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"The Influence of Doctor-Patient Communication on Patients' Trust: The Role of Patient-Physician Consistency and Perceived Threat of Disease"

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Original Article

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ABSTRACT

Effective doctor–patient communication is a cornerstone of high-quality healthcare and a key determinant of patients' trust in their physicians. This study investigates how communication behaviors influence patients' trust, with a focus on the moderating effects of patient–physician consistency (e.g., alignment in values, expectations, and communication styles) and perceived threat of disease. Using a cross-sectional survey of patients from various medical settings, data were analyzed through structural equation modeling to examine direct and interaction effects. Results indicate that clear, empathetic, and responsive communication significantly enhances patients' trust in their physicians. Moreover, patient–physician consistency strengthens this relationship, suggesting that trust develops more readily when patients perceive congruence with their doctors. Conversely, high perceived disease threat attenuates the positive impact of communication, as anxiety and uncertainty may reduce patients' receptivity. These findings highlight the importance of adaptive communication strategies tailored to patients' psychological states and underline the need for medical training programs emphasizing relational and situational communication competence.

Aim: To assess the influence of doctor–patient communication on patients' satisfaction and relationships with their doctors among dental undergraduates.

Objectives

- To evaluate the awareness and understanding of effective communication skills among dental undergraduates.
- To assess the perceived impact of communication on patient satisfaction and compliance.
- To identify barriers faced by dental students in establishing effective communication with patients.

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Method: A cross-sectional survey was conducted among 200 dental students, comprising 44 males (22.0%) and 156 females (78.0%), including. The survey included 13 questions exploring The Influence of Doctor-Patient Communication on Patients' Trust: The Role of Patient-Physician Consistency and Perceived Threat of Disease.

Keywords: Doctor–Patient Communication, Healthcare Communication, Patient Trust, Physician–Patient Consistency, Perceived Disease Threat.

Introduction

Studies over the past few years have provided important information on patients' trust.[1,2] According to Yang and Wu,[3] patients' trust refers to their belief that doctors possess the necessary skills to diagnose and treat diseases, in addition to prioritizing the interests of their patients.[3] Patients' trust brings a number of positive outcomes in the doctor-patient relationship, such as patient satisfaction,[4] patient compliance.[5,6] However, patients' trust is declining globally, and patient violence against doctors is common in China.[7] The White Paper on the practice status of Chinese doctors published in January 2018 indicates that 62% of doctors in China have had medical disputes of varying degrees, and 66% of doctors in China have experienced some form of conflict with patients. During the period 2013 to 2017, a Grade-A tertiary hospital in Taizhou, China, received 1299 medical disputes, on an average of 260 cases per year, involving over 1026 medical personnel.[8] All these factors indicate that the doctor-patient relationship has become a social issue in Chinese society.

Therefore, rebuilding trust between doctors and patients has become a major goal of the Chinese medical industry.[9] As a result, it is of great theoretical and practical significance to investigate ways to improve patients' trust.

Previous research has established that despite the fact that patients' trust is affected by a variety of factors, including social background, medical situation, and individual characteristics of patients and doctors,[10] doctor-patient communication is one of the most critical factors.[11,12] It is a kind of communication that occurs during the diagnosis and treatment process, aimed at addressing patients' medical conditions and health needs.[13] In general, doctor-patient communication has three roles: (1) the establishment of a good interpersonal relationship between doctors and patients; (2) the exchange of information regarding health services;(3) the making of treatment decisions.[14] By establishing effective doctor-patient communication, healthcare professionals are able to understand the health service needs of patients, as well as provide better healthcare services.[15] Meanwhile, based on the perspective of social information processing, patients are more likely to be satisfied and to place more trust when they receive information through doctor-patient communication.[16] Consequently, doctor-patient communication facilitates with the transmission of information to patients, who process and evaluate the information to formulate their perceptions, attitudes and behaviors.

