

Interpersonal trust in a hospital context: a proposed analysis of the effects of proximities

*La confiance interpersonnelle en milieu hospitalier :
une proposition de lecture par la Proximité*

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ABSTRACT

Interpersonal trust is defined as a social resource that facilitates cooperation by enabling better coordination of interaction. The "Proximity school" shows that the closer the players are on a spatial, cognitive, social, organizational or institutional dimension, the greater the likelihood that they forge a strong relationship. Through the case study of a French cancer diagnosis, treatment and research center - Centre de Lutte Contre le Cancer (CLCC)- our research objec-

tive is to analyse how the proximities between actors in a public hospital are involved in the construction of interpersonal trust. The notion of trust is characterized by its cognitive and affective dimensions according to a grid of proximity. We show how proximity affects trust in these two dimensions.

Key-words

Trust, proximity, public hospital, case study, interpersonal

RÉSUMÉ

La confiance interpersonnelle est définie comme une ressource sociale qui facilite la coopération en permettant une meilleure coordination des interactions entre des acteurs. L'École de la Proximité montre que plus ces acteurs sont proches sur un plan spatial, cognitif, social, organisationnel ou institutionnel, plus la probabilité qu'ils nouent une relation est forte. À partir de l'étude du cas d'un Centre de Lutte contre le Cancer (CLCC), notre objectif de

recherche vise à analyser en quoi les proximités entre les acteurs d'un établissement hospitalier participent à la construction de la confiance interpersonnelle. La confiance est ainsi caractérisée dans ses dimensions cognitive et affective à partir de la grille de la proximité. Nous montrons quels sont les effets des proximités sur la confiance dans ses deux dimensions.

Mots-clés

Confiance, proximités, hôpital, public, interpersonnel

INTRODUCTION

Trust, a basic fact of life in society that brings people together, is a solution to the specific problems posed by risk (Luhman, 2001) and helps to reduce social complexity (Luhmann, 2006). By making it possible to go beyond approaches centred solely on the rational calculation of the actors, the notion of trust makes it possible to take another look at the coordination between economic agents (Morgan and Hunt, 1996). For economists and managers, it is first seen as an interpersonal phenomenon established between members of an organization (Lewicki and Bunker, 1995b; Ramonjavelo *et al.*, 2006; Rajaobelina, 2011) and forms the foundation of organizational relationships (Granovetter, 1985). Interpersonal trust is a social resource that facilitates cooperation by enabling better coordination of interaction (Mayer *et al.*, 1995; Mac Allister, 1995).

To study the construction of interpersonal trust, a lot of work has focused on studying the effect of diverse environmental variables, most often taken in isolation. Some authors have studied the effects of culture, power, social norms or economic factors on trust (Lewicki *et al.* 1998; Lorenz, 1992; Granovetter, 1985; Khelif and Zéghal, 2002). Others have proposed a more integrated approach by developing the notion of "climate": they speak of a climate of trust (Donada and Nogatchewsky, 2007), a working climate (Clot, 2016), an ethical climate (Chouaib and Zaddem, 2012), and, more broadly, an organizational climate (Wimbush and Shepard, 1994; Savoie and Brunet, 2000) without specifying their respective contents. While it seems certain that the environment acts on trust, a more integrated analytical framework still needs to be built in order to understand its mechanisms. This work aims to fill this gap by seeking to characterize the nature of the climate of trust and its effects on the construction of interpersonal trust.

For this, we propose to mobilize the work of the "Proximity school". This School studies the conditions for the emergence, the maintenance and even the destruction of economic relations (Bellet *et al.*, 1993; Torre and Gilly, 2000; Pecqueur and Zimmermann, 2004; Boschma, 2005; Torre and Rallet, 2005; Knoben and Oerlemans, 2006; Rychen and Zimmermann, 2008; Carrincazeaux, Grossetti

and Talbot, 2008; Balland *et al.*, 2015). It shows that the closer the actors are, the deeper the relationship they will develop (Cassi and Plunket, 2014). In general, this approach has been used to address inter-individual relationships (Grossetti, 2008) and, in particular, how interpersonal trust is built in organizations (Dupuy and Torre, 2004). More specifically, work on the spatiality of organizations (Dale and Burrell, 2008; Taylor and Spicer, 2007) suggests that, taken in isolation, geographic space (the "empty space" according to Lefebvre, 1974) cannot guarantee the exchange of knowledge and information. Space must also be understood as the product of social practices (Dale, 2005; Torre and Rallet, 2005).

The social characteristics of space in the diversity of non-spatial forms of proximity have been established through the literature (Bellet *et al.*, 1993; Torre and Gilly, 2000; Broekel and Boschma, 2012; Hansen, 2014), and now identified in management science work (Amin and Cohendet, 2004; Grillitsch and Nilsson, 2015; Knoben and Oerlemans, 2006; 2012; Wilson *et al.*, 2008). These forms of proximity naturally weave the bonds of interpersonal trust constituting a grid of analysis that deserves to be explored. We propose to apply this approach to the case of a French cancer diagnosis, treatment and research center - "Centre de Lutte Contre le Cancer" - (now CLCC). The hospital governance is characterized by, at the least, a tripartite relationship (administrators, doctors, managers) that impacts the overall functioning and the relationships within this organization. Indeed, it gives rise to the numerous tensions of public governance (Bartoli *et al.*, 2012) and to organizational deviances (Carassus *et al.*, 2012) that a descriptive analysis of the interpersonal relations can identify or even manage, by establishing mutual trust.

Today, the hospital practitioners are highly involved in administrative tasks, compelling them to communicate and negotiate, more than before, with the administrators and managers of their institutions. While role tensions are identified and experienced by these actors to which they are obliged to adapt (Pierru, 2012), a certain interest in management seems to characterize them gradually, which is not without incidence on their way of understanding their relations of trust with the administrators and the doctors (Georgescu and Naro, 2012). This is the case with the CLCC 'Jean Perrin', located in Clermont

Ferrand. In 2013, the Center showed a substantial economic deficit, prompting a supervisory authority to impose a plan in order to reestablish economic balance. This plan included significant cuts in expenditure and reductions in staff. Numerous conflicts associated with a relative instability in the management have emerged, including the forced departure of the Deputy Director General in 2014. To explain these tensions, the actors evoke a climate that is not conducive to the development of interpersonal trust relationships. Therefore, our research objective aims to analyse how the proximity of the actors of the CLCC Jean Perrin participates in the building of interpersonal trust. To do this, we seek to construct a reading grid capable of describing the effects of these proximities on interpersonal trust.

This work is organized as follows: in the first and second parts, we return successively to the definitions of interpersonal trust and proximity, then we present our theoretical framework. We explain the chosen methodology and the nature of our data in a third part, then we present and discuss our results in a fourth part before concluding.

