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Trust In Nurse-Patient Relationships With Applying Medical Sociology Key Concepts; Review

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Abstract

The aim of this study was to report the results of a literature review of empirical studies on trust within the nurse–patient relationship. A search of electronic databases yielded 34 articles published between 1980 and2011. Twenty-two studies used a qualitative design, and 12 studies used quantitative research methods. The context of most quantitative studies was nurse caring behaviours, whereas most qualitative studies focusedon trust in the nu[1]rse–patient relationship. Most of the quantitative studies used a descriptive design, while qualitative methods included the phenomenological approach, grounded theory, ethnography and interpre- tive interactionism. Data collection was mainly by questionnaires or interviews. Evidence from this review suggests that the development of trust is a relational phenomenon, and a process, during which trust could be broken and re-established. Nurses' professional competencies and interpersonal caring attributes were important in developing trust; however, various factors may hinder the trusting relationship.

Keywords *Caring, literature review, nurse behaviour, nurse–patient relationship, trust.*

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Introduction

Nurses usually care for individuals who are most vulnerable when illness and other conditions do not allowthem to be autonomous or self-regulative.[1] They are also the closest health-care providers to patients. Patientsusually have no choice but to trust them, especially when they are critically ill. Therefore, trust is a vital valuein nurse–patient relationships. The concept of trust in the nurse–patient relationship is widely discussed in theoretical nursing ethics literature.[2] Trust is described as a belief that our good will be taken care of[3] oras an [2]attitude bound to time and space in which one relies with confidence on someone or something,[4] and as a willingness to engage oneself in a relationship with an acceptance that vulnerability may arise.[5–7] Trusthas been conceptualised mostly by addressing the imbalances of power in nurse–patient relationships that increase the vulnerability and dependency of the truster.[8–10] In line with this conceptualisation, trust is alsoconceived as an internal good of nursing practice and as a normative ethical concept.[11] For example, Carter[1]

suggested that 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.

The concept of trust is also of particular interest in empirical nursing literature. Especially, theorganisational aspects of trust have been described extensively. Studies have shown that trust has positiveassociations with many aspects of working life, including organisational citizenship behaviours and organisational commitment,[12] workplace empowerment of nurses[13] and job satisfaction.[14,15]

In addition to the organisational aspects of trust, individual empirical studies clarify that trust also playsan essential role in the individual nurse–patient relationship. The nurse–patient relationship is the cornerstone of nursing work, and trust is critical in this relationship because without trust, it is not possibleto effectively meet the needs of patients and to improve their satisfaction with nursing care. However, thevalue of trust in the nurse–patient relationship should be based on the best available empirical evidence. Thus, there is a need to collate all up-to-date information from empirical research relating to trust within the nurse–patient relationship.

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Review

Aim

The aim of this literature review was to identify empirical studies on trust within the nurse–patient relationship and to analyse and synthesise the results. Specific questions that guided this review were as follows:

1. What is the patients' level of trust in nurses, and what is the importance of the 'trust relationship' component in nurses' behaviour as perceived by patients and nurses?
2. What are the preconditions for trust in the nurse–patient relationship?
3. What are the characteristics of trust in the nurse–patient relationship?
4. What factors (barriers and facilitators) influence trust in the nurse–patient relationship?
5. What are the outcomes of trust for patients and nurses within the nurse–patient relationship?

Search strategy

An extensive search of the electronic databases, Medline, CINAHL, PsycINFO, Social Science Citation Index, Scopus, Academic Search Premier and Informaworld, was conducted using a combination of the following keywords: 'trust', 'trustworthiness', 'nurs*' and 'nurse–patient relationship'. Articles were included if they met each of the following criteria: (a) original empirical studies with a qualitative or quantitative method design, (b) about trust, (c) within the nurse–patient relationship and (d) published in English between 1980 and 2011. Articles that focused on organisational trust or trust within nurse–physi- cian or nurse–family relationships were excluded, as were editorials, conceptual analyses, review articles, case studies, opinions, position papers of nursing organisations, books and dissertations. We used the snow- ball method to identify additional studies.

Methodology

Initially, we evaluated all identified studies on the basis of titles and/or abstracts against the inclusion cri- teria. Those deemed irrelevant were excluded. Subsequently, we retrieved and evaluated the complete text of articles that met our inclusion criteria. All included empirical articles were read thoroughly to obtain an overall understanding of the material. We then extracted data from the included studies using a specifically designed data extraction form. This form included subheadings of 'Aim/Purpose', 'Background',

'Methods', 'Results/Findings' and 'Conclusions' to perform a detailed analysis. The content of each articlewas summarised under the subheadings of the data extraction form. The data abstraction and synthesis process consisted of re-reading, comparing, categorising and relating the data to each other. To providean overall picture of the methodology of the empirical studies, the methodological characteristics of the studies were incorporated into different tables. The co-author (C.G.) carefully reviewed and commented on the data collection and analysis process.

