APPLICATION OF THE REINA TRUST AND BETRAYAL MODEL TO THE EXPERIENCE OF PEDIATRIC CRITICAL CARE CLINICIANS

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Background Trust is essential in the workplace, yet no systematic studies of trust among pediatric critical care professionals have been done.

Objective To determine the feasibility of measuring trust in a pediatric intensive care unit by using established scales from the corporate world and to determine what behaviors build, break, and rebuild trust.

Methods The Reina Trust and Betrayal Model was used to explore contractual, competence, and communication trust. Nurses and physicians in a pediatric intensive care unit completed online surveys to measure organizational, team, and patient trust. Quantitative data from 3 standard survey instruments and qualitative responses to 3 open-ended questions were analyzed and compared.

Results Quantitative data from all 3 instruments indicated moderate to high levels of trust; scores for competence and contractual trust were higher than scores for communication trust. Scores indicated agreement on behaviors that build trust, such as pointing out risky situations to each other, actively striving to build supportive and productive relationships, and giving and receiving constructive feedback. Foremost among trust-breaking behaviors was gossip, which was more troublesome to respondents with longer experience in critical care. Responses to the open-ended questions underscored these themes. The most frequently cited items included encouraging mutually serving intentions, sharing information, and involving and seeking the input of others.

Conclusion The Reina trust scales and open-ended questions are feasible and applicable to pediatric critical care units, and data collected with these instruments are useful in determining what behaviors build, break, and rebuild trust among staff. (*American Journal of Critical Care.* 2010;19:e41-e51)

T rust is necessary for the development of healthy relationships and for the well-being of individuals within organizations, particularly health care. The Institute of Medicine[1] asserts that efforts to reduce errors, improve the quality of care, reduce nursing turnover, enhance productivity, and address other systemic issues of the health care system all depend on the perception of health care professionals that the professionals' team members, leaders, and organizations are trustworthy. Although trust may be understood globally as "social capital,"[2] it is also necessary for day-to-day practice reality.

What Is Trust?

Trust is a complicated and multidimensional concept with diverse interpretations.[3,4] Psychologically, trust can be interpreted as involving attachment[5] or as a causal factor in the development of the self.[6] Behaviorally, trust and its counterpart, betrayal, are understood as 2 dichotomous forces that affect the quality of relationships at the organizational, team, interpersonal, and intrapersonal levels.[7] In human interactions, the dynamics of trust and betrayal are instrumental in developing and maintaining relationships, achieving outcomes and goals, and ensuring the integrity of individuals, processes, and structures.[3]

Trust is built incrementally and behaviorally.[7-9] Perceptions of trust or betrayal are influenced by a person's capacities and expectations of self and others.[6,7,10] The capacity for trust expands or contracts, depending on positive or negative experiences, beliefs about how the world works, and perceptions of reality at a particular moment.[6,7] This concept and its role in developing and maintaining relationships with patients[11] or between nurses[12] has been addressed. The Reina Trust and Betrayal Model, the focus of our research, has been used in other investigations.[13,14]

Measurement of Trust

Valid measures of trust within health care settings are limited.[3] No general measurement exists to determine trust between physicians and patients[15-20]; patients, physicians, and insurers; nurses and patients[21-23]; parents and nurses[24]; nurses[12]; and nurses and the children they care for.[25] Although extensive research has been done on measurement of patients' satisfaction, little empirical research has been done on the correlates of patient-physician or nurse trust.[3] Attempts to measure interpersonal trust between health care professionals and patients are just beginning, and few measures exist of team, organizational, and leadership trust in health care organizations. Use of a behaviorally based construct to measure trust across different contexts (eg, individual, group, and organizational levels) has not been reported.

Studies on the organizational level have targeted the relationship of managed care and economic models and patient-client perceptions of trustworthiness,[26-30] patients' trust in their insurers,[20] and health care system distrust.[31] The Reina trust scales, used in corporate environments since 1993, have also been used in several studies.[32-36] Mendoza[32] used the Team Trust Scale (TTS) and found statistically significant results: the contractual, communication, and competence trust mean group scores increased over time (posttest and post-posttest) when the pretest score was used as a covariate. To date, no systematic studies of trust among pediatric critical care professionals have been done.

