. Trust is regarded as the mirror image of risk (Das and Teng 2004) or a 'risky investment' (Di Luzio 2006), always carrying an element of risk because we can never fully control the actions of others (Frowe 2005).

Most of the authors refer to the vulnerability and dependency of the truster as defining attributes of trust, a view supported by the philosophical literature (Baier 1986; Mayer, Davis, and Schoorman 1995; Frowe 2005). Vulnerability is also emphasised in the nursing ethics literature. For instance, Sellman (2005) observes that vulnerability is part of the

human condition; however, 'people who are or who become recipients of health care in general and nursing care in particular, can be considered more than ordinarily vulnerable because they are not always in a position either to make judgments about protective actions or to know when they are being exploited. This is why it is necessary for those charged with the protection of patients to have certain dispositions that are consistent with the protection of more-than-ordinarily vulnerable people' (Sellman 2005, 8). According to him, the dispositions of trustworthiness need to be cultivated by both individual nurses and professional organisations.

Implications for nursing ethics practice, education and research

The normative conclusion is that these articles support the idea that nurses' professional responsibility is to provide optimal care based on their professional and moral promises. Providing optimal care requires their understanding of the meaning, scope and limits of trust in interpersonal (and perhaps institutional) relationships. This requires nurses to be aware of the unequal power relationships between them and patients, to recognise patients' vulnerability and to develop their professional competencies and qualities if they are to be considered trustworthy as individuals and as representatives of their profession.

Trust is a value-laden concept because it refers to the accepted vulnerability of patients and their positive expectations rather than their fears of harm. Although teaching abstract ethical concepts is difficult, nursing students can learn how to be sensitive to their patients' vulnerabilities and needs, how to develop trusting relationships, and the kinds of personal and professional qualities required of a good nurse. Nursing educators, therefore, have a particular responsibility to ensure that nurses are equipped with the attitudes and knowledge required for trusting nurse-patient relationships. To this end, Gastmans (2002) proposes a contextual attitude-versus-action and integral-versus-rationalistic model of ethics education that requires integrating the cognitive, affective and motivating factors of ethical conduct. Specific educational tools to enable nursing students and practicing nurses to engage in ethical reflection during clinical practice are described by Vanlaere and Gastmans (2007).

One of our significant findings that may be promising for future research is the inadequate exploration of the concept of trustworthiness in argument-based nursing ethics literature, which indicates a need for further clarification of the concept of trustworthiness in nursing. In addition, a review of the empirical studies on trust and trustworthiness

in nursing and a systematic comparison between the empirical and argument-based nursing ethics literature on trust and trustworthiness would provide a deeper understanding of these concepts.

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