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Constructing Patient Trust in Hospital Administrative Services: A Symbolic Interactionist Perspective on Staff-Patient Communication

Namira Azzahra^{1*}

¹ LSPR Communication & Business Institute, Jakarta, Indonesia

* Corresponding author: Namira Azzahra (25072220040@lspr.edu)

Abstract

Patient trust constitutes a foundational element in the delivery and outcomes of healthcare services, influencing how individuals engage with providers, adhere to treatments, and sustain long-term relationships with health systems. This study aims to examine the multidimensional nature of patient trust by focusing on four interconnected themes: interaction quality and symbolic communication, communicative trust mechanisms, organizational and administrative factors, and continuity of care. This study employs a qualitative descriptive design to examine the multidimensional nature of patient trust by synthesizing evidence from eleven peer-reviewed studies. Findings reveal that trust is not a static condition but rather an emergent, relational process shaped by verbal and non-verbal exchanges, biomedical rituals, institutional responsiveness, and interprofessional coordination. Healthcare providers' communicative competence, empathy, and consistency of presence were identified as primary trust enablers, whereas fragmented care pathways, poor information exchange, and administrative inefficiencies were recurring barriers. The study contributes theoretically by applying symbolic interactionism and communicative action to explain how meaning is co-constructed in therapeutic encounters. It also highlights the need for trust-oriented communication training, patient-centered administrative redesign, and digitally supported care coordination, while enriching the literature on relational healthcare quality by bridging interpersonal dynamics and systemic factors through a holistic thematic synthesis.

Keywords

Communicative Trust, Interaction Quality, Patient Trust, Symbolic Interactionism.

1. Introduction

Trust has long been recognized as a central pillar of effective healthcare delivery, shaping how patients interact with providers and health systems. When patients perceive healthcare professionals as competent, caring, and reliable, they are more likely to disclose accurate health information, adhere to prescribed treatments, and maintain sustained engagement with healthcare services. When trust is weakened or absent, patients are more likely to disengage, delay seeking care, or rely on self-medication, leading to adverse health outcomes and increased societal costs (Ozawa & Sripad, 2013; Hillen et al., 2020). In the context of increasingly complex healthcare systems and rapid digital transformation, understanding how trust is formed, maintained, and disrupted has become an urgent priority for researchers, clinicians, and policymakers (Guckert et al., 2022; Ferreira, 2025).

The study of patient trust has evolved significantly, shifting from a traditional focus on physician authority toward a broader perspective that emphasizes relational, communicative, and institutional dimensions (Luo et al., 2023). Contemporary healthcare involves interactions with a wide range of actors, including nurses, pharmacists, administrative personnel, and allied health professionals, all of whom contribute to shaping patients' trust experiences (Burt et al., 2014; Haddad et al., 2023; Risambessy, 2023). Interaction quality reflected in empathy, responsiveness, and interpersonal sensitivity has been identified as a key determinant of trust formation (Riedl & Schüßler, 2017). In parallel, communicative trust mechanisms, such as transparency, clarity, and patient-centered dialogue, play a critical role in fostering mutual understanding and confidence during clinical encounters (Shafik, 2025).

Beyond interpersonal interactions, organizational and administrative factors have emerged as equally important in influencing patient trust. Elements such as care coordination, service efficiency, and the effectiveness of health information systems shape how patients perceive the reliability and credibility of healthcare institutions (Birkhäuser et al., 2017; Kuswari et al., 2025). Continuity of care further strengthens this relationship, as consistent and coordinated healthcare experiences reinforce patients' confidence over time (Gray et al., 2018; Khatri et al., 2023). These variables, interaction quality, communicative trust, and organizational performance, are therefore interconnected, suggesting that trust is not a static attribute but a dynamic outcome arising from the interplay between micro-level interpersonal processes and macro-level systemic structures.