> Efforts to reduce errors and improve care depend upon the perception of health care professionals as trustworthy.

Conceptual Model for the Study

The conceptual model for this study was the Reina Trust and Betrayal Model (see Figure), which is used to identify 3 components of transactional trust and the specific behaviors that foster those components of trust[7]:

1. Contractual trust (trust of character): Confidence in the intentions, consistency, and reliability of individuals to honor commitments makes or breaks contractual trust, especially in the workplace.
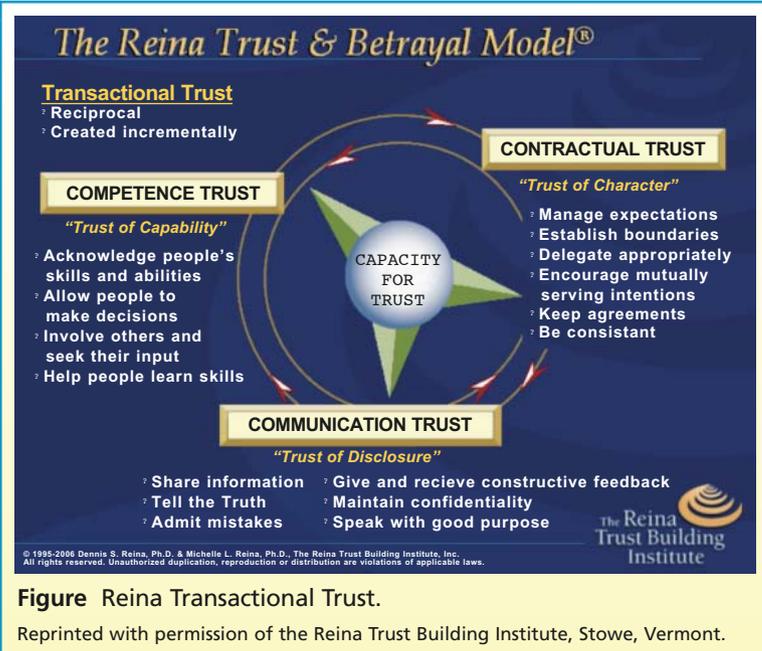
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Figure Reina Transactional Trust.

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2. Communication trust (trust of disclosure): Communication trust contributes to the development of safe and productive work environments where a person's capacity to trust in self and others increases and the organization's capacity to perform expands.

3. Competence trust (trust of capability): Acknowledging and respecting a person's competence to do what is needed in a particular situation, whether the situation involves an interpersonal interaction, role, or specific skills, builds trust. A person's sense of competence is related to his or her sense of self-worth and job-related performance.

Objectives

The purpose of this study was to determine the feasibility of measuring levels of trust between pediatric critical care nurses and physicians in relation to their organization and work group and levels of perceived trust in health care professionals by patients and patients' families. In addition, data were analyzed to identify themes about the behaviors that build or break trust in the pediatric critical care unit (PICU).

Methods

The study was reviewed by the appropriate institutional review board. The investigation consisted of 2 phases. In phase 1, baseline quantitative data were collected on 3 dimensions of trust by using 3 Reina trust scales. In Phase 2, responses to 3 open-ended questions were analyzed qualitatively, coded, and compared with the results from phase 1.

Phase 1

Instruments. The Reina trust scales consist of open-ended questions and a self-report 5-point Likert

scale used to measure behaviors that contribute to the 3 types of transactional trust. The Reina Organizational Trust Scale (OTS) consists of 54 items used to measure the level of trust between employees and management across the organization, department, or division. The Reina Team Trust Scale (TTS) consists of 48 items used to measure the level of trust within a team. The Reina Patient Trust Scale–Health Care Professional (PTS-HCP) consists of 46 items used to measure the level of trust health care professionals think patients and patients' families have for the health care team. Details on each of the 3 scales, with representative items in each category, are provided in Table 1.

