ISSN 2664-8059 (Print) & ISSN 2706-767X (Online)
South Asian Research Journal of Nursing and Healthcare
Abbreviated Key Title: South Asian Res J Nurs Health Care

| Volume-8 | Issue-2 | Mar-Apr- 2026 | **DOI: https://doi.org/10.36346/sarjnhc.2026.v08i02.005**

Original Research Article

Communication Strategies that Foster Trust in Doctor–Patient Relationships: An Empirical Study in Indian Healthcare Settings

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Article History
Received: 07.03.2026
Accepted: 24.04.2026
Published: 27.04.2026

Abstract: ***Background:*** Trust between doctors and patients is foundational to effective healthcare delivery. Communication behaviours of physicians have been identified as key antecedents of trust formation; however, empirical evidence from Indian healthcare contexts remains sparse. ***Objective:*** This study examines the impact of six physician communication strategies — active listening, empathetic communication, information disclosure, non-verbal cues, patient-centred communication, and shared decision-making — on doctor-patient trust and, consequently, on patient satisfaction in Indian outpatient settings. ***Methods:*** A sequential explanatory mixed-methods design was employed. Quantitative data were collected from 320 adult outpatients across government and private hospitals in three Indian cities using validated scales (WFPTS, PSQ-18, physician communication scales). Structural equation modelling (SEM) was used to test the proposed conceptual model. Qualitative data were gathered through 26 semi-structured interviews analysed using reflexive thematic analysis. ***Results:*** All six communication strategies significantly predicted doctor-patient trust (total $R^2 = 0.61$). Patient-centred communication (beta = 0.37) and empathetic communication (beta = 0.34) were the strongest predictors. Trust, in turn, strongly predicted patient satisfaction (beta = 0.69, $p < .001$). SEM confirmed model fit (CFI = 0.96, RMSEA = 0.049). Qualitative findings identified five trust-shaping themes: listening as trust currency, emotional validation, transparency, cultural congruence, and systemic barriers. ***Conclusion:*** Communication strategies are robust predictors of trust and satisfaction in Indian clinical encounters. Healthcare institutions should invest in structured communication training, ensure cultural and linguistic responsiveness, and address systemic barriers — particularly consultation time constraints — to strengthen the therapeutic relationship.

Keywords: Doctor-patient communication, trust in healthcare, patient satisfaction, Indian healthcare, mixed-methods, structural equation modelling, empathy, active listening.

1. INTRODUCTION

The doctor-patient relationship is widely regarded as the cornerstone of clinical medicine. At its heart lies trust — a psychological state through which patients extend vulnerability to physicians in expectation of competent, honest, and caring responses (Mechanic & Meyer, 2000). Trust is not simply an emotional predisposition; it is a functional mechanism that enables patients to disclose symptoms fully, adhere to treatment regimens, and engage actively in their own care.

Despite the universality of this dynamic, the mechanisms through which trust is cultivated — and the role of physician communication in this process — are shaped profoundly by cultural, structural, and societal contexts. India presents a particularly significant and under-studied setting. With a population exceeding 1.4 billion, a healthcare system marked by wide rural-urban disparities, multiple languages, diverse cultural traditions regarding health and authority, and a large informal medical sector, the communication dynamics shaping trust in Indian clinical encounters merit dedicated empirical inquiry.

Internationally, a growing evidence base links physician communication behaviours — including active listening, empathy expression, clarity of information, and shared decision-making — to improved patient trust and satisfaction (Street *et al.,* 2009; Birkhauer *et al.,* 2017). However, the applicability of findings from Western healthcare systems to Indian contexts is constrained by differences in the doctor-patient hierarchy, limited consultation time in public facilities, multilingual patient populations, and the significant influence of family members in medical encounters.

This study addresses this gap by empirically investigating the relationship between six physician communication strategies and doctor-patient trust in Indian outpatient settings, and examining the downstream effect of trust on patient satisfaction. A mixed-methods design integrates quantitative modelling with qualitative depth, offering both statistical precision and contextual richness.