1. INTERPERSONAL TRUST

According to Offe (1999), trust is first and foremost a person-to-person relationship. It is not possible to talk about trust at the level of an organization since one can only trust its members and the relationships that are established between them. This is called interpersonal trust.

1.1. A belief of individuals about other individuals

We return to the concept of interpersonal trust, generally defined by its cognitive and affective dimensions, noting that the role of the relational environment is hardly taken into account. The first empirical work on intra-organizational trust emerged in the 1990s. A significant part of this work used either the Agency Theory (Jensen and Meckling 1976) or the Transaction Cost Theory (Williamson 1985) to characterize the interpersonal relationships between two agents.

Trust allows these agents to take risks: “*where there is trust there is a feeling that others are not taking advantage of me*” (Porter *et al.*, 1975: 497). Trust is based on the fact that we will find what we expect rather than uncertainty (Deutsch, 1973). For Mac Allister (1995), it expresses a feeling of security about the future behaviour of a third person and the willingness to act on the basis of the other person’s words, actions and decisions. Mayer *et al.* (1995) then define interpersonal trust as the willingness of one party to be vulnerable to the actions of another party based on positive expectations, without any form of control being necessary. It becomes an acceptance of one’s own vulnerability to others (Lorenz, 1988; Rousseau *et al.*, 1998) and, generally, a belief of individuals about other individuals. Interpersonal trust is generally understood through its cognitive and emotional dimensions (Lewis and Weigert 1985; Mac Allister 1995; Jeffries and Reed 2000).

The cognitive dimension of trust is based on the individual beliefs and information about the reliability and the seriousness of the other. The individual chooses whom to trust, but also why and when, on the basis of what they consider to be “good reasons”. These “good reasons” refer to a partial knowledge of the other (McKnight, Cummings and Chervany, 1998). Trust is therefore based on some knowledge of the other’s integrity, honesty, reliability and competence (Johnson-George and Swap, 1982; Rempel *et al.*, 1985; Kumar *et al.*, 1995; Ganesan and Hess, 1997).

Emotional trust is a very specific relationship, emotionally attached, which makes it more difficult to build (Jeffries and Reed, 2000). It is often associated with an investment of time and feelings (Mac Allister, 1995). The emotional dimension is not necessarily based on a rational choice to trust, as emotions can create a kind of temporary irrationality in the decision to trust (Mayer *et al.* 1995; Schoorman *et al.*, 2007). Morrow *et al.* (2004) evoke intuition, feelings and instincts as being at the origin of emotional trust in a professional environment. The emotional investment in a relationship of trust is explained by the certainty of those involved that the feelings they are investing are reciprocal. In professional relationships between superiors and managers or between peers, emotional trust translates into behavioural

patterns of mutual aid, interest in others, support and open communication (Sherwood and DePaolo, 2005). All of these factors would reduce the anxiety associated with the sense of vulnerability inherent in the trust relationships.

In summary, the distinction between cognitive and affective trust suggests that these two forms of trust develop according to different psychological processes. Cognitive trust implies a computational approach; affective trust refers more to a process of empathy. Chua *et al.* (2008) show that cognitive trust develops in members who control the economic resources as well as that individuals develop emotional trust in those with whom they have deep positive ties, including bonds of friendship, counselling or mentoring. Of course, these two dimensions are linked. According to Mac Allister (1995), emotional trust would explain the willingness to use knowledge about people (cognitive trust) as a basis for action. It is the emotional bonds between the actors that will allow trust to progress because they will encourage the repetition of interaction that will, in themselves, build a stronger more resistant trust and thus overcome minor offences (Droege *et al.*, 2003; Zaheer, Albert and Zaheer, 1999).

1.2. The role of the relational environment is still unclear

The relational environment is recognised as playing an essential role in the building of trust (Nilsson and Mattes, 2015). Various factors are generally referred to as a history of trust:

- a cognitive factor based on the sharing of technical or professional knowledge (McKnight and Chervany, 2006; Williams, 2001);
- a social factor founded in common personal relationships (Hardin, 1992; Rotter, 1971);
- an organizational factor by sharing a workplace or joint venture (Gargiulo and Gokhan, 2006);
- an ideological factor characterized by similar values or ideologies (Bachmann and Inkpen, 2011; Möllering, 2006; Shapiro, 1987; Zucker, 1986).

As we underlined in the introduction, the literature sometimes addresses the question of the role of the relational environment *via* the notion of “climate”. Since the 1950s, the concept of organizational climate has been the subject of work that has established its importance in connection with employee behaviour (Frederiksen, Jensen and Beaton 1972; Schneider 1975; Wimbush and Shepard 1994). Trust is sometimes seen as a positive organizational climate largely initiated by the management's leaders (Dirks and Ferrin, 2002) who encourage accountability. It becomes a facilitator of relational exchange and interprofessional collaboration. For Baier (1994), trust is considered to be the source of a presumption of reliability (*trustworthiness*) in the other.

This presumption is not necessarily conscious. Further, when the climate of trust exists, each member of the group has confidence in the others without this resulting from an individual decision. A climate of trust would exist if several conditions are met (Karsenty, 2015):

- a form of familiarity (normality) perceived by the actor; each occupies his rightful place, thus demonstrating his commitment to his function;
- a trust in the institution. This trust is independent of the people themselves because it is impersonal trust (Shapiro, 1987). It is essential to give meaning to roles and behaviours;
- when several actors are acting together, they recognize common values in each other, an essential condition for establishing a climate of trust (Hartmann, 2007). The climate of trust proves to be a particularly critical element at difficult moments, or at times of crises, in the functioning of an organization marked by the loss of shared values.

According to the sociological work on organizations, the climate of trust is the result of conditions that favour informal interchanges. In this regard, the actors must be able to have a space of communication, i.e. the time and the physical possibilities to communicate. These works on the climate of trust offer a very detailed illustration of favourable conditions for formal and informal exchanges within an

organization. These works perceive in rules, norms, values (Karsently, 2015), elements of the relational environment which, in contact with the actors, permit the exchanges favourable to a climate of trust. If these conditions are widely accepted and discussed in the literature, the ways in which they come into play with the actors of organizations remain relatively unexplored. This represents a conceptual weakness in the concept of a climate of trust because, in essence, to best reflect the role of these conditions in trade, it must also be analysed in its dynamic dimensions in order.

The zones and moments of contact between the actors make it possible to document the ways in which the climate of trust is built by both the interaction between actors and, at the same time, their systems of representation by applying the work of the "Proximity school". This can describe a relational environment; a mixture of organization, actors and representations, the articulations of which have scarcely been analysed to date. Interpersonal trust may broaden the description of these articulations. In turn, this would allow a better understanding of the frame of the relational environment involved, or not, in the building of the climate of trust.