Psychometric Evaluation. Before their formal administration, the Reina trust scales were subjected to rigorous development. This work included linking the theory of transactional trust[7] to the specific behaviors[7] (see Figure) within each trust dimension (type of trust) and establishing the face validity of these items through extensive research within organizations and consultation with organizational development professionals in academic and practice settings. During the initial development, internal consistency and reliability of the dimensions were assessed, and each item was examined for its integrity as a component of its respective scale. These analyses resulted in modifications in the wording of some items, which improved scale reliability on subsequent administrations. (For more details, see http://www.reinatrustbuilding.com/index.php?contentId=125.)

Internal Consistency Reliability. The internal consistency reliability of the OTS during the 3 most recent administrations was assessed by using Cronbach α to overcome the limitations of other measures of reliability, such as split-half and test-retest.[37,38] The reliability coefficients for the OTS, TTS, and PTS-HCP are provided in Table 2. Additionally, results from 3 different organizations and 132 respondents yielded reliability coefficients for the OTS ranging from 0.90 to 0.93, values exceeding the α value of 0.80 or higher considered suitable for widely administered rating scales. The predictive validity of the OTS has yet to be assessed; its concurrent validity has been assessed by comparing the mean ratings within one's group, which in general are higher than those outside of one's group. The results of the TTS closely reflect those of the OTS (Table 2.)

A bidirectional measure of trust between workers and customers in business settings, the Customer Trust Scale, is undergoing beta testing. The PTS-HCP used in this study is an adaptation of the Customer Trust Scale in which the survey

Table 1
Representative items from Reina Trust Scales

Scale name and structure	Trust building	Trust breaking
Reina Organizational Trust Scale		
33 items measuring trust between employees • 11 on each of 3 dimensions (contractual, communication, and competence trust) • On each dimension, 3 items on behaviors that break trust, 8 on behaviors that build trust	Contractual trust: Employees in this organization support one another and the common good of the organization. Communication trust: Employees in this organization actively strive to build supportive and productive relationships. Competence trust: Employees in this organization are capable of performing their job responsibilities.	Contractual trust: Employees in this organization accept credit for work they did not perform. Communication trust: Employees in this organization speak negatively to each other. Competence trust: Employees in this organization are unwilling to consider new ideas or methods.
21 items assessing trust in management • 7 on each of 3 dimensions (contractual, communication, and competence trust) • On each dimension, 5 items on behaviors that build trust, 2 on behaviors that break trust	Contractual trust: Managers in the organization are clear and explicit in their expectations of employees. Communication trust: Managers willingly share information that is pertinent to employees' jobs. Competence trust: Managers in this organization gather and weigh information before making decision on important matters.	Contractual trust: Managers' expectations of employees are unreasonable. Communication trust: Managers conceal and avoid responsibility for mistakes. Competence trust: Managers in this organization fail to take action on important matters.
Reina Team Trust Scale		
48 items measuring the level of trust within a team • 16 items on each of 3 dimensions (contractual, communication, and competence trust) • On each dimension, 12 items on behaviors that build trust, 4 on behaviors that break trust	Contractual trust: Members of this team keep agreements or renegotiate if they cannot. Communication trust: Members of this team communicate openly and honestly with each other. Competence trust: Members of this team are given the training necessary to do their jobs.	Contractual trust: Members of this team send mixed messages by saying one thing and doing another. Communication trust: Members of this team share confidential information inappropriately. Competence trust: Members of this team avoid looking for ways to improve their skills and work processes.
Reina Patient Trust Scale–Health Care Professional		
43 items measuring the level of trust that health care professionals perceive patients and patients' families as having for the health care team • Contractual dimension: 16 items, 12 on behaviors that build trust, 4 on behaviors that break trust • Communication: 13 items, 10 on building trust, 3 on breaking trust • Competence: 14 items, 10 on building, 4 on breaking trust	Contractual trust: This organization does "whatever it takes" to deliver quality care to patients and families. Communication trust: This organization advises patients and families appropriately and recommends products that serve their needs. Competence trust: This organization keeps current with latest information, skills, and technologies needed to serve patients or families.	Contractual trust: This organization operates with hidden agendas when interacting with patients and families. Communication trust: This organization disregards ideas suggested by patients or families. Competence trust: This organization exercises poor judgment with respect to the patients' needs.

was customized by using language specific to health care; therefore, the psychometric data on both instruments are not yet available.