1.1 Research Objectives

The study pursues the following objectives:

(1) To identify and validate key communication strategies that predict doctor-patient trust in Indian outpatient settings.
(2) To examine the mediating role of doctor-patient trust in the communication-satisfaction relationship.
(3) To explore socio-cultural and structural moderators of trust-building communication in Indian healthcare.
(4) To generate actionable recommendations for communication training in Indian medical education.

1.2 Research Hypotheses

On the basis of prior theory and literature, this study proposes the following hypotheses:

H1: Active listening positively predicts doctor-patient trust.
H2: Empathetic communication positively predicts doctor-patient trust.
H3: Information disclosure positively predicts doctor-patient trust.
H4: Non-verbal communication cues positively predict doctor-patient trust.
H5: Patient-centred communication positively predicts doctor-patient trust.
H6: Shared decision-making positively predicts doctor-patient trust.
H7: Doctor-patient trust positively predicts patient satisfaction.

2. Conceptual Framework and Model

The conceptual model underlying this study integrates communication theory, trust formation theory, and patient satisfaction frameworks into a unified empirical structure. Drawing on Street et al.'s (2009) pathways model, Hall et al.'s (2001) multidimensional trust framework, and the expectation-confirmation theory of satisfaction (Oliver, 1980), we propose that physician communication strategies operate as antecedents of interpersonal trust, which in turn mediates the effect of communication on patient satisfaction.

Two sets of moderating variables qualify this primary pathway: (1) socio-cultural context variables — including language congruence, family involvement norms, and patient health beliefs — which modulate how communication behaviours are received and interpreted; and (2) structural factors — including consultation duration, continuity of care, and healthcare setting type — which constrain or enable trust-building communication.

Figure 1 presents the conceptual model proposed for this study. Each hypothesised path is labelled (H1–H7) corresponding to the research hypotheses outlined in Section 1.2.

MODERATING VARIABLES				
Socio-Cultural Context Language congruence Family involvement Cultural beliefs			**Structural Factors** Consultation duration Continuity of care Healthcare setting	
COMMUNICATION STRATEGIES (Independent Variables) H1: Active Listening H2: Empathetic Comm. H3: Info. Disclosure H4: Non-Verbal Cues H5: Patient-Centred Comm. H6: Shared Decision-Making	-->	**DOCTOR-PATIENT TRUST (Mediating Variable)** Fidelity Competence Honesty Confidentiality Global Trust	-->	**PATIENT SATISFACTION (Dependent Variable)** Technical Quality Interpersonal Manner Communication Overall Satisfaction

Figure 1: Conceptual Model: Communication Strategies, Doctor-Patient Trust, and Patient Satisfaction

Note. Arrows represent hypothesised directional relationships (H1–H7). Dashed-boundary boxes indicate moderating pathways. --> denotes positive directional influence.

3. LITERATURE REVIEW

3.1 Communication and Trust: Theoretical Foundations

Trust in the medical relationship has been conceptualised as both an attitudinal and behavioural construct. Hall et al. (2001) delineated five dimensions of physician trust — fidelity, competence, honesty, confidentiality, and global trust — arguing that each is responsive to different physician behaviours. Communication quality, in particular, has been linked to fidelity (the sense that the doctor acts in the patient's best interest) and honesty dimensions (accurate, transparent information sharing).

Rotter's (1967) interpersonal trust theory posits that trust is an expectancy — a generalised belief that another party's word, promise, or statement can be relied upon. In clinical encounters, physician communication behaviours serve as primary signals that either confirm or disconfirm these expectations. A physician who listens without interruption, maintains eye contact, speaks plainly, and explains the reasoning behind clinical decisions communicates trustworthiness through both content and process.

The biopsychosocial communication model (Engel, 1977) and its elaboration in the Calgary-Cambridge framework (Silverman *et al.,* 2013) provide a comprehensive taxonomy of physician communication behaviours. These frameworks identify gathering information, building relationships, providing structure, and planning as core communication tasks — each of which can be enacted in ways that promote or undermine patient trust.