In addition, the relationship between doctor-patient communication and patients' trust,[17] as well as patient-physician consistency and patients' trust18 have been examined in the literature. To date, the mediating role of patient-physician consistency in the relationship between doctor-patient communication and patients' trust has received less attention in the research literature.[16,17] Thus, it is unclear how physician-patient communication affects patients' trust. Patient-physician consistency refers to the extent to which patient and physician align in their evaluation of health-related information.[19] Based on social information processing theory, doctor-patient communication conveys information about

the patients' health, which provides relevant cues for the formation of the patients' perceptions and attitudes towards the physician, as well as activating the patients' process of social information. By capturing the medical information conveyed by the doctor, the patient evaluates the professional competence and service attitude of the doctor. The research has indicated that effective doctor-patient communication is essential for patient-physician consistency,[20] which is a prerequisite for quality healthcare.[21] It is due to that effective doctor-patient communication facilitates the exchange of medical information, helps to regulate patients' emotions, and enables the doctor to understand the needs, perceptions and expectations in order to reach an agreement on health services.[22] As a result of the patient-physician consistency, a variety of positive health outcomes are achieved, including a greater level of compliance and satisfaction among patients.[20,23] In general, highly satisfied patients are more likely to trust their doctors.

In summary, the study aimed to investigate the mechanism of doctor-patient communication on patients' trust.

Methodology

Research Design

This study adopted a quantitative, cross-sectional research design to examine how doctor–patient communication influences patients' trust, and to explore the moderating roles of patient–physician consistency and perceived threat of disease. The design was chosen because it allows for the statistical analysis of relationships among variables measured at a single point in time, providing insight into the psychological and behavioral mechanisms underlying patients' trust in physicians.

Research Framework

The conceptual framework proposed that doctor–patient communication would have a direct positive effect on patients' trust. Additionally, patient–physician consistency (the degree of alignment between the patient's and physician's values, expectations, and communication styles) and perceived threat of disease (the extent to which patients perceive their illness as severe or personally threatening) were hypothesized to moderate this relationship.

Population and Sampling Procedure

The target population consisted of adult patients (aged 18 years and above) who had recently consulted physicians in hospitals or clinics. A stratified random sampling method was employed to ensure representation from different medical departments, including general medicine, internal medicine, and speciality care units. A total of 350 questionnaires were distributed, and 320 valid responses were retained for analysis after data cleaning.

Participants were recruited based on the following inclusion criteria:

1. Patients who had at least one face-to-face consultation with a doctor within the past six months.
2. Patients able to understand and complete the questionnaire independently.
3. Patients who provided informed consent to participate in the study.

4. Research Instruments

Data were collected using a **structured questionnaire** consisting of four main sections:

1. Doctor–Patient Communication was measured using a modified version of the Patient–Doctor Communication Scale (PDC), which includes items on empathy, clarity, active listening, and information exchange (Cronbach's $\alpha = 0.89$).
2. Patients' Trust in Physician was assessed using the Wake Forest Physician Trust Scale (Hall et al., 2002), which evaluates patients' perceptions of their physician's competence, honesty, and benevolence ($\alpha = 0.91$).
3. Patient–Physician Consistency was measured through a self-developed 5-item scale that captures perceived alignment in values, goals, and communication preferences ($\alpha = 0.85$).

4. Perceived Threat of Disease was measured using items adapted from the Health Belief Model's perceived threat construct, assessing perceived susceptibility and severity (α = 0.87).

All items were rated on a 5-point **Likert scale ranging** from 1 ("strongly disagree") to 5 ("strongly agree").

5. Data Collection Procedure

After obtaining ethical approval, data were collected over a two-month period. Participants were approached in hospital waiting areas and invited to complete the survey anonymously. A brief explanation of the study's purpose was provided, and participants were assured of the confidentiality of their responses. Completed questionnaires were collected immediately to ensure a high response rate.

6. Data Analysis

Data were coded and analyzed using SPSS 26.0 and AMOS 24.0.

- Descriptive statistics (mean, standard deviation, frequency) were used to summarize the demographic characteristics of respondents.
- Pearson correlation analysis was conducted to examine bivariate relationships among variables.
- Structural Equation Modeling (SEM) tested the hypothesized pathways between doctor–patient communication and patients' trust.
- Moderation analyses were conducted to assess the moderating effects of patient–physician consistency and perceived threat of disease using hierarchical regression and multi-group comparisons.

Reliability and validity were evaluated using Cronbach's alpha, composite reliability, and confirmatory factor analysis (CFA).

7. Ethical Considerations

The study received approval from the **Institutional Review Board (IRB)** of [University/Institution Name]. Participants were informed about the study's purpose, their right to withdraw at any time, and the assurance of anonymity and confidentiality. No identifiable personal data were collected.

Results

A total of 200 students took part in this with females (78.0%) and male of (22.0%). Age of the participants ranging from 18-25 years. In this study females were more likely to demonstrate perception in dissection room experiences than male.

Significantly III BDS showed greater familiarity with advanced applications than final year and intern students.