Sample. The sample was drawn from registered nurses and physicians in a PICU in a mid-Atlantic medical center. Although the nurses were the primary focus, comparison of their responses with those of their physician colleagues helped in understanding the applicability of the scales and the narrative responses to the open-ended questions. Groups with small numbers of clinicians (eg, social work, child

life) were not included to avoid concerns about anonymity. A total of 85 pediatric critical care professionals (70 nurses, 15 physicians) were eligible to participate in the study. Results of similar studies[39] suggested that the response rate would be at least 50%. On the basis of incentives and interest in the topic, 65% participation was projected.

Recruitment. Participation was voluntary. All full-time and part-time PICU nurses, fellows, and attending physicians received an e-mail and a written invitation explaining the project; nonrespondents

Table 2
Reliability coefficients for the 3 Reina Trust Scales

Scale	No. in current sample	Reliability coefficient (Cronbach α)
Reina Organizational Trust Scale	56	Evaluation of trust between employees 0.82 Contractual 0.76 Communication 0.79 Competence Evaluation of management trust 0.42 Contractual 0.79 Communication 0.72 Competence
Reina Team Trust Scale	39	0.92 Contractual trust 0.92 Communication trust 0.86 Competence trust
Reina Patient Trust Scale– Health Care Professional	28	0.93 Contractual trust 0.91 Communication trust 0.70 Competence trust

were sent a second invitation 2 weeks after the initial mailing. Presentations at regularly scheduled staff meetings provided an outline of the project and an overview of the Reina Trust and Betrayal Model. Volunteers completed the informed consent process. A gift certificate for the unit was offered as an incentive.

Data Collection. Instructions for supplying baseline demographic data and completing the Reina trust scales were provided online and on paper. All participants used the secure online method for data collection. Each instrument required 15 to 20 minutes of a respondent's time; each instrument was completed within 14 days, with a 4-week interval between each subsequent instrument. All participants gave their consent to participate in the study.

> **Overall scores indicated moderate to high levels of trust among team members.**

Phase 2

Sample. Data from participants who completed the online survey and provided narrative responses to the 3 open-ended questions that accompanied each instrument, asking what builds, breaks, and rebuilds trust, were analyzed.

Data Analysis. The qualitative responses to the open-ended questions were analyzed by using a standard iterative process of open coding of the transcribed responses.[40-44] The data consisted of 26 pages of narrative responses coded to 1 or more of the 16 behaviors identified in the model as contributing to building or breaking trust[7] (see Figure). Results of the qualitative analysis were compared with a summary of means from the 3 Reina trust scales. The key objectives were to identify, describe, and compare themes in the data.[42] The raw narratives were imported into NVivo 8 (computer program,

QRS International, Cambridge, Massachusetts) and sorted by instrument and by question. Codes reflecting the 16 behaviors were used to organize the data into categories that could be retrieved and linked to each other.[42] The behaviors were grouped under contractual trust (6), communication trust (6), or competence trust (4). Each statement was coded to 1 or more behaviors; frequency counts were made of the coded data. Second-level pattern coding was used to organize the data into relationships among emerging themes.[43] Results were compared with a summary of means from the Reina trust scales. Interrater reliability was 0.60 to 0.85 on sample narratives; as a further reliability check, a structured feedback session with PICU clinicians was used to validate findings and themes.