3.2 Communication Strategies: Key Constructs

3.2.1 Active Listening

Active listening encompasses attentive, reflective engagement with the patient's narrative. Behaviours include maintaining eye contact, avoiding interruptions, using verbal acknowledgements, and paraphrasing to confirm understanding. Studies in primary care settings have consistently linked active listening to higher trust scores (Thom *et al.,* 2002; Fagerli *et al.,* 2020). In India, where patients may feel inhibited from challenging or questioning medical authority, active listening may play a uniquely critical role in creating psychological safety for disclosure.

3.2.2 Empathetic Communication

Empathy in the clinical encounter involves both cognitive (understanding the patient's perspective) and affective (responding emotionally) components. Physician empathy has been identified as among the strongest predictors of patient satisfaction and trust in international literature (Hojat *et al.,* 2011). Expressed empathy — verbal and non-verbal acknowledgement of patient distress — has been shown to reduce patient anxiety, facilitate disclosure, and strengthen therapeutic alliance.

3.2.3 Information Disclosure

Transparent, clear, and accessible information sharing is a cornerstone of informed consent and patient autonomy. Information disclosure refers to the degree to which physicians explain diagnoses, treatment options, risks, and uncertainties in ways patients can understand. In Indian healthcare, where medical paternalism has historically been prominent and health literacy is variable, the manner and completeness of information disclosure carry particular significance for trust (Mishra *et al.,* 2014).

3.2.4 Non-Verbal Communication

Non-verbal cues — including body language, facial expression, physical proximity, and vocal tone — carry substantial communicative weight. Roter and Hall (2006) demonstrated that physician non-verbal behaviours significantly predicted patient satisfaction independent of verbal content. In the Indian cultural context, non-verbal markers of respect (e.g., attentive posture, appropriate gaze) carry substantial social significance and are likely to be interpreted as trust signals.

3.2.5 Patient-Centred Communication

Patient-centred communication (PCC) reflects a philosophy and practice of care in which the patient's preferences, values, and lived experience are placed at the centre of clinical dialogue. PCC encompasses agenda-setting, eliciting patient ideas and concerns, and tailoring information to individual needs. Epstein and Street (2011) identified PCC as the most consistently effective communication approach for building trust and improving health outcomes.

3.2.6 Shared Decision-Making

Shared decision-making (SDM) involves an iterative process in which physician and patient jointly deliberate about clinical options and reach a treatment decision that reflects both medical evidence and patient preferences. SDM has gained increasing policy attention in India's National Health Policy, though its uptake in routine practice remains inconsistent. Research suggests that perceived participation in decisions is associated with higher trust and greater treatment adherence (Shay & Lafata, 2015).

3.3 Trust in the Indian Healthcare Context

India's healthcare system is characterised by stark structural heterogeneity: a large government sector serving the majority of the population under significant resource constraints, alongside a thriving private sector catering to urban and upper-income populations. Trust dynamics differ markedly across these settings. Government hospitals, often overcrowded and under-staffed, afford little time for relationship development, while private clinics may offer greater consultation time but raise concerns about commercial motivations.

Cultural factors further complicate trust in Indian clinical encounters. The traditional guru-shishya (teacher-student) framing of the doctor-patient relationship has historically positioned physicians as authoritative figures whose pronouncements are not to be questioned. While younger, educated patients increasingly expect collaborative engagement, many first-generation healthcare users may interpret physician paternalism as confidence rather than dismissiveness (Supe & Burdick, 2006).

Language is a particularly salient variable. With over 22 officially recognised languages and hundreds of dialects, many clinical encounters in India involve some degree of linguistic mismatch between physician and patient. Code-switching, the use of culturally resonant metaphors, and family-mediated interpretation are common adaptive strategies that may substantially influence trust.

3.4 Patient Satisfaction as an Outcome

Patient satisfaction is a multi-dimensional construct reflecting the degree to which patients' expectations of care are met. The Patient Satisfaction Questionnaire (PSQ-18; Marshall & Hays, 1994) operationalises satisfaction across seven domains, with interpersonal manner and communication consistently emerging as the strongest drivers. The expectation-confirmation model (Oliver, 1980) provides a theoretical basis for satisfaction as a function of the congruence between expected and perceived physician behaviour — a framework well-suited to examining trust as a mediator.