Search outcome

The literature search yielded 34 appropriate publications (Tables 1 and 2). Countries of publication were United States (7), Sweden (5), Australia (5), Canada (4), China (3), United Kingdom (2), Ireland (2), Taiwan (1), Finland (1), Iran (1), Norway (1), South Africa (1) and Iceland (1). Twenty-two studies useda qualitative design,[16–37] and 12 studies used quantitative research methods.[38–49]

Participants included nurses;[16,18,20,26,32,36,43] patients;[19,21,24,28,31,34,37,38,41,44] nurses and patients;[17,22,23,25,27,29,30,35,42,45,47–49] African Americans[39,40] and a mixed group including parents of hospitalised children,[33] residents and nurses.[46]

Twenty studies were undertaken in hospital settings.[16,18,19,21–26,28,36–38,41–45,47,48] Eleven studies were carried out in other health-care settings including primary care districts[20] or clinics,[40] ambulatory health centre,[39] palliative care and hospices,[29,31] home care,[32,33,35] aged-care facilities,[46] oncology centres[49] and psychiatric community services.[27] In three studies, the setting was unclear.[17,30,34]

Most quantitative studies provided evidence of the importance of the 'trusting relationship' component of nursing behaviour as perceived by patients and nurses.[42–49] Two other quantitative studies focused on thepatients' level of trust in nurses.[39–41] Many studies provided insights into the preconditions for developing a trusting relationship;[16–19,22,27,29,30,32,33,35,37] however, only one study exclusively focused on this factor.[20]The context of most qualitative studies was the relationship between nurses and patients,[16,17,30] including specifically the relationship between nurses and children[18,26] and their parents,[33] nurses and chronically illpatients,[34] home care nurses and elderly clients,[35] nurses and patients in palliative care,[24,29] perinatal nurses and post-partum women,[23] nurses and patients in psychiatric wards[25,27,36] and patients with tracheostomy.[19]Factors that influence a trusting relationship were discussed in most studies. A number of studiesmentioned the outcomes of trust and a trusting relationship for the patient, and two studies discussed the outcomes of a trusting relationship for the nurse.[16,18]

Methodological characteristics

The methodological features of the included studies are summarised in Tables 1

and 2. All quantitative studies used a descriptive design. Three of the quantitative studies implemented a descriptive, cross-sectional design;[39,40,42] two studies had a descriptive comparative design[45,49] and one had a correlational design.[41]

The sample size of quantitative studies varied from 29 to 300. In all quantitative studies, data were collected using questionnaires and scales. These included the Trust in Provider Scale,[39] Cultural MistrustInventory, the Michigan Academic Consortium Patient Satisfaction tool, Group-Based Medical Mistrust Scale and Black Racial Identity Attitude Scale.[39,40] Burge[41] used the Trust Subscale of the Patient's Opinionof Nursing Care to assess trust of nursing staff. Studies that focused on perceived importance of nurse caring behaviours used the Caring Behaviours Assessment (CBA) tool[38,45,48] and the Caring Assessment Question-naire (Care-Q).[42–44,46–49]

Qualitative methods included the phenomenological approach,[18,19,22,23,26,29] grounded theory,[24,30,31,33–35,37] ethnography[22,25,32] and interpretive interactionism.[17] Five studies implemented a descriptive, qualitative design.[16,20,27,28,36] Most qualitative studies used unstructured or semi-structured interviews with participants or focus groups for data collection. In all ethnographic studies[22,25,32] and in one phenomenological design,[23]data were collected using participant observation and interviews. Thorne and Robinson,[34] who adopted thegrounded theory approach, also took field notes.

Critical appraisal

In accordance with Polit and Beck,[50] we extracted information on the presence of research questions or hypotheses, study design, sampling method, data collection and analysis and ethical considerations for thequality appraisal of the quantitative studies.

Three quantitative studies clearly mentioned research questions.[38,43,48] Burge[41] and Baldursdottir and Jonsdottir[38] stated the hypotheses, and they all provided the purpose or specific aims of the study.

Ten studies included non-probability convenience sampling.[38–40,43–49] One study used power analysis todetermine the sample size,[41] and in another, the sample size was determined by regression analysis.[40] Burge[41] described both inclusion and exclusion criteria; moreover, four studies described the inclusion criteria,[38,39,42,49] and two studies mentioned only the exclusion criteria.[47,48] Five studies mentioned no inclusion or exclusion criteria.[40,43–46] All quantitative studies described the data analysis in detail, and ethical issues were adequately addressed.

Regarding the included qualitative studies, critical appraisal was done using the critical appraisal tool suggested by Hawker et al.[51] Accordingly, the methodology of each of the qualitative studies, including theabstract and title, introduction and aims, sampling, data analysis, ethics, findings/results, transferability of findings and implications, was assessed and scored as 'good', 'fair', 'poor' or 'very poor'.