We propose to deepen the understanding of the role of the relational environment in the building of interpersonal trust, and thus, go beyond the notion of "climate" which remains vague, by applying the work of the "Proximity school".

2. THE " PROXIMITY SCHOOL"

This school assumes that the proximities shared by the actors in a professional environment have a paramount effect on their interaction.

2.1. *Actors located in a relational space*

The research on proximity does not define proximity independently but through its dimensions. The proximity approach is a reading grid that draws on various theoretical currents (institutionalism, interactionism, evolutionism, regulatory theory, organizational theory, etc.). This grid is comprised of questions asked to determine the influence of the location on the actors' interaction. Two types of locations are traditionally envisaged: location in a geographical space and location in a social space. Even if the number of distinguished dimensions varies according to the authors (cf. for an example of a synthesis Carrincazeaux, Lung and Vicente, 2008), all of them propose an analysis grid based on at least two types of proximity, geographical (2.1.1) and non-geographical (2.1.2) in which the articulations (2.1.3) produce in turn new proximities.

2.1.1. **Geographical proximity**

The position in the geographical space of actors, whether individuals or organizations, is questioned by the geographical proximity (Torre and Gilly, 2000; Pecqueur and Zimmermann, 2004). It is simply defined as the metric and/or temporal distance that separates the actors. We are close geographically for objective reasons: time, communication and costs because of the structure of the space. We are close geographically for subjective reasons: each one makes a judgment on the distance that separates him from the other. This judgement depends on the ability of each person to measure distances, to imagine a route or to cross obstacles (such as borders) (Lussault, 2007). Proximity cannot be approached solely on the basis of its geographical dimension because that would ignore the weight of human relations and the dynamics with which they are associated.

2.1.2. Non-geographical proximity

There is little consensus in the literature on the definition of this dimension of proximity. Organized proximity is defined by Torre and Rallet (2005) as the ability of an organization to connect and interact with its members. This capacity results from a similarity between the representations, beliefs and knowledge shared by these same members. This capacity is also the consequence of belonging to an organization, expressing the fact that the members of an organization interact effectively through and within the same framework of rules and behavioural routines according to their shared interpretations. These aspects have been highlighted in the management research which addresses the issue of the co-constructed or collective project that requires the stakeholders to have a common vision, shared values and a personal involvement. These elements refer to the logics of belonging and similarity and are necessary to strengthen the relationships and interaction (Ingham *et al.*, 2011; Arnaud, 2012).

Boschma (2005) suggests dividing the non-geographic proximity into four dimensions (organizational, cognitive, social, institution).

First of all, belonging to the same organization (firm, public authority, research laboratory, university, hospital, but also network, value chain, industry, etc.) qualifies as organizational proximity. It “ [...] binds agents involved in a finalised activity within a particular structure. [It] is deployed within organizations - firms, establishments, etc. - and, where appropriate, between organizations linked by a relationship of dependence or economic or financial interdependence - between companies belonging to an industrial or financial group, within a network, etc.” (Kirat and Lung, 1995: p.213). Its existence makes it possible to reduce the uncertainty inherent in any relationship and to control the opportunism of individuals. Secondly, cognitive proximity refers to the sharing by individuals of the same base of similar and/or complementary knowledge. It opens the way to mutual understanding. Its existence finds its origins in learning relationships (Cassi and Plunket, 2014). Thirdly, as economic relations are embedded in a social network (Granovetter, 1985), it is necessary to take into account the membership

of individuals in the same network. The bonds of friendship and kinship, which animate the latter, facilitates interaction and reduces conflicts as well as being constitutive of social proximity. Finally, and fourthly, the sharing of formal and informal institutions such as laws, rules, customs, values, etc. conditions interaction by providing it with a stable framework (Kirat and Lung, 1999): this is called institutional proximity.

2.1.3. Articulated proximities

These proximities are articulated. They can be strengthened in so far as a geographical proximity between two individuals plays positively on their social proximity, since the friendship is nourished by close encounters over time. The proximities can also compensate each other: an intense organizational proximity compensates for the spatial dispersion of organizations involved in the same value chain. Finally, they can be destroyed, since a geographical proximity can generate neighbourhood conflicts (pollution) or land use conflicts that put an end to the social proximity.

The proximities between individuals open the way to relationships, but without guaranteeing them. Thus, some individuals can be co-located and have no relationship. We can be related without interacting. The formation of a relationship is only more likely. Once activated, the relationships will in turn modify the existing proximities. For example, a professional relationship may develop into a friendly relationship that creates a social proximity. We treat them here as conditions since the objective of this work is to question the effects of proximities on interpersonal trust; the proximities are therefore both conditions and the result of the trust relationships.

2.2. Proximity and interpersonal trust building

We propose to update the effects of proximity on the interpersonal trust building processes. To do this, we use the typologies proposed by Boschma (2005) concerning the different forms of proximity as well as the one proposed by Mac Allister (1995) concerning the

cognitive and affective dimensions of interpersonal trust. These typologies offer precise definitions, which makes their operationalization easier.

Let us specify that the process of confidence creation by proximity is intrinsically combinatorial. This means that, most often, it is the articulated proximities that will create trust (Mattés, 2012; Nilsson, 2008). In other words, from an analytical point of view, we describe, separately, the effects of each dimension of proximity on trust. Empirically, the proximities play on trust simultaneously and can reinforce their effects: for example, if individuals bound by a friendship or a kinship can meet face-to-face frequently, the trust between them will then be strengthened by both the social and geographical proximities.

2.2.1. Geographical proximity: a confidence accelerator

According to Nilsson and Mattés (2015), geographical proximity is a confidence builder. Indeed, while the sharing of the same geographical space accentuates the possibility of face-to-face interaction, it also constitutes a cognitive referent. Furthermore, the physical structuring of geographical space by the transportation infrastructures allows the circulation of information, physical goods and individuals. Sharing the same geographic space allows the individuals to interact more frequently face-to-face (Bellet *et al.*, 1993; Kirat and Lung, 1999; Knoben and Oerlemans, 2006). The latter is understood as the reciprocal influence of individuals on their actions in the immediate physical presence (Giddens, 1987). It provides a direct access to information (Cassi and Plunket, 2014), makes discussions more interactive and reduces the risks of opportunism (Boschma, 2005). Face-to-face interaction therefore plays an essential role in building trust in its emotional dimension, requiring very frequent interaction between the individuals (Lewis and Weigert, 1985), by facilitating the exchange of emotions and feelings. It also plays a positive role in the building of cognitive trust through the transfer of tacit knowledge that it allows (Nilsson and Mattés, 2015). Tacit knowledge is indeed exchanged in the course of daily social interaction and is only accessible face-to-face (Nonaka, 1994).