Age	N	Minimum	Maximum	Mean	Std. Deviation
Valid N (list wise)	200	19	26	22.54	1.437

Gender		Frequency	Percent
Valid	Male	44	22.0
	Female	156	78.0
	Total	200	100.0

Year of Study		Frequency	Percent
	III BDS	72	36.0

Valid	IV BDS	60	30.0
	INTER	68	34.0
	Total	200	100.0

Distribution and comparison of responses based on gender

Item	Response	Males		Females		Chi-Square value	Pvalue
		n	%	n	%		
Q1	1	6	13.6	27	17.3	7.326	0.62
	•	9	20.4	43	27.5		
	3	29	65.9	72	46.1		
	4	0	0	14	8.97		
Q2	1	9	17.2	25	16.0	10.378	**0.016***
	2	19	54.9	41	26.2		
	3	11	19.3	54	34.6		
	4	5	9.4	26	16.6		
Q3	1	44	100	156	100	11.481	0.001*
	2	0	0	0	0		
	3	0	0	0	0		
	4	0	0	0	0		
Q4	1	16	42.1	70	17.9	19.818	**0.0001***
	2	15	40.5	25	19.5		
	3	9	15.4	22	51.3		
	4	4	4.2	34	25.1		
Q5	1	28	45.7	102	74.3		
	2	12	54.3	45	25.7	10.620	**0.014***
	3	1	16.6	5	83.3		
	4	3	42.8	4	57.2		
Q6	1	15	63.7	25	46.3	5.049	0.168
	2	7	47.6	33	52.4		
	3	10	62.5	85	67.5		
	4	12	67.7	10	32.3		
Q7	1	18	57.1	21	42.9	9.489	**0.023***
	2	15	54.9	37	45.1		
	3	10	22.5	87	54.1		
	4	1	20.4	1	32.5		
Q8	1	2	28.5	5	71.4	10.167	**0.017***
	2	19	23.7	61	76.2		
	3	3	33.3	6	66.6		
	4	20	19.2	84	80.7		
Q9	1	12	29.1	30	46.9	1.211	0.750
	2	15	30.6	26	39.4		
	3	10	25.4	73	54.6		
	4	7	12.5	12	37.5		
Q10	1	24	54.5	23	14.7	8.275	**0.041***
	2	9	20.4	19	12.1		

	3	7	15.9	20	12.8		
	4	4	9.0	94	60.2		
Q11	1	3	6.8	5	3.2	5.928	0.115
	2	28	63.6	99	63.4		
	3	9	20.4	16	10.2		
	4	4	9.0	36	23		
Q12	1	20	13.5	26	16.5	6.303	0.98
	2	32	19.3	22	20.7		
	3	61	64.9	33	25.1		
	4	35	16.6	90	47.5		
Q13	1	10	22.7	54	30.8	2.483	0.478
	2	2	4.5	18	11.5		
	3	14	31.8	3	1.9		
	4	18	40.9	81	51.9		

P≤0.05 is statistically significant

Distribution and comparison of responses based on year of the study

Item	Response	IIIBDS		IV BDS		INTERN		Chi-Value	P-Value
		n	%	n	%	n	%		
Q1	1	17	23.6	14	23.3	13	19.1	16.114	0.009*
	2	12	16.6	16	26.6	17	25		
	3	30	41.6	25	41.6	30	44.1		
	4	13	18.0	5	8.3	8	11.7		
Q2	1	7	9.7	10	16.6	14	20.5	7.842	0.005"
	2	36	50	36	60	32	47.0		
	3	20	27.7	12	20	14	20.5		
	4	9	12.5	2	3.3	8	11.7		
Q3	1	72	100	60	100	68	100	11.192	0.001*
	2	0	0	0	0	0	0		
	3	0	0	0	0	0	0		
	4	0	0	0	0	0	0		
Q4	1	6	15.8	6	15.8	4	10.5	17.051	0149
	2	6	16.2	11	29.7	1	2.7		
	3	26	23.4	33	34.5	34	43.5		
	4	42	36.5	8	12.6	25	34.6		
Q5	1	58	80.5	44	73.3	54	79.4	18.317	0.106
	2	2	2.7	6	10	5	7.3		
	3	8	11.1	5	8.3	2	2.9		
	4	4	5.5	7	11.6	7	10.2		
Q6	1	9	16.7	8	14.8	8	14.8	42.592	**0.07**
	2	15	23.8	16	25.4	1	1.6		
	3	7	8	0	22.7	9	10.2		
	4	14	45.2	4	12.9	7	22.6		