Seven studies having a structured abstract with complete information and a clear title scored good,[19,20,23,26,28,29,37] and the remainder having an abstract

with most of the information scored fair. All studies provided a clear statement of aim; however, only four included research questions,[21,31,33,35] and theremainder did not include any research questions.

Six studies used purposeful sampling,[16,19,23,29,30,37] two studies used convenience sampling[24,28] and one study used theoretical sampling.[33] In 12 studies, participants were selected via inclusion criteria,[16,18,19,21,22,24,26–28,31,35,36] of which 7 stated that data saturation was achieved.[24,26–28,31,35,37]

In most of the qualitative studies, data accuracy was ensured by means of audiotape recording and verbatim transcription and analysis for common themes. In three studies, data analysis was validated by thesecond author[20,33] or with investigator triangulation by two other authors.[17] In one ethnographic study, thefield notes and initial themes were confirmed by a committee,[22] and in two studies, formulated statementswere validated using a panel of judges,[21] or analysis was presented to the hospital management team, nurses and independent researchers for verification.[37] Only one study clearly mentioned the rigour of the study, which included indicators of credibility, dependability, confirmability and transferability.[26] As the findingsof most of the studies were not transferable to a wider population, scoring for this item was very poor. Ethical issues were not mentioned in two studies[30,34] but were mentioned clearly in the remainder.

Findings

The findings of this review are presented according to the questions that guided this review.

Patients' and nurses' perceptions of the importance of trust in nurse–patient relationships

A distinction should be made between studies that estimate the level of patients' trust in nurses on the onehand and studies that report the perceived importance of the 'trusting relationship' component of nurses' caring behaviour on the other. Quantitative studies that estimate patients' level of trust in nurses indicate that nurses are highly trusted by patients. Burge[41] suggests that patients who underwent total knee arthroplasty had a high level of trust in their nurses. Benkert and Tate[39] and Benkert and Wickson[40] estimate that low-income African Americans also held high levels of trust and satisfaction with their nursesdespite having moderate levels of mistrust in the health-care system and mistrust of European American care providers.

Quantitative studies focusing on patients' and nurses' perceptions of nurse caring behaviours reflect the perceived importance of the 'trusting relationship' component of nursing behaviour. Studies using the CBA tool indicated that the importance of the 'helping/trust' subscale was ranked fourth[45] or fifth[38] by patients ina total of seven subscales. Studies using the Caring Assessment Report Evaluation Q-sort (Care-Q) instrument, which includes a 'trusting relationship' subscale, also demonstrated the relative importance of this component of nursing behaviour according to patients. Many of the included studies indicated that 'trusting relationship' was rated by patients as fourth[43] or least important[42,44,48,49] in a total of six subscales.

However, there were significant differences between nurses' and patients' perceptions. In a study by Widmark-Petersson et al.,[48] nurses ranked this subscale highest, and two other studies indicated that nursesrated 'trusting relationship' items significantly higher than patients did.[46,47]

Preconditions for trust in nurse–patient relationships

Preconditions for trust referred to necessary conditions for trust formation in the nurse–patient relationship.Only one qualitative study specifically focused on this factor,[20] while many other qualitative studies revealed evidence related to the general context. Some of the included qualitative studies reported that clients have a pre-existing trust, which is related to familiarity and previous experiences with the hospital and health-care providers,[33] and a confidence[16,22] or initial trust in nurses due to their extensive education and employment.[30,35] However, certain conditions were considered to be essential for the development of trust. These included the availability and accessibility of the nurse, feeling emotionally and physically safe,[27] feeling at home and valued as an individual, feeling adequately informed[39] and respectful communication.[16,20,35] Thompson et al.[33] reported that the development of trust requires an evaluation of care, including whether parents' and children's expectations and needs were met.

Regarding professional qualifications, nurses' technical[19,30,33] or pedagogical competence[20] and their experience[19] and good bedside manner[16] were identified as preconditions for developing a trusting relationship. Continuity of service was also identified as a precondition for the development of trust.[20,32] Developing trust within the nurse–patient relationship requires time.[16–18,20,27,33,36] To achieve a trusting relationship with patients, it was important for nurses to build a rapport; however, before building a rapport,nurses and patients must feel comfortable with each other.[16] Getting to know a patient as a person first ratherthan as a patient was another precondition for developing a trusting relationship.[18,30] Moreover, a holistic approach to caring,[29] being in charge, anticipating and meeting expectations for the care and needs ofpatients,[33] being prompt, following through and enjoying the job[22] and acting as the patient's advocate[29,30]
were identified as preconditions for establishing trust.

Characteristics of trust in nurse–patient relationships

Building trust was characterised as a process that includes various stages during which trust could be established, damaged and repaired.