Results
Phase 1

Participants completed 3 online surveys to measure levels of trust between team members (TTS; n = 39), in relation to their organization (OTS; n = 56), and, from the staff's perspective, with patients and patients' families (PTS-HCP; n = 28). A total of 47 nurses (67% of PICU nurses) and 9 physicians (60% of the PICU physicians) completed the OTS. Participants were categorized by experience level of less than 3 years (13 participants), 3 to 5 years (9 participants), and more than 5 years (34 participants). Among the nurses, 2 had diplomas, 2 had an associate degree, 41 had a bachelor's degree, and 2 had a master's degree. Among the physicians, 4 were fellows and 5 were attending physicians. Of the 56 participants who completed the OTS, 28 (50%) completed the PTS-HCP, and 40 (71%) completed the TTS.

Congruence among the results of all 3 instruments was significant (Table 3). Overall scores on all 3 indicated moderate to high levels of trust among team members, with management, and (from the clinicians' perspective) with patients and patients' families. Higher scores in the competence and contractual trust areas indicated that respondents generally respected each other's capabilities, acted with mutually serving intentions, and strove to keep their agreements with one another and with their patients and the patients' families. Lower scores in the communication area (although still a generally healthy level) suggested a tendency of health care providers to participate in gossip or unfair criticism.

Scores on the TTS indicated agreement on behaviors that build trust. Respondents rated pointing out risky situations or areas of caution to each

Table 3
Mean transactional trust scores[a]: building and breaking behaviors

Measure	Team Trust Scale (n = 39)	Organizational Trust Scale (n = 56)		Patient Trust Scale–Health Care Professional (n = 28)	Pooled mean
		Employees	Management		
Contractual					
Building behaviors	4.23	4.39	4.42	4.32	4.34
Breaking behaviors					
(lower scores more desirable)	1.43	1.58	1.77	1.70	1.62
Communication					
Building behaviors	3.77	4.22	4.25	4.15	4.10
Breaking behaviors					
(lower scores more desirable)	2.10	1.79	1.78	1.58	1.81
Competence					
Building behaviors	4.19	3.95	4.50	4.38	4.26
Breaking behaviors					
(lower scores more desirable)	1.82	2.23	1.79	1.31	1.79

[a] Scoring system: 1 = almost never, 2 = occasionally, 3 = some of the time, 4 = frequently, 5 = almost always.

other and receiving constructive feedback without getting defensive as frequently occurring behaviors. They also rated actively striving to build supportive and productive relationships, being truthful with each other, and being able to speak their mind even when others disagree as occurring frequently within the team.

Communication trust scores on the TTS provided rates for behaviors that contribute to breaking trust. The items that scored the highest as breaking trust were gossip or participating in unfair criticism about other people (mean = 2.74) and shooting the messenger who brings bad news (mean = 2.18).

On the OTS also, gossip was the gravest threat to communication trust, particularly in the 2 groups with more years of experience in critical care (Table 4). On the positive side, those with more years of experience thought that professionals with more experience took on more responsibility, making the "management" of errors and mistakes more predictable.

Across all 3 instruments, ratings of communication trust had a pattern of disaffection that was evident through all demographic groups and converged on a few specific behaviors. Analysis revealed that the in the OTS and PTS-HCP scales, years of experience accounted for the greatest variation in the communication trust scores overall.

Phase 2

In phase 2, responses to the open-ended questions were coded to the 16 behaviors identified in the Reina Trust Model (Table 5). Analysis focused on patterns across the 3 survey instruments (Table 6). The 16 behaviors identified are expressed in their positive sense (eg, speaking with good purpose is described as speaking constructively and affirmatively), but each behavior also has a shadow side. Responses to question 2 (see following) were typically coded in this negative sense. The shadow side of speaking with good purpose, for example, is

Table 4
Relationship between mean scores[a] on Organizational Trust Scale communication trust-breaking behaviors and years in professional role

Trust-breaking behavior	Years in professional role		
	<3	3-5	>5
Share confidential information inappropriately	2.05	2.36	2.40
Gossip or participate in unfair criticism about other people	2.80	3.27	3.08
Employees speak negatively to each other	2.10	2.27	2.36
"Shoot the messenger" who brings bad news	1.25	1.27	1.46
Conceal and avoid responsibility for mistakes	1.21	1.09	1.08

[a] Scoring system: 1 = almost never, 2 = occasionally, 3 = some of the time, 4 = frequently, 5 = almost always. Values shown are mean scores.