4. METHODOLOGY

4.1 Research Design

A sequential explanatory mixed-methods design was adopted (Creswell & Plano Clark, 2018). In Phase 1, quantitative survey data were collected and analysed to test the structural model. In Phase 2, qualitative interviews were conducted to contextualise and elaborate the quantitative findings, with participant selection purposively guided by Phase 1 results. Ethical clearance was obtained from institutional review boards at each partner hospital, and all participants provided written informed consent. Data were collected between June and December 2024.

4.2 Study Setting and Participants

The study was conducted across eight healthcare facilities in three Indian cities: Delhi (metropolitan, mixed public/private), Lucknow (state capital, predominantly public), and Patna (mid-sized city, mixed). Facilities included two government tertiary hospitals, three private hospitals, and three community health centres. Adult outpatients (age >= 18 years) who had completed at least one full consultation were eligible. Patients with cognitive impairment, those in acute distress, and minors were excluded.

For the quantitative phase, 320 participants were recruited using systematic sampling (every third eligible outpatient). For the qualitative phase, 26 participants were purposively selected from survey respondents to ensure variation across gender, age, facility type, and trust level quartile. Table 1 presents the sociodemographic profile of the quantitative sample.

4.3 Measures

4.3.1 Communication Strategies

Six validated sub-scales were used to measure physician communication behaviours, each rated on a 5-point Likert scale (1 = Strongly Disagree to 5 = Strongly Agree): (a) Active Listening Scale (5 items; adapted from Bodie, 2011); (b) Empathetic Communication Subscale (6 items; from the Consultation and Relational Empathy [CARE] Measure); (c) Information Disclosure Scale (5 items; adapted from Kiesler & Auerbach, 2006); (d) Non-Verbal Cues Scale (4 items; adapted from Roter & Hall, 2006); (e) Patient-Centred Communication Scale (6 items; adapted from Epstein *et al.,* 2005); (f) Shared Decision-Making Questionnaire-Physician version, SDM-Q-Doc (5 items; Scholl *et al.,* 2012).

4.3.2 Doctor-Patient Trust

Trust was measured using the Wake Forest Physician Trust Scale (WFPTS; Hall *et al.,* 2002), a 10-item validated instrument assessing five dimensions: fidelity, competence, honesty, confidentiality, and global trust. The scale has demonstrated strong psychometric properties in cross-cultural adaptations (Ozawa & Sripad, 2013).

4.3.3 Patient Satisfaction

The Patient Satisfaction Questionnaire Short Form (PSQ-18; Marshall & Hays, 1994) was used to assess overall satisfaction across seven domains. A composite satisfaction score was computed as the primary outcome variable.

Table 1: Sociodemographic Profile of Quantitative Sample (N = 320)

Characteristic	N	Percentage (%)	Cumulative %
Gender			
Male	193	60.3	60.3
Female	117	36.6	96.9
Prefer not to say	10	3.1	100.0
Age Group			
18 - 30 years	64	20.0	20.0
31 - 45 years	112	35.0	55.0
46 - 60 years	98	30.6	85.6
Above 60 years	46	14.4	100.0
Education Level			
Below secondary	48	15.0	15.0
Secondary / Higher secondary	96	30.0	45.0
Graduate	124	38.8	83.8
Postgraduate and above	52	16.3	100.0
Type of Healthcare Facility			
Government hospital	148	46.3	46.3
Private hospital	104	32.5	78.8
Clinic / Nursing home	68	21.3	100.0
Type of Consultation			
First-time visit	118	36.9	36.9
Follow-up visit	202	63.1	100.0
Total	**320**	**100.0**	—

Note. *Percentages may not sum to 100 due to rounding.*

4.4 Data Analysis

Quantitative data were analysed using IBM SPSS 27 and AMOS 24. Following data screening (normality, missing values, outliers), descriptive statistics and Pearson bivariate correlations were computed. Reliability of all scales was assessed using Cronbach's alpha. Hierarchical multiple regression tested the independent contribution of each communication variable to trust prediction. Structural equation modelling (SEM) examined the full hypothesised model, including mediation of trust in the communication-satisfaction pathway. Model fit was evaluated using CFI, TLI, RMSEA, and SRMR.

