Trust: at the heart of clinical culture

KEY WORDS
- Ability
- Culture
- Integrity
- Respect
- Team
- Trust

In this article in the Leadership and Management series, the role of trust is examined. What trust is, how it can manifest in the healthcare setting, how it can be earned and the benefits of gaining team member trust are explored.

We use the term trust widely in discussions about leadership, management and in the clinical setting. Trust appears to be an important element of healthcare professionals' lives and those of their leaders and managers. It is therefore important to understand what trust means, where it comes from and how it can be used to improve care. Trust has to be earned. As a leader, one cannot take for granted that the team will trust you; what any leader can be sure of is that trust is more easily lost than gained.

The last paper in this series discussed delegation and how delegation can be used to grow and develop members of the wider healthcare team as well as free time for the leader to spend on other things. One of the key threads of delegation is the development of trust: from the leader, who demonstrates they trust the staff member to undertake a given task, and from the staff member that the manager has given them a task they are capable of doing and that the manager will support them in achieving.

This paper in the leadership and management series examines what trust is and how it might manifest in the clinical setting. It also explores how trust might be earned and the benefits of having the trust of the team for the leader. What this paper cannot do is provide a recipe for gaining and using trust in the clinical setting. This is because gaining trust is as much about who one chooses to be as it is about how one chooses to behave.

DEFINING TRUST

Rousseau et al (1998, p395) studied trust in a variety of settings and came to the conclusion that trust is "a psychological state comprising the intention to accept vulnerability based upon positive expectations of the intentions or behavior of another". What this definition presents us with is an interesting state of being; namely vulnerability. To become voluntarily vulnerable, the team member or leader must have faith — trust — that the other party will act in a way that will not exploit that vulnerability. Mayer et al (1995) suggest three characteristic traits a leader needs to demonstrate in order for the team to show trust in them:

- Ability to do the job
- Benevolence, i.e. kindness and caring
- Integrity, i.e. consistency in expressed values and ways of behaving.

Mayer et al suggest trust is multidimensional and the various dimensions have to be in place for team members to place trust in the leader or manager. Scholtes' (1988) model of trust (see *Figure 1*) concurs with this Scholtes shows how care and ability work together to demonstrate trust; what is clear in Scholtes' model is that trust cannot develop without both elements being in place:

Thinking about the definitions of trust given by Mayer et al and Scholtes, and applying this to the Rousseau et al model, we might conclude that to gain trust, which exposes followers' vulnerabilities, the manager must:

- Demonstrate that trust is well placed, i.e. the manager must show they can do the job
- Demonstrate it is safe to trust them, i.e. the manager must show they care about people and will not exploit their vulnerabilities.

THE BENEFITS OF DEVELOPING TRUST

What, then, are the benefits of gaining trust within the team? Two examples from outside of healthcare demonstrate the impact of trust on performance. In their study of business performance, Davis et al (2000) correlated trust to increased sales and profit and reduced employee turnover. Simons and McLean Parks (2002) demonstrated that increased customer satisfaction and profitability were

PETER ELLIS
Nursing Director, Hospice in the Weald, Pembury, Tunbridge Wells

related to the collective trust of employees in their managers. These sorts of findings are echoed widely in other literature, for example Judge et al (2001) suggest job performance is a function of trust over and above satisfaction in the job itself.

Dirks and Ferrin (2002) in their meta-analysis make the powerful assertion that: 'trust in leadership was most strongly related to work attitudes, followed by most of the citizenship behaviors, and finally job performance.' They go on to make another important observation about the benefits of trust in the workplace, namely improved attitude, which is a key element in how the values of the individual, team and organisation are expressed in action. It is worth reflecting on the Francis report, which prompted leaders to demonstrate an 'emphasis on and commitment to common values throughout the system by all within it' (Francis, 2013). In short, values drive attitudes which in turn drive behaviours, and all are influenced and tempered by the level of trust the team has in its leader. Dirks and Ferrins (2002) expressed this collective trust and behaviour as 'citizenship.' The idea of citizenship suggests a shared identity, agenda and behaviour; the sense of trust, engenders belonging and the desire to achieve common goals. Again trust, being two-way, suggests the individuals involved will always act in a consistent manner regardless of the presence of the leader because they want to retain that trust.

There appears to be one clear and important message here for the health and social care leader and manager: if you want to have a happy, productive, consistent workforce, develop a genuinely trusting relationship with them.

DEVELOPING TRUST

The question now becomes: 'How do I as a leader develop the trust of my team?' Taking the suggestion from earlier, we need to explore two golden threads: care and ability.

Care can be demonstrated by:

- Role-model caring behaviour
- Consulting the team on things that matter
- Being a transformational leader (see later in the series)
- Listening to the team
- Saying thank you when deserved
- Showing interest in people and their families
- Always acting fairly
- Being consistent.

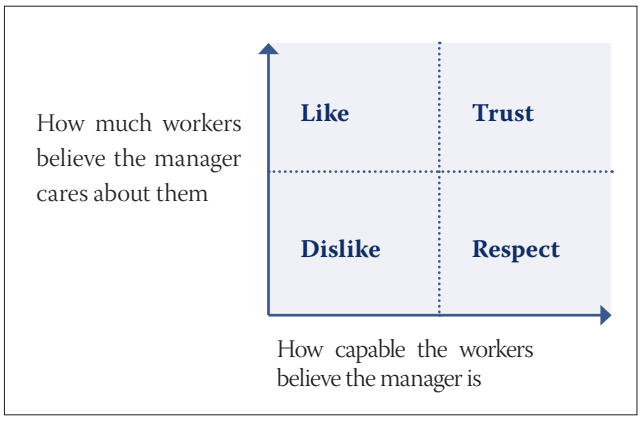

Figure 1. The two dimensions of trust based on Scholtes (1988)

One often hears leaders suggest this is not part of their role, after all it is not in their job description. This is short-sighted, however, and in the healthcare setting frankly downright dangerous. As we have seen, the impact of gaining trust is that the team members perform better, more consistently and are happier. What manager would not want this from their team?

The demonstration of ability is quite different from demonstrating care. Returning to Scholtes' (1988) model, respect is not enough in the clinical setting because respect does not ensure consistent positive behaviours; it is less visceral than trust and does not guarantee anything other than a mechanistic achievement of the task in hand. In this sense, ability for the health and social care leader or manager is not about hard-nosed managerial behaviours but about demonstrating an understanding of the delivery of care. In the caring professions, managerial ability is about translating policy into practice in a way that does not compromise quality of care – and for some, depending on the leadership position, ability is about returning to the floor and working alongside staff in the provision of care.

CONCLUSION

In this paper we have worked with a definition of trust that suggests it arises out of a relationship where people choose to make themselves vulnerable. Trust cannot be forced on people; they have to come to it willingly. We have seen that trust can reap benefits for the receivers of care, carers, leader, team and wider organisation. We have also demonstrated that trust is made up of at least two facets: ability and caring. WUK

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