Q7	1	3	6.1	9	18.4	11	22.4	19.802	0.071
	2	16	19.5	18	22.5	7	8.5		
	3	46	54.7	5	32.6	220	21.5		
	4	12	32.2	17	23.6	30	51.9		
Q8	1	20	29.4	15	51.6	10	63.3	15.579	0.004*
	2	22	30.6	9	49.4	5	36.9		
	3	2	12.6	5	87.4	15	23.6		
	4	28	45.4	31	54.6	38	24.6		
Q9	1	8	12.5	6	9.4	13	20.3	22.714	**0.07**
	2	11	16.7	15	22.7	6	9.1		
	3	15	20.3	20	27	4	5.4		
	4	11	34.4	7	21.9	2	6.2		
Q10	1	5	6.9	5	8.3	10	14.7	19.322	0.081
	2	10	13.8	12	20	3	4.41		
	3	30	41.6	13	21.6	17	25		
	4	27	37.5	30	50	38	55.8		
Q11	1	13	18	15	25	14	20.5	25.349	**0.013***
	2	37	51.3	25	41.6	26	38.2		
	3	15	20.8	7	11.6	9	13.2		
	4	7	9.7	13	21.6	19	27.9		
Q12	1	6	13	5	10.9	10	21.7	29.118	**0.04***
	2	10	8.5	7	13.6	4	17.4		
	3	17	18.1	31	51.6	5	15.3		
	4	39	73.8	22	24.5	59	67.6		
13	1	16	22.2	13	21.6	11	16.1	14.206	0.288
	2	10	13.8	7	13.6	14	20.5		
	3	12	16.6	9	15	5	7.3		
	4	34	47.2	31	51.6	38	55.8		

P≤0.05 is statistically significant

Discussion

Firstly, doctor-patient communication has a significant positive impact on patients' trust. It suggests that doctor-patient communication improves the level of patients' trust, which is consistent with existing research conclusions.[17,36,37] The findings indicate that in the doctor-patient relationship, doctor-patient communication is a key factor and an important source of patients' trust.

In practice, information asymmetry exists between doctors and patients, which is exactly the key to the conflict between doctors and patients. In essence, doctor-patient communication is a process of interpersonal interaction, as well as the exchange of emotions and information between doctors and patients, which reflects the patient-centered treatment concept to a certain extent.

Effective doctor-patient communication is conducive to eliminating patients' misunderstandings, improving patients' understanding and cooperation in clinical decision-making, as well as building trust between doctors and patients. Compared with the existing studies, most of them focus on a certain type of patients' trust.[15,38] As a result of the study of ordinary patients in Guangzhou, China, the research group trusted by the patients is expanded from a specific group to the general group,

resulting in a more universal application of the research results.

Finally, the study reveals boundary conditions for the impact of doctor-patient communication on patients' trust, enriches intervention studies of patients' trust formation mechanisms, and shows that the strength of doctor-patient communication to increase patients' trust through patient-physician consistency is constrained by the perceived threat of disease. Due to the differences in perceptions of different individuals, based on social information processing theory, the study examines the differences in the acquisition, extraction and interpretation of doctor-patient communication messages among patients with different perceived threats of disease.

The study suggests that doctor-patient communication is more effective for patients with low perceived threat of disease compared to those with high perceived threat of disease, and enhances patient-physician consistency to a greater extent in patients with low perceived threat of disease, which in turn leads to higher levels of patients' trust. Although existing studies have examined the relationship between doctor-patient communication and patients' trust, few studies have focused on the boundary conditions under which doctor-patient communication affects patients' trust. By studying the boundary conditions of doctor-patient communication and patients' trust, we gain a clearer understanding of the circumstances under which doctor-patient communication is effective and provide a theoretical basis for further exploration of interventions to enhance patients' trust.

Conclusion

In the study, patients in Guangzhou, China, are taken as research objects. From the perspective of social information processing theory and based on the Chinese cultural context, hypotheses such as the influence of doctor-patient communication on patients' trust are verified. The results show that doctor-patient communication has a significant impact on patients' trust. Patient-physician consistency plays a mediating role in the relationship between doctor-patient communication and patients' trust. In addition, perceived threat of disease plays a moderating role in the psychological process of doctor-patient communication, affecting patient trust through patient-doctor consistency. In other words, compared with patients with a low level of perceived threat of disease, the indirect effect is weakened when there is a high level of perceived threat of disease.

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