Trust as a dynamic process. The development of trust was described as an ongoing and dynamic process, from feeling comfortable to building a rapport,[16] that cannot be hastened.[18,20] The trust-building process betweennurse practitioners and black female patients involved trying to understand each other, individualising and sharing of self.[17] For patients with chronic illnesses, the process developed from general naive trust into specific reconstructed trust.[34]

This reconstructed trust was no longer characterised by blind faith in the humanity of the system; rather, it was characterised by a confident expectation of what the health-care professional could offer. In another study, the trust that elderly patients had in nurses was similar to 'naive trusting' described by Thorne and Robinson;[34] however, as patients were satisfied with nursing care, trust intensified in strength and depth, and the trusting relationships spiralled upwards.[35] In Sacks and Nelson's[31] study, trust emerged from the sufferer's relationship with another through the process of evaluating congru-ence between expected and real actions, and this process included the categories of dynamic experience, experiencing uncertainty and losing trust, and regaining trust. The stages that home care nurses and elderly clients proceed through were identified as initial trusting, connecting, negotiating and helping phases.[35]

Trust as a relational phenomenon. Trust was regarded as the foundation of any therapeutic relationship[19,27,36] and an essential element of nurse–patient relationships.[18,35] It is considered inherent in the relationship between a nurse and children and between a nurse and parents.[18,33] Establishing a trusting relationship with patients was identified as an important facet of the nurse's role[26] and as a basis for continued care and treatment.[36] Hem et al.[25] state that trust is not something that nurses possess or are given; instead, it is something that they earn and have to work hard to achieve. It requires a two-way relationship between the person who makes themselves trustworthy and the person who puts their trust in them.[18] Thus, trust within nurse–patient relationships was described by Thorne and Robinson[34] as a reciprocal phenomenon. Reciprocity was also identified by Mok and Chiu[29] as an important element of nurse–patient relationships in palliative care. Their study showed that nurse–patient relationships evolve from a professional relationship to a focus on mutual understanding in which the professional relationship involves fulfilling obligatory functions and expectations and progresses to one of trust and connectedness. Morse[30] described the connected nurse–patient relationship as one in which the nurse, while maintaining a professional perspective, views the patient first as a person and second as a patient, and the patient respects the nurse's judgement and chooses to trust.

Trust as a fragile and ambiguous phenomenon. The findings of several studies suggested that trust is a fragile phenomenon. The study of Hem et al.[25] revealed how distrust was expressed in the nurse–patient relation-ship in a psychiatric department, and how trust can be created in an environment that is characterised by distrust. Both trust and distrust were exposed as 'fragile' phenomena that can easily 'tip over' towards their opposites.[25,36]

In paediatric settings, the experiences of nurses revealed the ambiguity of trust stemming from a perception of dichotomy, whereby the importance of maintaining trust was acknowledged, but breaking trust became essential to carry out painful or frightening procedures for children.[18,26] Bricher[18] described this dichotomy as two faces of a trusting relationship: trust that allows a procedure to be undertaken with minimal distress and trust that

allows the relationship to be re-established after a distressing procedure.

Factors that influence trust in nurse–patient relationships

The findings of included studies indicated that various factors may facilitate or impede the development of a trusting relationship, some of which were related to personal and professional characteristics of nurses or vulnerability of patients.

Factors that facilitate trust. Besides the preconditions for establishing trust, studies also reported several factors that facilitate trust in nurse–patient relationships. For instance, Belcher[16] reported that personal life and home environment could affect a nurse's state of mind and potentially influence the ability to effec- tively communicate. Gaining the trust of parents and children[18,35] and promoting parents' participation in children's care to reduce their anxiety[26] were also highlighted as facilitating factors. Moreover, trusting in their patients' competence to make, share or delegate decisions in such a way that their own interests wereprotected played an important role in fostering trust in professionals.[34]

Nurses' personal qualities were important aspects in developing trust. These were identified as honesty, trustworthiness,[23,27] confidentiality,[16,32] commitment to providing the best care,[16] authenticity,[32] sensitivity,humility and the ability to see the whole situation.[20] Moreover, awareness of patients' unvoiced needs; understanding of patients' suffering;[29] demonstrating care and tolerance;[25] displaying a genuine and respect-ful attitude;[32] accepting patients' cultures, lifestyles and decisions without prejudgement[35] and providing good advice, reassurance and encouragement[28] were important for developing trusting relationships.

Factors that hinder trust. A number of variables hindered the development of trust within nurse–patient relationships. One such factor is lack of the necessary knowledge and skill to undertake nursing procedures. Moreover, using medical terminology or jargon which the patient does not fully understand creates a language barrier that hinders effective communication and the building of a trusting relationship.[16] Additionally, failure to anticipate or understand the information needs of patients,[37] depersonalising the patient by referring to him or her by medical diagnosis or bed number,[30] neglecting responsibilities and remaining distant undermined patients' trust of nurses.[25] Work-related factors and emotionally challengingnursing procedures such as busy workload, inadequate time, lack of parental understanding[18,26] and value or power conflicts between nurses and patients[17] could also hamper the development of a trusting relationship.

Outcomes of trust in nurse–patient relationships

Trust resulted in positive outcomes in the professional role and job satisfaction of nurses and in the illness experiences of patients, and both outcomes have been shown to affect the quality of patient care.