Let us add that the geographical space is not a neutral receptacle for face-to-face interaction. All of the actors associate values, representations, customs, lifestyles, history, names, physical and administrative boundaries - in short, institutions - to a geographical area. The members of a territory therefore share articulated geographical and institutional proximities. Space then plays a role in the typification process, which consists of identifying people, objects and actions with generalizable "types" (Lagroye *et al.*, 2006) according to their location. To claim to be in a place is, therefore, to claim by association, a social group; the whole provides a feeling of loyalty (Alvesson and Lindkvist, 1993) of empathy (Giddens, 1987) and, ultimately, of trust (emotional dimension).

2.2.2. Institutional proximity: building the cognitive and affective dimensions of trust

This aspect of proximity is based on a sharing of individuals beliefs, values and traditions (Turner and Makhija, 2006). First of all, it allows the development of the cognitive dimension of trust. Indeed, "institutions" encode information and thus supplement the limits of rationality. In this sense, they reduce the uncertainty associated with any interaction. They also regulate conflicts during the selection phases, because, as categories, they function as filters allowing only the processing of information considered acceptable by the individuals, that is, that does not or only slightly contradicts with their values. The passage of various compromises then becomes possible between the members of one or more organizations. These compromises include the understanding of existing problems and how to solve them in order to achieve a common goal. Common interests and objectives then develop and, finally, each member directs his behaviour towards the interests of the group and in accordance with the common values and rules (Kirsch, 1996; Eckel and Grossman, 2005). Affective trust, which implies a sharing of values (Chowdhury, 2005) and an interest in others (Sherwood and DePaolo, 2005), is thus strengthened.

2.2.3. Organizational proximity: generates the cognitive dimension of trust

According to Dupuy and Torre (2004), organizational proximity generates trust because, when one belongs to an organization, one applies its rules understood as responses to previously defined situations. These rules relate to the internal hierarchy, production standards, social dialogue procedures, etc. Sharing an organizational proximity implies a double commitment: on the one hand, an explicit commitment to respect the internal rules and, on the other hand, an implicit commitment because it is not necessary to make a prior declaration of compliance with a procedure. In the latter case, trust involves *self-control* (Ouchi, 1979; Langfield-Smith and Smith, 2003; Dekker, 2004): the individual who is trusted tends to conform to the expectations of the other. Finally, this dual commitment, by accentuating the reliability of behaviour, reinforces the cognitive dimension of trust, which is empathetic and more calculating (Lewicki *et al.*, 2006; Bachmann and Inkpen, 2011; Nilsson and Mattes, 2015).

2.2.4. Cognitive proximity: building the cognitive dimension of trust

Some similarity in knowledge bases is needed to develop the cognitive dimension of trust so that everyone can verify the codified knowledge held by the partners (Kumar *et al.*, 1995; Ganesan and Hess, 1997). This knowledge is formalized by patents, scientific publications, explicit knowledge, databases, etc. Storable because it is written on a durable medium, it is accessible without a face-to-face interaction.

This same cognitive proximity is also useful for exchanging the tacit knowledge held. The latter is difficult to formulate into a formal language. It is personal knowledge, embedded in individual experience. This knowledge is therefore subjective, carried by individuals (Nonaka and Takeuchi, 1995). As noted above, face-to-face interaction greatly facilitates this transfer (Nonaka, 1994). The geographical and cognitive proximities are in this case articulated to develop the cognitive dimension of trust.

INTERPERSONAL TRUST		
PROXIMITIES	EMOTIONAL DIMENSION	COGNITIVE DIMENSION
GEOGRAPHICAL PROXIMITY	Face-to-face: exchange of emotions; typification	Face-to-face: tacit knowledge exchange
COGNITIVE PROXIMITY		Codified and tacit knowledge exchange
INSTITUTIONAL PROXIMITY	Sharing values Interest in others	Reducing uncertainty
ORGANIZATIONAL PROXIMITY		Reliability of behaviour
SOCIAL PROXIMITY	Kinship, friendship	

Table 1 – The effects of the proximities on interpersonal trust
(Source : authors)

2.2.5. Social proximity: building the emotional dimension of trust

Social proximity between two individuals through kinship and friendship promotes the building of trust (Granovetter, 1985) based on affection (Bigley and Pearce, 1998; Droege *et al.*, 2003) and attachment (Jeffries and Reed, 2000). Mac Allister (1995) stresses the importance of the effects of interpersonal trust on organizational and individual effectiveness. It refers to a sense of security in connection with the future behaviour of a third person and the willingness to act on the basis of the other person's decisions. This trust is not something that pre-existed the social relationship, nor stored information or a resource from which actors can draw (contrary to the reputation, for example). Time plays a decisive role here: trust emerges through repeated and successful interaction. Each interaction is an opportunity to respect the commitments given to the other to justify their trust. There is a commitment to the transparency and reciprocity (Larson, 1992). Participation in the interaction becomes sufficient if one is determined to respect the constraints. Trust then feeds on physical encounters, with the positive effects of the social and geographic proximities being increased further (Howells, 2002). Table 1 summarizes the effects of proximities on the creation of interpersonal trust.

3. METHODOLOGY AND DATA

The purpose of this descriptive and comprehensive research is to evaluate the relevance of an analytical framework based on the forms of proximity to characterize used to trust and thus to understand its effects on interpersonal trust. The aim of our project is to validate the interest of this approach, centred on proximities, with a view to proposing a reading grid of interpersonal trust.

3.1. Methodology: the case study

The very nature of the topic in question, interpersonal trust, requires the use of qualitative methods to understand the interaction between actors and

the explanatory potential of a "proximity-interpersonal trust" model. To do this, we use a unique case study. A unique case is particularly relevant when the problems and circumstances studied are complex (Wacheux, 1996), highly contextualised and when the study is part of a relatively new field (Evrard *et al.*, 2009). This is the case with hospitals and the ensuing management issues that arise. "*The case study makes it possible to study whether knowledge is or is not compatible with the researcher's experience of the practical situation in question, and whether the actors consider that it provides useful points of reference for them to think and act in this situation towards their goals*" (Avenier and Gavard-Perret, 2012).

This work constitutes the first phase of a research program on the management of health organizations, here, developed within a CLCC. It brings together a group of management researchers, managers (general management and services) and staff representatives (doctors, practitioners, logisticians). As a first step in this research, our attention focus on the CLCC Jean Perrin in Clermont Ferrand. It allows us privileged access to materials (quantitative data, free and semi-directive interviews) and to participate in all of the meetings relating to the projects and strategy of the CLCC. Our objective here is to test and evaluate the explanatory power of the proximity grid on trust. In fact, we rely specifically on primary data; the reports of four meetings and a series of seven semi-directive interviews (lasting an average of 44 minutes) conduct with the CLCC staff (Table 2) divided into four categories; managers, doctors, nursing staff and support staff. The interviews were recorded, transcribed and analysed for content.