Table 5
Behaviors for coding qualitative statements

Contractual trust behaviors
  Manage expectations
  Establish boundaries
  Delegate appropriately
  Encourage mutually serving intentions
  Keep agreements
  Be consistent in behavior

Communication trust behaviors
  Share information
  Tell the truth
  Admit mistakes
  Give and receive constructive feedback
  Maintain confidentiality
  Speak with good purpose

Competence trust behaviors
  Acknowledge people's skills and abilities
  Allow people to make decisions
  Involve others/seek their input
  Help people learn skills

roughly understood as gossip or speech that is in some way harmful or corrosive to trust. Gossip may play a much larger role in certain communities and may not necessarily reflect trust-breaking speech.

Question 1: What Builds Trust? The strongest contractual trust factor was a sense of "we" and a shared mission; mutually serving intentions was stressed on all 3 surveys. Managing expectations was highlighted on the PTS-HCP. The strongest factor in communication trust across all 3 surveys was information sharing, to which telling the truth and giving and receiving constructive feedback were added on the TTS. The strongest factor in competence trust involved acknowledging people's skills and abilities. The standout in terms of building competence trust was involving others and seeking their input; analysis of the PTS-HCP indicated that this response was prominent in the answers to all 3 questions.

> Behaviors occurring frequently included "receiving constructive feedback without getting defensive."

Question 2: What Breaks Trust? The most prominent breaches of contractual trust involved lack of team work, boundaries, and managing expectations. Numerous comments, collected under the code of speaking with good purpose, addressed gossip as defensive or negative communication spoken with negative intent. Communication issues were related to sharing information and perceived openness of communication. In competence trust, a significant number of responses focused on how staff and patients were consulted and involved in decision making. The next most prevalent class of comments was criticizing people's skills and abilities.

Question 3: What Rebuilds Trust? Responses indicated that giving feedback, greater accountability for attitudes and behaviors of all levels of staff and management, improved communication, and addressing gossip were important in rebuilding trust. Other categories mentioned included managing expectations as a strategy to strengthen contractual trust. For communication trust, speaking with good purpose was mentioned as an antidote to gossip and negative language. For competence trust, a blend of sharing information and involving others was perceived as offering opportunities for improvement.

Across All 3 Questions. Overall, the quantitative and qualitative data suggested that the climate of trust in this PICU was relatively high. However, the findings on communication trust, particularly in the more experienced cohort, suggest opportunities may exist to intervene to rebuild trust with this group. Also, the "work" relationship between patients' families and the health care team was an area needing attention. In competence trust, the most problematic behaviors involved acknowledging people's skills and abilities (TTS, OTS) and involving others and seeking their input (PTS-HCP).

Discussion

Participants responded with ease to the online survey and did not appear to be deterred by the time required. The decrease in the number of participants during the study period may be due in part to patient acuity and staffing issues and the implementation of system-wide changes. Anecdotal reports that some participants found some "redundancy" in the scales may reflect the use of the Transactional Trust model and similar questions throughout, done purposely to ensure consistent and systematic measurement.

The area at greatest risk for breaking trust within this PICU was communication trust and its 6 behaviors: share information, tell the truth, admit mistakes, maintain confidentiality, give and receive constructive feedback, and speak with good purpose.[7] The most pervasive behaviors identified as breaking trust included gossip (not speaking with good purpose), breaking confidentiality, and not giving constructive feedback.

Speaking with good purpose refers to going directly to an individual with an issue or concern pertaining to him or her. This behavior reflects integrity, trust in self, a sense of compassion toward others, and an individual's intent to work through issues in a respectful and responsible manner. When people speak with good purpose, they speak to what happened constructively and affirmatively

Table 6
Selected qualitative responses to 3 open-ended questions

Question 1: What builds trust?

We have a strong respectful team within the unit that respects one another. When one team member is drowning, everyone else will pitch in to help out. At the end of the day, everyone knows that they contributed.