Outcomes for the patient. The study of Benkert and Wickson[40] showed that patient satisfaction was positively related to trust in nurse practitioners and receipt of care in a nurse-managed centre. However, Burge[41] found no statistically significant relationships between patients' trust of staff nurses, level of post-operative pain and discharge functional outcome. Qualitative studies reported that trust in nurse–patient relationships promoted self-trust of a woman's corporeal and experiential reality, thus empowered a birthing woman,[23] and it directly addressed the well-being of the woman and her child.[32] For patients with chronic illness, trust was a meaningful and powerful component in shaping their illness experience. Trust from the health-care professional fostered their satisfaction with health-care relationships; it promoted and maintained patient competence with regard to illness management.[34] For patients with borderline personality disorder and patients who were suffering, trust enabled hope,[27,31] and for dying patients, trusting relationships with nurses facilitated their adjustment to illness, gave the incentive to continue living, helped them to find a sense of peace and security and eased their suffering.[29] Trust also played an important part in talking about depression and alcohol problems,[36] reassuring patients,[21] and psychological preparation of patients with tracheostomy during tube change.[19]

Outcomes for nurses. When trust developed successfully, patients were more compliant with care, and this increased job satisfaction for nurses. This in turn affected their contribution to patients' recovery and had a positive impact on care.[16] A trusting relationship allowed nurses to undertake painful procedures with a minimum of distress.[18]

Discussion

Methodological issues

Some methodological limitations of this review need to be considered. The first concerns the inclusion of both quantitative and qualitative studies. Whittemore and Knafl[52] suggested that the complexity inherent in combining diverse methodologies can contribute to lack of rigour, inaccuracy and bias. We minimised this risk by (a) clearly formulating the purpose and research questions of the review, (b) clearly documenting the literature search process and (c) systematically analysing the empirical data. Nevertheless, due to the variety of methodological approaches, we obtained highly fragmented empirical material, which made it difficult to compare, categorise and integrate the findings.

With the exception of three quantitative studies[39–41] that explicitly focused on trust in nurse–patient rela-tionships, the context of all others was nurse caring behaviours. However, despite the fact that trust-related findings of these studies were limited, we included them to provide additional evidence of the perceived importance of trust within the nurse–patient relationship. Since the quantitative studies provided evidence of the measurement of trust, whereas the focus of most qualitative studies was on patients' and/or nurses' experiences in relationships, it was not possible to make comparisons of quantitative and qualitative studies. Despite these limitations, the major

strengths of our study should be highlighted. Quantitative research facilitates the development of quantifiable information using statistics and thus produces more objective, reliable and generalisable results, whereas qualitative research is concerned with exploring and understand-ing human experiences and gaining in-depth insight into the people's attitudes, behaviours and value systems.[53–55]An integrative review that combines both quantitative and qualitative studies has the potentialto provide a rich, detailed and highly practical understanding of trust between nurses and patients, which canbe more relevant to nurses.[52–55] Thus, our inclusion of both quantitative and qualitative studies enabled us toprovide a more comprehensive understanding of trust in nurse–patient relationships. Moreover, a rigorousmethodological approach to identifying, critically appraising and analysing the empirical articles by two independent researchers minimised the risk of bias and enhanced the quality of this review.

Substantive findings

Evidence from this review suggests that trust is a relational phenomenon and is vital for an effective nurse–patient relationship. The development of a trusting relationship between nurse and patient was con-sidered a dynamic and ongoing process that includes various stages from initial trust to a specific recon- structed trust, during which trust could be shattered and re-established. This implies the fragile aspect of trust, which was particularly important for patients with specific conditions such as children with traumaticinjuries and burns who required repeated painful procedures and whose voices are mostly silent;[18,26] patients with psychiatric conditions who have been committed involuntarily to hospital, restrained and exposed to coercive measures[25,36] and patients receiving palliative care.[29,31] A recent review of trust and trustworthiness in theoretical nursing literature also indicated that trust is conceptualised as a process and relational phenomenon within the context of nurse–patient relationships.[2] Consistent with theoretical nursing literature, the current review provides evidence of the fragile nature of trust. It additionally contributes to the literature by making this characteristic more concrete; for instance, by indicating the emotional challenges of paediatric nurses and the dichotomy they perceived between maintaining trust versus feeling a need to break trust in order to carry out painful procedures.