Qualitative interview data were audio-recorded with consent, transcribed verbatim, and translated where necessary. Reflexive thematic analysis (Braun & Clarke, 2006) was conducted across six phases: familiarisation, initial coding, theme development, theme review, theme definition, and write-up. Two independent coders achieved inter-rater reliability of kappa = 0.84. Member-checking was conducted with eight participants.

5. RESULTS

5.1 Descriptive Statistics and Reliability

Table 2 presents means, standard deviations, and Cronbach's alpha values for all study constructs. All reliability coefficients exceeded the threshold of 0.80 (ranging from 0.83 to 0.93), indicating good-to-excellent internal consistency. Mean scores on communication variables ranged from 3.65 (SDM) to 3.92 (Active Listening), suggesting moderate-to-high perceived quality across all communication dimensions. Trust (M = 3.81) and satisfaction (M = 3.74) scores were similarly in the moderate-to-high range.

Table 2: Descriptive Statistics and Reliability Coefficients for All Study Constructs (N = 320)

Construct	Items	Cronbach's Alpha	Mean	SD	Reliability
Active Listening (AL)	5	0.88	3.92	0.61	Acceptable
Empathetic Communication (EC)	6	0.91	3.84	0.68	Acceptable
Information Disclosure (ID)	5	0.86	3.71	0.72	Acceptable
Non-Verbal Cues (NVC)	4	0.83	3.78	0.66	Acceptable
Patient-Centred Communication (PCC)	6	0.90	3.88	0.64	Acceptable
Shared Decision-Making (SDM)	5	0.87	3.65	0.74	Acceptable
Doctor-Patient Trust (DPT)	10	0.93	3.81	0.59	Acceptable
Patient Satisfaction (PS)	7	0.89	3.74	0.62	Acceptable

Note. *All alphas > 0.80 indicate acceptable-to-excellent reliability. SD = Standard Deviation.*

5.2 Bivariate Correlations

Table 3 presents the Pearson correlation matrix for all study variables. All communication sub-scales were significantly and positively correlated with doctor-patient trust (r = 0.61 to 0.74, all p < .001) and patient satisfaction (r = 0.55 to 0.72, all p < .001). Doctor-patient trust and patient satisfaction were strongly correlated (r = 0.75, p < .001), providing preliminary support for the mediation hypothesis. No multicollinearity concerns were indicated (all VIF values < 3.0 in subsequent regression).

Table 3: Pearson Correlation Matrix for Study Variables (N = 320)

Variable	AL	EC	ID	NVC	PCC	SDM	DPT	PS
1. AL	**1.00**	0.62**	0.54**	0.58**	0.67**	0.51**	0.71**	0.64**
2. EC		**1.00**	0.60**	0.63**	0.72**	0.56**	0.74**	0.68**
3. ID			**1.00**	0.49**	0.58**	0.62**	0.66**	0.60**
4. NVC				**1.00**	0.55**	0.47**	0.63**	0.57**
5. PCC					**1.00**	0.59**	0.78**	0.72**
6. SDM						**1.00**	0.61**	0.55**
7. DPT							**1.00**	0.75**
8. PS								**1.00**

Note. *AL = Active Listening; EC = Empathetic Communication; ID = Information Disclosure; NVC = Non-Verbal Cues; PCC = Patient-Centred Communication; SDM = Shared Decision-Making; DPT = Doctor-Patient Trust; PS = Patient Satisfaction. ** p < .001 (two-tailed).*

5.3 Multiple Regression Analysis

Hierarchical multiple regression was conducted with doctor-patient trust as the dependent variable. Demographic controls (entered in Step 1) accounted for 8% of variance. The six communication strategies entered in Step 2 accounted for an additional 53% of variance (F change (6, 313) = 81.4, p < .001), yielding a total model R^2 of 0.61. All six communication predictors made statistically significant, independent contributions to trust. Table 4 presents the full regression solution.