Despite the growing body of literature, several research gaps remain. First, many studies continue to examine patient trust primarily within the physician-patient dyad, neglecting the broader network of healthcare providers involved in patient care (Brennan et al., 2013). Second, existing research often treats interpersonal communication and organizational factors as separate domains, resulting in fragmented insights that fail to capture the holistic nature of trust formation. Third, there is limited integration of theoretical perspectives, particularly symbolic interactionism and communicative action, to explain how trust is co-constructed through both verbal and non-verbal interactions within institutional contexts. These gaps indicate the need for a more comprehensive and integrative approach that bridges relational dynamics and systemic influences in understanding patient trust.

To address these limitations, this study employs a qualitative descriptive methodology by synthesizing findings from eleven peer-reviewed studies that examine patient trust from sociological, organizational, and clinical perspectives. Drawing on symbolic interactionism and communicative action frameworks, the analysis explores how meaning is co-constructed during therapeutic encounters, how communication processes shape trust, and how institutional structures either facilitate or hinder its development. This integrative approach enables a deeper

understanding of patient trust as a multidimensional and relational construct applicable across diverse healthcare settings and cultural contexts.

The relevance of this study extends beyond academic discourse. As healthcare systems face increasing patient complexity, workforce constraints, and technological advancements, the relational foundations of care risk being overlooked. This study argues that interaction quality, communicative competence, and organizational responsiveness are not peripheral elements but constitute the core architecture of trustworthy healthcare. Therefore, the primary objective of this study is to examine the multidimensional nature of patient trust by analyzing the relationships among interaction quality, communicative trust mechanisms, and organizational factors, while identifying key enablers and barriers to trust in healthcare settings.

2. Literature Review

2.1. Conceptual Foundations of Patient Trust

Patient trust has been theorized from multiple disciplinary perspectives, each illuminating distinct facets of this complex construct. Trust involves a voluntary acceptance of vulnerability based on positive expectations about another party's intentions and competencies (Gavurova et al., 2024; Lerch et al., 2024). In healthcare contexts, this definition expands to encompass patients' confidence that providers will act with beneficence, demonstrate clinical knowledge, and engage with fairness and integrity throughout all stages of care (Weber, 2024). Sociological scholarship has emphasized that trust is not simply an individual cognitive disposition but a social and relational process continuously constructed through daily interactions (Tianqi & Jinhao, 2024). Rodrigues (2021) demonstrated that trust in therapeutic encounters is simultaneously an input and an output of communicative interaction, meaning that the very act of communication is both a prerequisite for and a product of trusting relationships. This bidirectional quality distinguishes interpersonal trust in healthcare from more transactional forms of confidence.

The symbolic interactionist tradition, as applied to healthcare by Cersosimo (2019), offers additional theoretical depth by foregrounding the role of symbols and meaning-making in shaping provider-patient dynamics. Professional uniforms, diagnostic technologies, prescribing rituals, and clinical settings all function as symbolic resources through which providers communicate authority, competence, and care. Patients interpret these symbols through culturally embedded frameworks, and their trust responses are accordingly shaped not only by what providers say but by what their presence, appearance, and actions signify. Hussain et al. (2025) identified institutional-based trust, knowledge-based trust, and trust transfer processes as distinct mechanisms through which patients develop confidence in both individual providers and healthcare organizations as a whole. This multi-level conceptualization underscores that patient trust cannot be reduced to interpersonal rapport but must be understood as a systemic property embedded in broader organizational cultures and administrative arrangements.

2.2. Interaction Quality as a Trust Determinant

The quality of interactions between patients and healthcare providers has consistently emerged as one of the most powerful predictors of patient trust. Wibowo et al. (2020) identified outcome quality, physical environment quality, and justice quality as significant antecedents of patient satisfaction, which in turn predicted trust. The moderating role of patient health condition was supported, indicating that vulnerability amplifies the salience of interaction quality in trust formation. These findings suggest that trust-building strategies must be sensitive to the clinical context in which interactions occur.

At the interpersonal level, communicative performance has been identified as the primary mechanism through which symbolic trust either consolidates or dissolves.