This review suggests that although patients have a generalised trust in nurses as professionals, the development of trust is strongly related to the professional competence and interpersonal caring attributes of nurses as human beings. Effective communication; awareness of patients' needs; empathy; a respectful, sensitive and caring attitude and being trustworthy were important for developing a trusting relationship. In theoretical nursing literature, general trust in nurses' professional competency was also emphasised by several authors,[8–10] and trustworthiness was related to nurses' personal character traits, including generos- ity, charity and compassion;[9] honesty and reliability[10] and goodwill.[8,10] Moreover, with the exception of Sellman,[10] who described trustworthiness as a virtue, neither the theoretical

nursing literature nor the empirical studies included in this review clarified the concept of trustworthiness. Nevertheless, the findingsof this review on nurses' personality and their perception of trust as a commitment to provide the best careimply their obligation to be competent and trustworthy professionals. Theoretical nursing literature addressed this obligation by emphasising nurses' moral commitment.[9,10] Given the high level of patient trust in nurses and the association between patient trust and satisfaction as indicated by several quantitativestudies,[39,40] it seems that in spite of the many emotionally challenging situations nurses experience when caring for vulnerable patients, they honour their moral commitment by expressing a caring attitude. However, the findings of the quantitative studies included in this review also revealed that patients ranked the importance of trust in nurses' caring behaviours lower than nurses did. Moreover, this review indicates that a number of factors may hinder the development of a trusting nurse–patient relationship, including lackof necessary knowledge and skill, dissatisfaction with care and depersonalising the patient. To protect theirposition in the eyes of the public and to continue to be effective care providers, factors that facilitate or hinder trust must be considered by nurses.

Implications for nursing education and research

One of the key findings in this study is that trust is a dynamic and relational process. Trust is crucial in nurse–patient relationships not only for the quality and positive outcomes of nursing care but also, as evidenced by the qualitative studies, for patients. However, trust is fragile, and in addition to the inherent vulnerability of patients, trust itself involves vulnerability and dependency. Therefore, we recommend thatnurses be aware of the vulnerabilities of their patients and the fragile nature of a trusting nurse–patient relationship. Moreover, as this review indicates, the development of trust is related to the interpersonal caring attributes of nurses as well as their professional competencies. This suggests the need for increasedemphasis on appreciating the nature of trust and on developing personal and professional qualities throughcontinuing education programmes and undergraduate and graduate nursing programmes.

Another notable finding of this review is that quantitative studies specifically focused on trust in the nurse–patient relationship are rare. Although it can be difficult to assess trust because numerous factors influence its meaning, conceptualisation and interpretation, more quantitative research on the variables thatinfluence trust and the outcomes of trust within nurse–patient relationships would provide more objectiveevidence and generalisable results. Finally, although impersonal trust and organisational trust are differentconstructs, trust in health-care systems and organisations and trust in nurse–patient relationships are interrelated. Therefore, there is need for further research on the characteristics of organisational trust and its link with trust in nurse–patient relationships.

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Conflict of interest

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Table 1. Quantitative studies included in the literature review

Author(s)	Country; care setting	Aim of the study	Design and sample considerations	Data collection	Data analysis	Ethical
Baldursdottir and Jonsdottir[38]	Iceland; University hospital	To identify nursing behaviours that patients perceived to be indicators of caring in the emergency department	Descriptive design 300 emergency department patients RR: 60.7%	Cronin and Harrison's Caring Behaviours Assessment tool	Descriptive statistics Mann–Whitney U test and Kruskal–Wallis analysis	Approval from the Ethics Committee Informed consent obtained
Benkert and Tate[39]	United States, Michigan; primary care clinics	To examine correlates of low-income African Americans' level of trust in health-care providers	Descriptive cross-sectional design 145 low-income African Americans	Trust in Provider Scale, Cultural Mistrust Inventory, the Michigan Academic Consortium Patient Satisfaction tool	Descriptive statistics Independent sample t tests The ANOVA	Approval from the Human Investigation Committee Informed consent obtained
Benkert and Wickson[40]	United States, Michigan; primary care clinics	To analyse relationships between cultural mistrust, medical mistrust and racial identity and to predict patient satisfaction among African American adults who are cared for by primary care nurse practitioners	Descriptive cross-sectional design 100 community-dwelling adults	Cultural Mistrust Inventory, Group-Based Medical Mistrust Scale, Black Racial Identity Attitude Scale, Trust in Physician Scale, the Michigan Academic Consortium Patient Satisfaction Questionnaire	Descriptive statistics Correlations Stepwise multiple regression analysis	Approval from the Institutional Review Board Informed consent obtained
Burge[41]	United States,					

	To examine the relationship between patient trust of nurses, level of post-operative pain and discharge functional outcome following total knee arthroplasty	Correlational design	Descriptive statistics	Approval from the Trust subscale of the Patient's Opinion of Nursing Care Numeric Analog Scale	Spearman's correlations Multiple linear regression	Institutional Review Board of University of Arkansas Informed consent obtained
Arkansas; 28-bed medical surgical unit of hospital			68 patients			
g et al.[42] Taiwan; oncology inpatient units of three hospitals	To explore differences in the perceived importance of nurse caring behaviours between patients with cancer pain and oncology nurses	Descriptive cross-sectional and correlational design	50 cancer patient and staff pairs	Brief Pain Inventory – Chinese Version Care-Q Background data sheet	Descriptive statistics Paired t tests Pearson's correlations	Approval from the Human Subjects Committee Informed consent obtained
Greenhalgh et al.[43] and Finland; a general a psychiatric hospital	To describe caring behaviours of nurses	Descriptive	118 nurses RR: 66%	Care-Q Chi-square test	Descriptive statistics	Written permission from the head of departments Confidentiality assured