There is excellent communication within the PICU, particularly at the nursing–nursing manager level. Issues are handled promptly and in an up-front, nonjudgmental way.

Individuals are very capable, skilled and support team members. All members of the team, MDs and RNs alike, pitch in together when a situation calls for it.

They (patient/families) believe that the HCT will do whatever it takes to help their child.

HCT is willing to listen to families and incorporate their suggestions into plans.

People are willing to listen. When you have a really bad day (which happens frequently), there is always someone willing to sit and let you talk things out. This is extremely important in dealing with arrests and deaths of patients.

The HCT encourages family to make suggestions to improve the patient's condition and values families' opinions regarding the patient's health status.

Question 2: What breaks trust?

Criticism: this is a big factor in breaking trust, when other nurses criticize your skills or lack of knowledge, instead of teaching you the right way to do things. Judgmental employees: many nurses and RTs judge people by their mistakes or differences instead of their strong points and point out their weak points in front of others. This does not promote a strong work environment.

In general, people may take any constructive criticism as something that hurts, alienates, and builds distrust, but this is much more severe when criticism is not kind, polite, or direct (eg, behind the back).

Not sharing thought processes: If a physician or nurse explains their thought process on why they think something or want something done, then everyone is on the same page, if not, and especially if the therapy, (for example) is new or unique or unconventional, the rest of the team won't trust the person as much as they would if it was explained to them.

Question 3: What rebuilds trust?

Reduce the amount of chatter about others in the unit. This makes me feel uncomfortable, because you never know what someone is saying about you behind your back. More supportive environment—need more nurturing senior nurses, many new employees have felt threatened and hurt by their comments.

On complicated cases, it is important to plan multidisciplinary meetings with [patient's family] so that the family can gather info from all services involved at one time.

Abbreviations: HCT, health care team; MD, physician; PICU, pediatric intensive care unit; RN, nurse; RT, respiratory therapist.

and stand up for each other. Conversely, when people gossip, criticize, and shun others, trust between individuals, teams, and throughout an organization is undermined.[45,46] Although accurately discerning the intentions of people who gossip is difficult, the items reported here reflect the perceived impact or damage that communication such as negative gossip causes others.

In general, the longer clinicians work in this environment, the greater tendency they have to speak negatively to each other, shoot the messenger, and share information inappropriately. These tendencies indicate a strain on the interpersonal or human side of relationships and may be a result of years of unresolved issues. People who lack the capacity to trust themselves and others tend to project negative feelings outward and into negative behaviors. Clearly, the respondents with more experience were more pessimistic about communication in the unit, perhaps

reflecting a tendency among them to use gossip as a coping mechanism. The term gossip is used in organizational development to describe rumor spreading, backbiting, and hearsay.[7] From a broader perspective, gossip is a much more complex phenomenon.[47,48] Some think that gossip plays a key role in how nurses carry out the emotional labor associated with the nurses' work,[49] whereas others consider it a kind of "glue" that holds communities together.[50] Gossip as speech about others is often compared with nit-picking among primates as a foundationally binding social behavior and evidence of interpersonal engagement. In this sense, speaking with good purpose could be interpreted as positive gossip and not speaking with good purpose as negative gossip.

Negative gossip tends to break trust. Typically, people gossip when they feel they have no place to air their concerns constructively and appropriately.

Often people have a need be listened to and heard. As outgrowths of accumulated frustration and pent-up feelings, these gossiping behaviors reflect the tendency to project blame and resort to finger-pointing rather than collaborate and extend generosity. Negative gossip can be an indication of systemic organizational issues and can be a problem if unaddressed.

Gossip, both positive and negative, can also be a vehicle for letting leaders know issues exist that need to be dealt with in appropriate, constructive ways.

The cost of broken trust[46,51] is high in critical care. When nurses experience betrayal of this type, their integrity may be threatened, or their work rendered meaningless, and they may disconnect from the essence of whom they believe they really are. This type of corrosive gossip in the workplace is clearly a topic for exploration or interventions in the work setting, and an urgent need exists to create workplaces that are trustworthy and healthy and support the integrity of health care professionals.[52]

Speaking with good purpose is closely related to maintaining confidentiality. Confidentiality is the behavioral demonstration of respect for a person's right to control what information is disclosed to others. Confidentiality involves keeping promises made to honor a person's request that certain information not be disclosed to others and having others honor the person's choices. Sharing private information without permission breaks trust and can have devastating consequences for individuals, teams, and organizations.