Table 4: Multiple Regression: Communication Strategies Predicting Doctor-Patient Trust (N = 320)

Predictor	B	SE	Beta	t	p	VIF
(Constant)	0.41	0.18	—	2.28	.023	—
Active Listening (AL)	0.31	0.06	0.28**	5.17	<.001	
Empathetic Communication (EC)	0.38	0.07	0.34**	5.43	<.001	
Information Disclosure (ID)	0.22	0.06	0.19**	3.67	<.001	
Non-Verbal Cues (NVC)	0.18	0.05	0.16**	3.60	<.001	
Patient-Centred Comm. (PCC)	0.42	0.07	0.37**	6.00	<.001	
Shared Decision-Making (SDM)	0.19	0.06	0.17**	3.17	.002	
Model fit: R^2 = 0.61, Adjusted R^2 = 0.60, F(6, 313) = 81.4, p < .001						

Note. *B = unstandardised coefficient; SE = standard error; Beta = standardised coefficient; VIF = Variance Inflation Factor. ** p < .001. Model R^2 = 0.61; Adjusted R^2 = 0.60; F(6, 313) = 81.4, p < .001.*

5.4 Figure 2: Standardised Regression Coefficients

Figure 2 presents standardised beta coefficients for each communication strategy as a predictor of doctor-patient trust, arranged in descending order of effect size. Patient-centred communication (beta = 0.37) and empathetic communication (beta = 0.34) are the two strongest predictors, followed by active listening (beta = 0.28). Non-verbal cues (beta = 0.16), though the weakest predictor statistically, remain significant and theoretically meaningful.

Figure 2: Standardised Beta Coefficients: Communication Strategies as Predictors of Doctor-Patient Trust

Note. Beta (standardised) coefficients from hierarchical multiple regression (Step 2). All coefficients significant at p < .001. Bar colours correspond to individual constructs; values shown to the right of each bar.

5.5 Structural Equation Modelling Results

SEM was used to test the full conceptual model including the mediating role of doctor-patient trust in the communication-satisfaction relationship. The measurement model demonstrated acceptable fit prior to structural path estimation. Table 5 presents all standardised path coefficients and model fit indices.

All six communication-to-trust paths were significant (H1–H6 all supported). The trust-to-satisfaction path was the strongest in the model (std. beta = 0.69, p < .001), supporting H7. Indirect effects of each communication strategy on patient satisfaction (mediated by trust) were all significant at p < .001 (bootstrapped 95% CI, 1000 iterations). The direct effects of communication strategies on satisfaction became non-significant when trust was included, indicating full mediation.

Table 5: Structural Equation Model: Path Coefficients and Model Fit Statistics

Path From	Path To	Std. Beta	SE	p	Significance
Active Listening	Doctor-Patient Trust	0.28	0.05	<.001	Supported (H1)
Empathetic Comm.	Doctor-Patient Trust	0.34	0.06	<.001	Supported (H2)
Info. Disclosure	Doctor-Patient Trust	0.19	0.05	<.001	Supported (H3)
Non-Verbal Cues	Doctor-Patient Trust	0.16	0.05	<.001	Supported (H4)
Patient-Centred Comm.	Doctor-Patient Trust	0.37	0.06	<.001	Supported (H5)
Shared Decision-Making	Doctor-Patient Trust	0.17	0.05	.002	Supported (H6)
Doctor-Patient Trust	Patient Satisfaction	0.69	0.05	<.001	Supported (H7)
Model fit: CFI = 0.96, TLI = 0.95, RMSEA = 0.049 [0.038, 0.061], SRMR = 0.057					

Note. *Std. Beta = standardised path coefficient; SE = standard error; p = significance level. Model fit: CFI = 0.96, TLI = 0.95, RMSEA = 0.049 [90% CI: 0.038–0.061], SRMR = 0.057.*

5.6 Qualitative Findings

Thematic analysis of 26 in-depth interviews (average duration: 52 minutes) generated five overarching themes that illuminate how communication behaviours translate into trust — and what systemic factors obstruct this process in Indian healthcare settings. Table 6 presents themes, sub-themes, and illustrative participant quotes.