Specifically, these primary data enabled us to identify the contributions of proximity to trust. The interviews took place in 2016 and 2017. They were structured around two main themes:

- the climate of trust,
- the place of proximity and its possible effects on the climate of trust.

FUNCTION OF THE PERSON INTERVIEWED	CATEGORY	RESPONDENT CODE	DURATION OF THE INTERVIEW
Deputy Director of the institution	Manager	E1	1 hour 15
Imaging department Health Executive (former nurse)	Nursing staff	E2	51 Minutes
Director of Financial Affairs	Support function	E3	39 minutes
Chief Medical Officer in charge of quality	Doctor	E4	48 minutes
Doctor in charge of the unplanned entry unit	Doctor	E5	54 Minutes
Medical Secretary	Support function	E6	37 Minutes
Resuscitation Department Executive (former nurse)	Nursing staff	E7	58 Minutes

Table 2 – Characteristics of Respondents
(Source : authors)

3.2. Presentation of the case

The CLCCs are private non-profit health establishments that participate in the public hospital service in France. They belong to the field of Private Health Establishments of Collective Interests (ESPIC). Created in October 1945, they are financed by the public health insurance scheme and are controlled by the Ministry of Health, under the same conditions as the public hospitals. They carry out prevention, research, teaching and care missions. The particularity of the CLCCs lies in their comprehensive and multi-disciplinary model of care for people with cancer. Even more than elsewhere, this requires interaction and communication between actors with very diverse professional profiles. The management of these establishments is ensured by a director who is a doctor, assisted by a secretary general and a management team which calls upon a diversity of professional

cultures (manager, medical, nursing, etc.) and which involves the doctors in management responsibilities.

Until 1996, the CLCCs had a particularly protected status (Mériade *et al.*, 2017). On the one hand, the institutions were able to take advantage of the logic of the welfare state and, on the other, of their status as private non-profit actors. It is on this basis that they built and justified their own mission. In the CLCCs, militant discourse, servant discourse of the state or even innovative organizational discourse were mixed with a relative harmony while, at the same time, generating two pitfalls; a real lack of concern on the part of the management (the effects being concealed by the overall funding) and a weak capacity for strategic monitoring in the face of changes in their environments. Since the 1980s, there have been many signs of the hospital's financial development (Angelé-Halgand and Garrot, 2015): the Juppé Plan (1996)

implemented to control health expenditure has introduced a quasi-market, the T2A financing system (activity-based pricing), the HPST law (2009), and the creation of GHTs (territorial hospital groups) in 2016, which are emblematic of this “evolution of powers to the detriment of the medical profession” (Angelé-Halgand and Garrot, 2015, p. 50). The evolution of the context is reflected in the spread of a logic of competition which is expressed in the massive groupings of private clinics, a restructuring into territorial hospital groupings (GHTs) and questions on the positioning of CLCCs. Two threats are perceived by the CLCCs. On the one hand, the loss of certain activities, notably the most profitable ones which would be recovered by the private for-profit sector, and, on the other, the risk of a merger imposed in the long term with the University Hospital Centres (CHUs). It is clear that the status of the trust that has prevailed until now is being questioned. The relations between hospitals and the regional health agency (ARS), which is responsible for ensuring the distribution of resources, as well as the interpersonal relations between the medical, nursing and management teams, or between doctors and their patients, are calling into question the place of trust in the changing contexts.

The CLCC Jean PERRIN, founded in 1973, is one of 18 CLCCs grouped under the aegis of Unicancer, a national federation. Recognized as a center of excellence in its specialty, since its opening, it has maintained an ambivalent relationship with the city's University Hospital with which it shares the same site. It has also been recognized as a center of excellence in its specialty as a regional hospital. Since its inception, a certain co-operation has been maintained with the CHU, particularly due to their geographical proximity, however, the two institutions have never developed a joint institutional or medical project. At the beginning of the summer of 2015, the Unicancer federation designed and distributed the Unicancer Group Strategy project, whose ambition was to adapt the CLCCs to changes in the context of the Regions' reforms and the financial constraints of the institutions. The project proposed the strengthening of the national management of the CLCCs by Unicancer as well as the merger, in the very short term (12 months), of several centres in order to increase their capacities. Notably, the CLCC Jean Perrin de Clermont-Ferrand and the CLCC Léon BERARD de Lyon were registered in this merger logic for January 2017.

This strategy, of which little is understood at the CLCC level, finally reveals a certain cognitive distance between the Unicancer federation and the institutions. It is contested by a report in July 2016 from the French public financial supervisor (Cour des comptes) which is the subject of two levels of discussions. Firstly, internally, where the principle of strengthening management and the merger with another CLCC is assimilated to the movements of the private hospital sector (search for economies of scale, productivity gains) and also such perceived as being in opposition with the social and institutional project based on the public service mission, the disinterested action and the local action on a territory. This illustrates a form of stressing of the organizational proximity. Moving on to the external issues, the Unicancer project faces two paradoxical objectives: on the one hand, by strengthening the centres through merger, they would gain in power and autonomy. On the other hand, there is an incompatibility with the recommendations of the central authorities, in particular the HPST law. This law encourages, on the contrary, the need to overcome the logic of the institutions in favour of the logic of the territory and patient path (Mériade, 2019). The patient path imposes close co-operation and synergy of means with the CHU and other local health actors, and thus, ultimately, reinforces the institutional and organizational proximities. In this context, we can assume that the question of the climate of trust is a particularly critical element when carrying out the necessary transformations as outlined above, just as the question of the link between proximity and trust between the actors and the individuals responsible for the daily implementation of the public service mission proves to be central.

4. RESULTS

The comparison of our analytical framework with the data collected shows that there is a strong link between the climate of trust, proximity and interpersonal trust. The climate of trust proves to be a key and particularly critical point having a strong impact on the functioning of the hospital. It is a major concern in the hospital world because of the current alterations. As our first discussions showed, in these organizations the trend is moving towards

a weakening of the climate of trust¹ because of the tensions generated by the evolving context and the new practices being spread. The first phase of analysis consisted in examining the content of the meetings and the preliminary interviews with the deputy director of the CLCC which enabled us to identify four categories of actors on whom to focus our attention in order to identify the mechanisms of trust: managers (administrative decision-makers such as the financial director and the director of human resources), doctors, nurses and support staff (accounting services, logistics, information system, etc.). The results of our analysis make it possible to identify the nature of the cognitive and affective dimensions of interpersonal trust and to update the way in which proximity is expressed in a context of marked transformations and their effects on the relationship of trust.

This first comparison, between the proposal for a theoretical framework of analysis and the knowledge of the field, highlights the central role of trust “*Our organization can only function because there is trust*” (E2) and makes it possible to identify its cognitive and emotional dimensions.