Responses from our participants also indicated that the manner in which feedback is given can either build or break trust. When feedback is given and received in the spirit of supporting the relationship, both parties grow and develop. This situation requires an expanded capacity for trust on the part of both the one giving and the one receiving. The ability to share information and feelings about one's own or another's behavior and performance is critical to maintaining effective working relationships and central to expanding a capacity for trust. Our results indicate that confusion about distinctions between (1) information that is shared among unit leaders, preceptors, and mentors and (2) gossip was a potential area for broken trust. Newer nurses who overheard conversations

about their own or others' clinical competence in relationship to making patient assignments, for example, were likely to misconstrue the comments as criticism or negative gossip rather than as intentions to match patients' needs with nurses' capacities. Awareness about the potential for broken trust in these contexts offers beneficial opportunities to reduce the incidence and negative impact of such events.

By underscoring the importance of trust as a measure of team and organizational health, our findings honor the core purpose and spirit of why people work in health care. All aspects of the transactional trust model are related to key precepts set forth for the nursing profession,[53] professional standards for a healthy work environment,[52,54] and regulatory[55] and policy[56] statements. By contributing to work environments where a person's capacity to trust in self and others increases and the organization's capacity to perform expands, trust is essential to developing and sustaining relationships; team cohesion and productivity; patient safety; and individual, team, and organizational integrity.[52,56] Because 60% of errors in health care can be attributed to communication failures,[56] building communication trust is a nonnegotiable imperative. Our findings suggest that new models for developing skills in communication among interdisciplinary teams and with patients and patients' families are needed. Innovative models of learning based on the transactional trust framework offer promising opportunities to develop more than techniques by addressing the underlying issues that affect the quality of communication, collaboration, and honoring of individuals' personal capacities. Building sustainable trust through education, systems, and leadership fosters effective relationships, promotes workplace environments that are adaptive and energized, and supports efforts to transform the work environment from one of negativity and competition to one of optimism, healing, and renewal.

Limitations

This pilot study had limitations. Because we studied a single PICU, the results may not be generalizable to other PICUs or health care settings. A variety of instruments based on the Reina Model were used to measure different levels of transactional trust. Although the instruments have been reliable in business settings, further psychometric evaluation is needed. This study was the first application of the PTS-HCP. Our results indicate the feasibility and relevance of this scale to PICU clinicians, but the scale needs further psychometric refinement, particularly the dimension of contractual

> Gossip surfaced as the gravest threat to communication trust.

> Since health care errors are attributed to communication failures, building communication trust is a non-negotiable imperative.

trust. In addition, the development of a companion scale to measure the perceptions of patients and their families of the trustworthiness of clinicians, health care teams. and health care organizations is needed. This study is a first step toward the development of such a scale.

We have also introduced a trust construct that is complex and predicated on several deeper constructs that involve the origins of trusting behavior[6] as well as on the creation of both relationships[57,58] and social structures.[59] This construct certainly deserves more focused attention and will become increasingly valid with larger and more controlled studies. We also used a hybrid approach, with both surveys and analysis of open-ended narratives. The narratives are unique to the individuals that wrote them and reflect specific experiences and not the general experience of any class of health care practitioners.

Conclusions

The Reina Trust instruments are applicable to PICUs and are useful in measuring trust in that environment. Heretofore, we have lacked theoretically grounded instruments to help clinicians and administrators understand the impact of their behaviors on others' perceptions of trustworthiness. The data collected with the Reina scales is useful in determining what behaviors build, break, and rebuild trust among PICU clinicians. On the basis of our findings, interventions to build communication trust, particularly to reduce corrosive gossip and judgmental interactions, appear to be a fruitful area of investigation.

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