Dissertation Abstract

I show that in the context of nursing, trust isn't a property of the dyadic relationship between nurses and patients, but instead is a feature of nurse-patient-healthcare institution triads. Understanding trust as triadic in the healthcare context is important, I argue, because it emphasizes the pervasive role institutions have on breakdowns in trust between nurses and patients that is otherwise obscured. Nursing is a profession that exhibits features of both interpersonal and institutional accounts of trust. On one hand, nursing work demands the cultivation of trust in the relationships between nurses and patients. On the other, the care nurses provide is a form of labor, highly professionalized, systematized, and resourced by healthcare institutions. Healthcare institutions, such as hospitals, are vested in the experiences and satisfaction of both nurses, their largest workforce population, and patients, their primary consumer. They also play a critical role in shaping the social and physical environments in which patients receive care and nurses work. As such, healthcare institutions are a primary particpant in cultivating normative expectations of trust in the nurse-patient relationship. However, the very healthcare institutions that create those normative expectations in the first place, also create certain conditions that lead to or promote trust-betrayal. Thus, healthcare institutions set up expectations for trust relationships between nurses and patients that are nearly impossible for nurses to fulfill. I call this the Dilemma of Professionalized Trust (DPT).

Given the identification of this dilemma I further explore both a consequence and an explanation of the problem in this research project. A consequence of the trust-betrayal in DPT leads to the experience of blame between nurses and patients. I argue that institutions again are an active participant in cultivating organizational and social practices of blame in response to DPT. These institutional blaming practices get taken up by individual nurses and patients, shaping how blame is leveraged between them. This examination emphasizes how nurses and patients unjustly lay blame with only each other, without accounting for the triadic trust relationship present between nurses, patients, and institutions.

Finally, I transition from examining the consequences of DPT to assessing the specific context of nursing work that explains why it occurs in the first place. One such explanation is that the normative expectations of nursing taps into societal norms about feminized care work. This includes unjust gendered expectations of women to be especially caring and trusting, even and perhaps especially, in their response to blame. In their prioritization of maintaining or repairing the trust-relationship with their patients, nurses are precluded from expressing a more authentic range of emotion in response to conflict with patients. If nurses acted otherwise, the therapeutic, trusting relationship between them could fall apart, jeopardizing patient care and safety. Misogynistic social norms also reinforce these unjust gendered attitudes, further preventing nurses from otherwise resisting them. In turn, nurses' responsiveness to blame, in which they prioritize the preservation or repair of the trusting relationship above all else, places nurses in an oppressive double bind: regardless of whether they submit to sexist attitudes or resist them, nurses reinforce an unjust understanding of women in relationships.