4.1. The affective and social dimensions

The affective dimension of interpersonal trust, although present, appears relatively attenuated in the discourse of the interviewees. It is essentially associated with friendships; “*If you are friends and get along, you have a natural cooperation that goes beyond work and it has a direct impact on trust*” (E4). The empathy that is a marker of the affective dimension of interpersonal trust is mostly absent in the respondents’ description of relations between the categories of staff. It stands out in speeches almost exclusively from the perspective of the patient/caregiver relationship. Moreover, we can identify a disconnection between interpersonal trust and “human proximity” (seen by respondents in its affective dimension): “*We can place trust in someone with whom we do not have*

any human proximity” (E6). This is probably explained by the particularity of the context studied (the hospital universe) where the cognitive dimension of trust seems to take precedence over the affective one. However, at the same time, some respondents naturally refer to the need for social proximity in order to build trusting relationships; “*The link between human proximity and trust is almost natural*” (E7), “*If you share a friendly human proximity with someone you do not have to create trust*” (E5). Moreover, they emphasize the role of the geographical proximity in building trust; “*With the management, trust comes through physical presence*”; “*how can you trust people you never see?*” (E6).

However, the geographical proximity plays an ambivalent role in the affective trust. While it brings individuals closer together and promotes their social interaction, the *verbatim* analysis also reveals the ambiguity of a very close geographical proximity, which can lead to a weakening of trust between individuals who are too close “*the most suspicious people are the closest to the hierarchy*” (E2); “*working in the same block all day does not necessarily bring people closer together*” (E7).

From another angle, the cognitive, social and institutional proximities are interviewed again with the multiplication and the reinforcement of staff skills. Some categories that have received more training, such as nurses or health managers are emancipating themselves from the medical staff (doctors) and are demanding autonomy: “*we no longer call the health managers supervisors, because we no longer monitor what the staff do, they are professionals, they are responsible for their actions*” (E2). The social proximity that once existed, for example, between doctors, health care professionals and carers, is withering. The hierarchical link of subordination, or even devotion, of managers and staff to the doctor is transformed, modifying social relations. Thus, the relationship between the different “corporations” has changed, the norm has replaced the trust; “*Cancerology is a small world, everyone knows everyone else*” (E4). “*The doctors are first and foremost colleagues. Even in*

¹ Our interview guide focused on trust and proximity. It was not intended to explore the notion of mistrust that is generally regarded as the opposite of trust, or mistrust, that refers to a background of doubt towards others and lies halfway between trust and mistrust. we will talk about the weakening of trust rather than mistrust or distrust as distrust, mistrust and trust seem to be different mechanisms and our work is about trust. For more details on the conceptual nuances associated with these terms, see: Marzano M. (2010) “Le contrat de défiance”, Editions Grasset and Algan Y., Cahuc P. and Zylberberg A. (2012) “la fabrique de la défiance”, Albin Michel.

difficulty, they will know how to look after each other” (E2). These developments are probably fuelled by the certification processes. It would seem that these have contributed to reducing trust by substituting mutual adjustment modes (for example between a nurse and the doctor for the mode of administering a treatment) with a more formal adjustment mode based on rules and procedures and generating a certain distance, the individuals finally having less need to interact because of the codification of each other's roles.

While this form of institutional proximity generates a certain amount of interpersonal trust of a cognitive nature (complying with the rules), it limits the possibility of developing a more affective trust by limiting the interaction and thus the opportunities for meetings conducive to the development of social proximity. The lack of shared values between the young recruits and the older staff is regularly put forward to justify the development of a certain institutional distance “*The relationship with the young people is more difficult because they do not have the same values. Values are less important to them*» (E7). “*The young people, what they do, they do very well, they are immediately effective, the word value means nothing to them*” (E2). On the other hand, the increase in staff competence has effects that are not immediately visible. This results in a change in the social homogeneity and thus a reduction in the social proximity. Indeed, until recently, the recruitment of personnel for positions that did not require long studies or extensive training was carried out in the local area. The result was a marked link between the geographical and social proximities anchored in the territory. This was a unifying element between people from the same geographical area who shared common history and reference points (local culture). The development of competence is reflected in the recruitment of people from other regions, so the geographical distance is reflected by a form of diminishing of the social proximity which then requires reconstruction.

4.2. The cognitive dimension: languages, values and trust

The cognitive dimension is a strong marker of the respondents' discourse. It refers to the need to understand each other in order to be able to rely on the

actions of others and thus trust them: “*We have the same common knowledge base as the doctors, for whom I am a reliable interlocutor and this generates trust, because I do what I say and I say what I do*” (E7), “*With the managers, speaking the same language is proof of trust*” (E7). This cognitive dimension includes a very marked behavioural component (“*As soon as people know how you function, the trust relationships are established*” (E7)), which is itself part of a temporal dimension; “*We create trust like this, little by little, as we go along*” (E5), “*trust takes time to build but it can be destroyed in 2 minutes*” (E7). Interpersonal trust is intimately linked to the evaluation of the other's behaviour “*Knowing how the other works, how he will react to other situations are elements that help build trust*” (E6), “*trust for me is built more on the relationship than on the behaviour*” (E6), “*Trust in each other is based on our experiences of past exchanges*” (E5). The relationship between the individuals, the history and the density of this relationship is an important basis for the cognitive dimension of trust. Thus, the doctors interviewed frequently refer to the relationship with their colleagues marked by their joint studies at the faculty and then maintained in the exercise of their activity. They stress the importance of the expertise and the reliability of their colleagues in building interpersonal trust: “*One can have confidence because one knows that he will manage things well, not only professionally but also humanly, one knows that he is a good guy who has values and that he will behave well, but he is not necessarily a friend*” (E5).

Cognitive trust is also based on strong institutional values: the healthcare values infuse the whole organization (“*We manage in discussions on the healthcare values, which makes it possible to break many deadlocks, this strengthens trust between health-care providers and doctors having the same discourse*” (E7); “*The financial and healthcare values succeed in harmonizing well, because there are no symptoms of discomfort*” (E7)). Some respondents note, however, that these values have been reduced or even questioned to some extent: “*The economic and financial values have taken precedence over the old values*” (E2). Thus, the interpersonal trust of a cognitive nature, based on original values, must be nuanced. Managers are led to pursue objectives of a more economic nature that alter the trust that has prevailed until now between the various categories of staff and

managers. Even if the CLCCs have the particularity of being directed by a doctor, the imperatives of economic balance that guide the strategy and the actions generate a certain tension on the nursing values and contribute to alter the interpersonal trust but also to gradually transform the rules of evaluation of reliability and the seriousness of the other.