Table 6: Qualitative Themes, Sub-themes, and Illustrative Quotes (N = 26)

#	Theme	Sub-themes	Illustrative Quote
1	Listening as Trust Currency	Attentive listening; Eye contact; Avoiding interruptions	*"When he put the file aside and just looked at me, I felt respected for the first time." (P-07, F, 38)*
2	Empathy and Emotional Validation	Acknowledging patient anxiety; Compassionate tone; Emotional attunement	*"She didn't dismiss my fear. She said, 'Your worry makes complete sense.' That one sentence changed everything." (P-14, F, 52)*
3	Transparency and Honest Disclosure	Explaining diagnosis clearly; Disclosing uncertainty; Avoiding jargon	*"He told me honestly that he wasn't 100% sure but here is what we'd try. That honesty made me trust him more." (P-03, M, 61)*
4	Cultural and Linguistic Congruence	Language adaptation; Culturally sensitive metaphors; Family inclusion	*"She explained it in Hindi with an example from cooking. I finally understood." (P-19, F, 44)*
5	Systemic Constraints on Trust	Short consultation time; Frequent doctor rotation; Poor privacy	*"Different doctor every time. How can you trust someone you've just met for 5 minutes?" (P-22, M, 57)*

Note. *P = Participant; M = Male; F = Female; numbers indicate participant ID. Quotes translated from Hindi/Urdu where indicated and reviewed for accuracy by a bilingual researcher.*

5.6.1 Theme 1 – Listening as Trust Currency

Across gender, age, and facility type, attentive listening emerged as the most frequently cited trust-building behaviour. Patients distinguished meaningfully between physicians who appeared to be listening and those who were genuinely listening — a distinction often anchored in whether the physician-maintained eye contact, refrained from looking at the computer screen, and waited for the patient to finish speaking before responding. For many participants, the experience of being listened to was itself therapeutic, independent of clinical outcome.

5.6.2 Theme 2 – Empathy and Emotional Validation

Patients reported that empathetic communication — particularly verbal acknowledgement of fear, pain, or uncertainty — was a transformative trust-building act. This was especially significant in contexts where patients had internalised expectations of clinical detachment. Several participants described moments of physician emotional

acknowledgement as unexpected and deeply reassuring. The cultural script of the 'stern but competent' physician was challenged by experiences of affective engagement.

5.6.3 Theme 3 – Transparency and Honest Disclosure

Participants valued transparency, including acknowledgement of diagnostic uncertainty. Contrary to paternalistic assumptions that patients prefer physician certainty, many found honest statements of uncertainty trust-affirming rather than trust-eroding. However, transparency was valued most when delivered with compassion; bluntness without empathy was experienced as distressing rather than respectful.

5.6.4 Theme 4 – Cultural and Linguistic Congruence

Language emerged as a profound trust determinant. Participants described experiences of linguistic congruence — when the physician spoke in the patient's mother tongue, used culturally familiar metaphors, or invited a family member to assist in communication — as uniquely trust-affirming. Conversely, clinical encounters conducted entirely in English with non-English-speaking patients were described as alienating and trust-undermining, even when technical care quality was high.

5.6.5 Theme 5 – Systemic Constraints on Trust

Multiple participants identified structural features of the healthcare system as barriers to trust development: short consultation times (perceived as < 5 minutes by many government hospital attendees), frequent rotation of physicians in public facilities, lack of physical privacy in examination areas, and administrative burden that diverted physician attention from the patient. These systemic constraints were seen as undermining even well-intentioned communication behaviours.

6. DISCUSSION

6.1 Interpretation of Quantitative Findings

The finding that all six communication strategies significantly predicted doctor-patient trust — together accounting for 61% of trust variance — strongly affirms the centrality of physician communication in the trust formation process. This effect size surpasses that reported in many Western studies (Birkhauer *et al.,* 2017; r = 0.45), potentially reflecting the heightened salience of communication in Indian healthcare contexts where structural constraints make it the primary vehicle through which trust can be established within compressed time windows.