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Table 1.
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Author(s)	Country; care setting	Aim of the study	Design and sample	Data collection	Data analysis	Ethical considerations
Holroyd et al.[44]	Hong Kong; an acute public hospital	To identify the cultural specifics of care for Chinese patients in an acute care setting	Descriptive 29 patients RR: 72.5%	Care-Q	Descriptive statistics Validity and reliability measures	Informed consent obtained Confidentiality assured
O'Connell and Landers[45]	Ireland; teaching hospital	To compare the perceptions of nurses and relatives of critically ill patients on the importance of the caring behaviours of critical care nurses	Descriptive, comparative design 40 nurses and 30 relatives of critically ill patients	Questionnaire The Caring Behaviours Assessment tool	Descriptive statistics	Approval from Clinical Research Ethics Committee Informed consent obtained
Tuckett et al.[46]	Australia, Queensland; three not-for-profit aged-care facilities	To validate the Care-Q questionnaire in the residential aged-care setting	Descriptive, self-administered survey 37 residents (RR: 46%) and 90 nurses (RR: 48%)	Care-Q instrument	Descriptive statistics Validity and reliability measures Mann–Whitney U test	Approval from University Ethical Review Committee Informed consent obtained
Von Essen and	Sweden; university	To identify the perceptions of	Descriptive	Swedish versions of the Care-	Descriptive statistics	Approval from Ethical

Sjö den[47]	hospital and three private hospitals	patients and nurses of the most and least important nurse caring behaviours	81 patients and 105 nurses	Q instrument	t test and the ANOVA	Institutional Review board Informed consent obtained
Widmark-Petersson et al.[48]	Sweden; an oncology ward of a hospital	To investigate whether cancer patients and staff have different cognitive representations of the concepts 'caring' and 'clinical care'	Descriptive 32 cancer patients and 30 nursing staff	Swedish versions of the Care-Q instrument	Descriptive statistics Three-way ANOVAs Mann–Whitney U test	Informed consent obtained
Zamanzadeh et al.[49]	Iran; oncology centre	To determine the caring behaviours which oncology patients and oncology nurses perceive to be the most important	Comparative descriptive design 200 patients and 40 nurses	Care-Q instrument obtained	Mann–Whitney U test	Approval from Ethics Committee Informed consent

ANOVA: analysis of variance; Care-Q: Caring Assessment Questionnaire; Care-Q: Caring Assessment Report Evaluation Q-sort; RR: Response Rate.

Table 2. Qualitative studies included in the literature review

Author(s)	Country; care setting	Aim of the study	Design and sample	Data collection	Data analysis	Ethical considerations
Belcher[16]	Australia; metropolitan hospital	To explore and describe graduate nurse perceptions and experiences of developing trust in the nurse–patient relationship	Qualitative, exploratory and descriptive 7 nurses	Semi-structured interviews	Audiotape recording Transcription and coding the data Content analysis	Confidentiality assured Informed consent obtained
Benkert et al.[17]	United States; Michigan	To describe how nurse practitioners and patients in cross-racial relationships developed primary care relationship	Qualitative, interpretive interactionism 4 nurse practitioners and 20 black patients	Interviews Demographic sheet Adapted version of the family economics tool	Audiotape recording Bracketing, construction and contextualisation	Approval from Institutional Review Board Anonymity assured
Bricher[18]	Australia; acute care paediatric setting	To explore paediatric nurses' experiences of trust	Hermeneutic, phenomenological design 5 nurses	Unstructured interviews	Interpretive analysis	Approval from Human Research Ethics Committee Anonymity assured

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Donnelly and Wiechula[19]	Australia; ICU of a metropolitan acute care hospital	To investigate the lived experience patients have of a tracheostomy tube change	Hermeneutic phenomenological design 4 patients with tracheostomy	Interviews	Audiotape recording Hermeneutic analysis	Approval from Hospital's Ethics Committee Informed consent obtained
Eriksson and Nilsson[20]	Sweden; primary health-care districts	To examine the preconditions needed by district nurses to build a trusting relationship during health counselling of patients with hypertension	Descriptive qualitative design 10 nurses	Open-ended interviews	Audiotape recording and verbatim transcription Content analysis	Informed consent obtained Written permission from the head of health-care centres obtained Anonymity assured
Fareed[21]	United Kingdom; a local general hospital	To examine reassurance from the perspective of patients	Phenomenological design 8 patients	Unstructured interviews	Audiotape recording and verbatim transcription Colaizzi's procedural steps analysing	Approval from Hospital's Research and Ethics Committee Participants' autonomy ensured
Fosbinder[22]	United States, California; private acute care hospital	To discover from patients' perspectives what is important to them in their interactions with nurses	Ethnographic design 40 patients and 12 nurses	245 observations 85 semi-structured interviews	Constant comparison Daily field notes	Human subjects' approval met