4.2.1. An evolution of values: alteration of the cognitive and institutional proximities

The transformation of the context in which hospitals are evolving results in an alteration of the cognitive proximity due to an evolution of values (institutional proximity). “*The values that existed came from the staff*” (E2), now these historical values seem less present, yielding to more economic values imposed by an authority guided by the concern for economic balance. Since 2004, the introduction of activity-based pricing (T2A) has developed a logic of competition (Angelé-Halgand and Garrot, 2014), between the CLCC’s own services (in particular between services that treat various pathologies). “*In a hospital, there is a coexistence of services that we no longer hesitate to describe as profitable or unprofitable*” (E1). Within the institution, trust is deteriorating, on the one hand, towards those who carry out profitable activities, and, on the other hand, towards those who carry out unprofitable or less profitable activities. In the first case, the business owners are suspected of dealing with certain strong traditional values that exclude any economic approach. In the second case, the practitioners and their teams feel that they alone can support efforts to address unprofitable services. “*This internal competition in the capture of the resource, if it creates emulation, also induces a form of distance from the values*” (E1). The distance that sets in from hitherto shared values breaks down social proximity and alters the cognitive dimension of trust. The foundation of common values which constitutes the necessary cement for ambition and collective projects is weakened. To compensate for this reduction in the institutional proximity, a genuine process of institutionalisation around values is developing. Indeed, many initiatives to write value charters in the different departments give rise to a multiplication of value frameworks that are not homogeneous. Thus, they contribute to creating an institutional distance between the different

categories of services even though, traditionally, the purpose of charters is to unite through shared values and commitments.

This distance linked to the presence of objectives that are not as unifying nor shared collectively is amplified by the uncertainty of developments, in particular with regard to the possible convergence between actors working in the same area (CHU, CLCC) and the rationalisation of the healthcare provision in the territory (disappearance of services, outsourcing). This uncertainty leads each category of personnel to develop defensive strategies that feed a social and organizational distance. For example, doctors highlight their ability to adapt professionally, an attitude that illustrates the reckoning of the cognitive dimension of trust, while for the support staff, the future is more uncertain. The closure of certain services is now an option being considered. In order to be heard, doctors are turning to a stronger trade union commitment, which is synonymous with a particular form of institutional proximity. Thus, the doctor is no longer seen as the one who guarantees the future of the institution. We can identify deterioration in the trust between the medical and management personnel.

4.2.2. An evolution of languages: alteration of cognitive trust

The introduction of new languages, such as management control, alters trust by modifying the cognitive reference points on which it is built. This gives a new power to the managers that the other categories perceive as a form of interference in their action. It appears that the introduction of new languages results in the creation of a certain cognitive, but also social, distance. The coordination of procedures are experienced by the healthcare staff in particular as administrative constraints that reduce their presence with patients “*The quality has taken over a huge place in hospitals, it can create distance between people*” (E2); “*The logistics of quality and the administrative procedures reduce our presence at the foot of the bed*” (E2).

In terms of organizational proximity, the manager has the power to decide on cost reductions which in some cases lead to the decision to outsource a financially unbalanced service. The support services are the most affected by this new approach to business.

This situation creates a cognitive distance between the management and the support services. Until 2004, the director was an administrator, he was there to enforce the rules, and today, the director of a hospital is accountable to a supervisory authority. The management adopts new standards, new tools (performance indicators, reporting, etc.) poorly understood by the medical world. These have not yet necessarily been integrated by the support services or the other internal groups. More broadly, this evolution is part of the generalization of the principle of "accountability" (Facal and Mazouz, 2013). The structures in charge of public service missions are led to account for the use made of public money, amplifying the attention paid to the financial dimension. Thus, governance tensions are developing (Mériade, 2013) generating a reduction in trust towards the managers on the part of other internal groups (doctors, carers, health executives, support services). Moreover, this rationalizing approach (Angelé-Halgand and Garrot, 2015) leads to the regrouping of functions hitherto attached to user services (entities); "*The GHTs must reconfigure the functioning with the other establishments in the region*" (E1); "*In any case, the supervisory authorities ask us to cooperate*" (E3). Thus, a geographical distance can be created between users and service providers. However, geographical proximity seems essential for co-operation and knowledge sharing. "*Relocation is being experienced as a constraint by many staff*" (E4); "*We have a natural cooperation with the CHU because we are on the same site*" (E1)). By not being as close geographically, the user staff and the supplier services are less likely to meet physically and, thus, not as likely to develop interaction conducive to informal interchanges and mutual adjustment. This limits the development of the social and cognitive proximities.

These elements allow us to affirm that the climate of trust constitutes a central point in the development of the quality of interpersonal relationships. It is expressed in terms of proximity as well as geographical, cognitive, institutional, organizational or social distances. It is in this sense that our framework of analysis is particularly relevant because it also allows us to analyse the absent proximities that cause a relative lack of trust. Subsequently, this allows more precise discussions of the elements of proximity which, in the establishment studied, can impact the affective and cognitive dimensions of trust (Table 3).

5. DISCUSSION

These initial results allow us to determine an analytical grid designed to explore the relationships between proximity and trust among the personnel (Table 3). To this end, four categories of staff were highlighted: management leaders (decision-makers who have all the information), doctors, healthcare staff and support staff (accounting, logistics services, information system). In order to understand these relationships between proximity and trust, we propose an analysis grid that measures proximity based on the responses of the personnel belonging to these four categories (Table 3). Through this grid, we seek to measure the effects of the existence or absence of proximity on the affective and cognitive dimensions of trust.

A vertical and horizontal reading of the grid allows us to formulate certain conjectures relative to the significant impact that the proximities have on the affective and cognitive dimensions of the interpersonal trust in this establishment.

5.1. A low affective trust

In our case, it appears that affective trust is low and ultimately not very present in the institution. The work organization and the human resource management contribute very little to building trust of an affective nature. As a general rule, this is built on personal characteristics (open-mindedness, benevolence, availability, justice). Certain of these seem to take second place in the upper hierarchy of the establishment studied, in particular, availability. In this establishment, three forms of proximity, by their presence (geographical proximity) or by their absence (institutional proximity) and to a lesser degree, social proximity), impact affective trust. These results make it possible to highlight the key role in managing the geographical proximity between personnel. These directives, while bringing staff closer together, should nevertheless maintain a certain distance between the colleagues. At the same time, the organizing of the geographical proximity should also limit any form of spatial crowding. This would allow the construction of proximity with beneficial effects and reduces the risks inherent a lack of privacy and its more harmful effects.

On the theoretical level, with regard to geographical proximity, we had assumed that face-to-face interaction between individuals made it possible to foster the various proximities conducive to the development of a climate of trust. However, our results highlight that face-to-face interaction actually weakens the climate of trust. This is an innovative finding of which the ‘Proximity School’, for whom geographical proximity is the major vector of trust, makes little or no mention. This reveals the ambivalence that can be associated with geographic proximity in its impact on affective trust (Table 3).