Patient-centred communication emerged as the strongest predictor (beta = 0.37), consistent with international literature positioning PCC as a gold-standard approach (Epstein & Street, 2011). The strong performance of empathetic communication (beta = 0.34) is particularly noteworthy in the Indian context, given traditional expectations of physician detachment. This finding suggests that a cultural shift — at least among the study population — toward valuing emotional engagement may be underway, with significant implications for medical training.

The full mediation of communication effects on satisfaction through trust — confirmed by SEM — is theoretically important. It implies that communication strategies do not directly satisfy patients; rather, they build trust, and it is trust that drives satisfaction. This mediation model has practical implications: interventions focused purely on information delivery or procedural courtesy, without attention to trust, may yield diminished satisfaction returns.

6.2 Contextualising Qualitative Insights

The five qualitative themes complement and contextualise the quantitative model in important ways. The primacy of listening — aligned with the high quantitative beta for active listening — suggests this behaviour has particular resonance in Indian clinical culture, where patients may rarely experience being fully heard. The theme of cultural and linguistic congruence introduces a moderating variable not fully captured in the quantitative model, pointing to the importance of language-sensitive communication training.

The systemic constraint's theme highlights the boundaries of individual communication behaviour: even skilled communicators cannot build meaningful trust in five-minute consultations with patients they have never met before. Structural reforms — particularly in public-sector healthcare — are necessary complements to training-level interventions.

6.3 Implications for Practice and Policy

First, communication skills training should be integrated into undergraduate and postgraduate medical curricula in India as a core clinical competency, not an elective. Training should address all six identified communication dimensions, with special emphasis on patient-centred and empathetic communication techniques. Standardised patient simulations in regional languages offer a promising modality.

Second, healthcare institutions — particularly government hospitals — should examine appointment scheduling structures to ensure minimum consultation durations that permit basic trust formation. Research suggests that even

incremental increases in consultation time (from 5 to 10 minutes) yield measurable improvements in patient-reported experience.

Third, language and cultural training should be treated as integral to communication competence, not supplementary. Hospitals serving linguistically diverse populations should implement structured language-bridging protocols and consider culturally trained patient navigators for high-volume facilities.

Fourth, continuity of care models — including registered patient lists and named physician assignment — should be expanded in primary and secondary care settings to enable longitudinal trust accumulation, which qualitative data indicate patients greatly value.

6.4 Limitations

This study has several limitations. First, the cross-sectional design constrains causal inference, though the theoretical model is well-grounded and SEM-tested. Second, social desirability bias may have inflated trust and satisfaction self-reports. Third, all data were collected in urban or semi-urban centres; generalisability to rural and remote settings — where healthcare access and delivery patterns differ substantially — requires caution. Fourth, the study relied on patient-reported perceptions of physician communication; observational methods or physician self-reports would add complementary perspectives. Fifth, though validated instruments were used, some required contextual adaptation, and full psychometric validation in the Indian cultural context remains an important future step.

7. CONCLUSION

This study provides robust empirical evidence that physician communication strategies are significant antecedents of doctor-patient trust in Indian outpatient settings, and that trust fully mediates the effect of communication on patient satisfaction. Among six tested strategies, patient-centred communication and empathetic communication were the most powerful predictors of trust. Qualitative findings enriched the statistical picture, revealing that listening, emotional validation, transparency, cultural congruence, and structural constraints each shape the lived experience of trust in Indian clinical encounters.

These findings carry direct implications for medical education, clinical practice, and healthcare policy in India. As patient-centred care is increasingly incorporated into national health policy frameworks, empirical evidence of this kind provides an evidence base for translating aspirational principles into actionable communication training and institutional reforms. Trust is not a byproduct of good medicine — it is a precondition for it.

Future research should employ longitudinal designs to track trust development over multiple consultations, examine communication-trust dynamics in telehealth and digital health contexts, and develop and validate culturally adapted communication assessment tools for diverse Indian patient populations. Multilevel modelling incorporating both patient- and physician-level variables would further advance understanding of the complex interplay between individual communication behaviour and systemic healthcare context in shaping the trust that lies at the heart of healing.

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