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Table 2. (continued)

Author(s)	Country; care setting	Aim of the study	Design and sample	Data collection	Data analysis	Ethical considerations
Goldberg[23]	Canada; obstetrical hospital	To explore an experiential understanding of the relationships that perinatal nurses fostered with birthing women	Feminist phenomenological design 8 perinatal nurses and 8 post-partum women	Interviews Participant observation of nurses	Audiotape recording and verbatim transcription Thematic analysis	Approval from Research Ethics Review Board
Harstäde and Andershed[24]	Sweden; hospital	To describe what patients with cancer at the end of life consider to be good palliative end-of-life care	Grounded theory approach 9 patients in palliative care	Semi-structured interviews	Audiotape recording and verbatim transcription Thematic analysis	Approval from Medical Research Ethics Committee Informed consent obtained
Hem et al.[25]	Norway; acute psychiatric department	To investigate how various occupational ideals, including trust, challenge psychiatric nurses	Ethnographic design 5 patients and 6 nurses	Interviews Participant observation		Approval from Regional Committee for Medical Research Ethics Informed consent obtained
Hilliard and	Ireland; paediatric hospital	To explore the emotions	Phenomenological design	In-depth, unstructured	Audiotape recording	Approval from Hospital's

O'Neill[26]		experienced by children's nurses when caring for children with burns	10 nurses	interviews	and verbatim transcription Thematic analysis	Research Ethics Committee Informed consent obtained
Langley and Klopper[27]	South Africa; psychiatric community services	To develop a practice-level model for the facilitation of patients diagnosed as having borderline personality dis-order by the community psychiatric nurse	Qualitative, interpretive descriptive approach 6 patients and 4 clinicians	Informal, conversational interviews	Audiotape recording and verbatim transcription Thematic analysis	Approval from University Ethics Committee Informed consent obtained
Liu et al.[28]	China; two oncology hospitals	To develop an understanding of caring in nursing from the perspective of cancer patients in the Chinese cultural context	Descriptive design 20 cancer patients	Semi-structured interview	Audiotape recording Content analysis	Approval from Ethics Committees of the University and the hospitals ethics
Mok and Chiu[29]	China; home and hospital	To explore aspects of nurse–patient relationships in the context of palliative care	Phenomenological design 10 hospice nurses and 10 terminally ill patients Informed consent obtained	Unstructured interviews	Thematic analysis	Approval from the University Human Subjects Ethics Committee

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Table 2. (continued)

Author(s)	Country; care setting	Aim of the study	Design and sample	Data collection	Data analysis	Ethical considerations
Morse[30]	Canada	To provide an explanatory model for the development of various types of nurse–patient relationships	Grounded theory approach 86 nurses and 59 informants	Interviews and transcribing	Audiotape recording Content analysis	
Sacks and Nelson[31]	United States; three hospices participants' experiences of non-physical suffering	To uncover	Grounded theory approach 10 women and 8 men	Semi-structured interviews	Audiotape recording and verbatim transcription	Approval from the Institutional Review Board Informed consent obtained
Shepherd[32]	Australia; a regional city and rural area	To explore the nature of child health nurses' home visiting practice and how they address the health of mothers	Ethnographic design 12 nurses	Interviews Observations of home visits	Thematic analysis	Approval from the University Human Research Ethics Committee
Thompson et al.[33]	United States, Pennsylvania; parents' homes	To investigate the development of trust in parents of hospitalised children	Grounded theory approach 15 parents of hospitalised children	Semi-structured interviews	Constant comparative analysis of themes	Approval from Human Subjects Protection Office of Regulatory Compliance of the University Hospital Informed consent obtained
Thorne and	Canada	To explore patients'	Grounded theory approach	Field notes and		

Robinson[34]		perceptions of their relationships with professional health-care providers when chronic illness was involved	77 patients with chronic illness		interviews	
Trojan and	Canada; home care facility	To explore the development of	Grounded theory approach	Semi-structured	Audiotape recording	Informed consent obtained
Yonge[35]		trusting relationships between home care nurses and elderly clients	7 home care nurses and 6 elderly clients	interviews	and verbatim transcription	Ethical approval from the faculty of nursing
Wadell and Skarsater[36]	Sweden; psychiatric wards of two general hospitals	To describe mental health nurses' experiences of caring for persons with the dual disorders of major depression and alcohol abuse	Descriptive qualitative design 11 nurses	Content analysis	Approval from Ethics Committee of the University Informed consent obtained	Interviews
Walker et al.[37]	United Kingdom; a district general hospital	To understand how people evaluate and make sense of their experience of hospital care	Grounded theory approach 18 patients following discharge from hospital	Narrative interviews	Audiotape recording and transcription	Informed consent obtained

ICU: intensive care unit.