Institutional proximity is the second most important element in the building of affective trust. In the institution studied, it is experienced as a distance that is created as a result of the disappearance, or perceived alteration, of common values. As highlighted in our results, the institution's staff describe a disappearance of values that they associate with intergenerational conflicts. Thus, it appears that an institutional distance is gradually being established between the generations which, combined with a certain compartmentalisation of services, significantly reduces the importance of trust in its emotional dimension.

Finally, our results show that social proximity is indeed a relevant element in building the affective dimension of trust. Here again, the staff interviewed note a weakening of this social proximity (Table 3) in favour of the development of work rules and standards that limit human interaction and extra-professional exchanges.

In the end, our study reveals that these three forms of proximity (geographical, institutional and social), which can be expressed in various ways, remain nevertheless the main levers for building affective trust in an organization.

5.2. Cognitive trust, prescribed rather than built

At the same time, our analyses clearly show the importance of the cognitive dimension of trust fed by the five forms of proximity in our conceptual framework. However, cognitive trust is more a matter of prescription than construction. The respondents report the existence of a sense of cognitive trust often prescribed by the organization and its procedures

(see Table 3). Unlike affective trust, the trust based on the cognitive dimension is a point of particular attention because it seems to be taken into account by the management of the establishment and its staff. On the other hand, it seems more imposed on employees than really built around the existing proximities between staff. Indeed, the need to speak the same language and to understand each other seems fundamental.

While considering the affective domain, unduly close geographical proximity that is too close is sometimes perceived as deteriorating interpersonal trust, in terms of cognitive trust. This geographical proximity is claimed more so to share knowledge or common interpersonal or inter-institutional projects. Geographical proximity, by bringing staff closer together, enables them to check and validate the elements justifying their cognitive trust, particularly those relating to the skills and good professional attitudes of their colleagues.

More naturally, cognitive proximity also seems to be an important element in the building of cognitive trust. Thus, the development of skills, the professionalization of staff and a managerial culture allows respondents to have and to share common languages which, even if they are often prescribed, create trust between staff. Thus, in the CLCC studied, the quality is regularly defined, by the staff interviewed, as a central concept common to the whole centre, which necessarily brings them closer together because it creates obligations to monitor procedures or standards for the entire staff. On the other hand, if they bring the rules of work, such as quality, closer together, they can also, by their prescribed and peremptory character, generate frustrations among certain personnel by taking away their margin of freedom. The same is true for the development of the managerial culture of the staff, particularly doctors, who acknowledge that they have become closer to the managers through the deployment of service management, but insist on the limits of their skills in understanding all the speeches and management indicators that are transmitted to them. Although these two categories of staff gradually understand each other better, they do not yet speak exactly the same language.

In terms of cognitive trust, in the same way as the affective dimension, institutional proximity is

translated more by a distance between personnel, particularly concerning a reduction, an absence or a loss of common values. At the same time, a certain degree of social proximity exists and can therefore strengthen cognitive trust in some cases. It is fairly representative of the compartmentalization of services or professions within the establishment. This limits the effects of this proximity on the trust and therefore does not build cognitive trust between all the staff.

In the same way, cognitive trust has developed in this establishment from an organizational proximity between the staff but also in a rather imposed way by the management and the supervisory authorities which strongly encourage the services and their staff to come closer together.

Finally, while social proximity contributes significantly to the development of cognitive trust, we note that it is deployed more within departments or categories of staff (in the case of the doctor corps logic, for example) and much less between the departments or between the different categories of staff.

Thus, in the case studied here, the grid of proximity (Boschma, *op. cit.*) describes the five forms of proximity as significant levers for the deployment of cognitive trust. Nevertheless, this cognitive trust, in our case study, seems to have developed more by prescription of the establishment and its management than by a real research of proximity voluntarily built by the personnel.

INTERPERSONAL TRUST		
PROXIMITIES	EMOTIONAL DIMENSION (openness, justice, availability, caring)	COGNITIVE DIMENSION (competence, coherence, respect of promises)
GEOGRAPHICAL PROXIMITY	<i>Ambivalent geographic proximity</i>	<i>Geographic Proximity</i> = trusted source
COGNITIVE PROXIMITY		<i>Prescribed cognitive proximity</i> = professionalization of the personnel, Development of a managerial culture, of a common language
INSTITUTIONAL PROXIMITY	<i>Institutional distance</i> = loss of common values, intergenerational tensions	<i>Institutional distance</i> = value conflicts between categories of staff, little shared managerial values
ORGANIZATIONAL PROXIMITY		<i>Organizational proximity imposed</i> = closer links between institutions
SOCIAL PROXIMITY	<i>Social proximity</i> = essential but being reduced in favour of norms and rules	<i>Community social proximity</i> = corps logic, intra-service proximity

Table 3 – Impacts of proximity on interpersonal trust
(Source : authors)

CONCLUSION

This work aims to validate the interest of mobilizing a grid produced through the work of the “Proximity school” to understand how the proximities between the different categories of staff of a CLCC are expressed. Therefore, it helps to explore the role of proximity in building interpersonal trust. We focused on the analysis of interpersonal trust by studying both the strong and weak proximities that reinforce or weaken this trust.

The contributions of this research are twofold. They are first situated in the multidimensional approach of proximities respecting the five dimensions of Boschma (2005) to qualify the climate of trust and interpersonal relations. The preliminary results validate the interest of this model of analysis because they highlight, for this institution, the proximities that impact the interpersonal trust both in its affective and cognitive dimensions. In terms of managerial implications, this result specifies the levers of action that proximal analysis defines for managing the interpersonal trust within hospital organizations.

The second contribution comes from the analytical ability of our grid to explore the three-dimensional relationships between proximity, interpersonal relationships and trust. This makes it possible to characterize, in hospital establishments, both the constructed dimensions of affective trust and the more prescribed dimensions of cognitive trust.

The limitations of this work are inherent to its exploratory nature and to a strong concentration of data processed on a limited number of sources. Indeed, this first stage led to the proposal of a valid reading grid but will have to be applied in various contexts to test its robustness. Furthermore, our analyses did not explore the differences in the perception of the affective and cognitive dimensions of trust according to the categories of personnel. However, we were able to perceive significant nuances in the responses between healthcare staff or support functions and doctors or managers. In the future, a socio-demographic analysis of these data could allow more in-depth testing of the reading grid proposed here.

Moreover, a natural extension of this study, but a work in its own right, will consist in analysing the distrust from these proximities and distances. The notion of distrust is another very rich problem, but it requires a specific methodology and interview guide.

Finally, this work opens up research perspectives in the field of public management. It feeds the current studying the effects of NPM (New Public Management) on the working context of public organizations and the reification phenomena that can be observed (Angelé-Halgand and Garrot, 2015). The transformations in the contexts in which public organizations are evolving, and more particularly health organizations, are still little studied from the perspective of interpersonal relations, whereas the latter are often defined as essential to public performance in both its intra- and interorganizational dimensions.

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