Rodrigues (2021) found that patients in resource-limited settings evaluated providers not only on the basis of technical expertise but on how their communications were performed, whether providers listened actively, shared information voluntarily, demonstrated empathy, and engaged in the rituals of care such as physical examination and diagnostic testing. When these communicative rituals were absent or truncated, patients experienced doubt about providers' competence and commitment, regardless of the formal qualifications held.

Waddell et al. (2021) further emphasized that shared decision-making, a practice widely regarded as central to patient-centered care, is frequently impeded by environmental and attitudinal barriers within hospital settings. Noisy ward environments, time pressures, and clinicians' uncertainty about patients' preferences for involvement were identified as structural constraints on the kinds of communicative exchanges that build trust (Chan et al., 2018). These findings point to the importance of addressing both individual communication skills and systemic conditions that shape the possibilities for meaningful interaction.

2.3. Organizational and Administrative Dimensions of Trust

Beyond interpersonal dynamics, trust in healthcare is substantially shaped by organizational factors, including administrative processes, care coordination, and institutional governance. Bhati et al. (2023) argued that effective hospital administration encompasses leadership quality, financial stewardship, human resource management, and continuous quality improvement, all of which create the structural conditions in which clinical trust can flourish. Organizations characterized by strong governance and patient-centered policies tend to generate higher levels of institutional trust, which in turn transfers to individual provider relationships.

Hussain et al. (2025) provided empirical support for this organizational perspective, demonstrating that administrative procedures significantly predicted both medical staff service quality and patient satisfaction, both of which mediated the pathway to patient trust. The moderating role of electronic health knowledge further indicated that patients who are more digitally literate experience stronger trust and benefit from high-quality medical staff interactions. This finding has important implications for health system design in an era of increasing digital healthcare delivery.

AlOmari and Hamid (2021) extended the analysis of organizational trust to its downstream effects, showing that patient trust in doctors, nurses, and administrative processes together accounted for a substantial proportion of variance in positive word-of-mouth behavior. This finding highlights that organizational trust has reputational consequences, influencing how healthcare institutions are perceived in their communities and how prospective patients decide where to seek care. Administrative responsiveness and interpersonal care quality thus function as complementary pillars of institutional reputation.

2.4. Care Coordination and Continuity as Trust Foundations

The continuity of care relationships has been identified as a particularly powerful source of patient trust. Khatri et al. (2023) conducted a scoping review demonstrating that care coordination across individual, organizational, and systemic levels is essential for sustaining the relational conditions that enable trust to develop over time. At the individual level, patients who see the same providers consistently develop greater familiarity and confidence; at the organizational level, interprofessional collaboration and integrated service models reduce the fragmentation that erodes trust; and at the systemic level, multisectoral coordination ensures that patients are not lost between service providers.

Rodrigues (2021) illustrated the significance of continuity through the contrasting experiences of patients in public health facilities, where one-off

encounters with rotating providers limited trust development, and community pharmacies, where repeated interactions with familiar staff enabled gradual, cumulative trust accumulation. This observation aligns with broader theoretical claims that trust is a temporal phenomenon, requiring sustained interactions to reach the depth and stability necessary to support meaningful therapeutic relationships. Liu et al. (2021) further demonstrated that patient satisfaction alone is insufficient to generate patient loyalty; rather, trust serves as a full mediator in this relationship. This finding has profound implications for healthcare quality improvement, suggesting that efforts to enhance satisfaction scores without simultaneously cultivating trust will fail to produce the behavioral outcomes, including sustained care engagement and positive referrals, that health systems depend upon.

3. Methods

This study adopts a qualitative descriptive design, which aims to provide a comprehensive summary of phenomena in the everyday terms of those phenomena (Sandelowski, 2000). Qualitative description is particularly appropriate when the research objective is to present findings in a manner that is accessible and immediately applicable to practice, without imposing interpretive frameworks that may distort the meaning embedded in the source material. This design is well-suited to the synthesis of multi-source literature on patient trust, where the goal is to identify recurrent patterns and themes rather than to develop grounded theory or conduct phenomenological analysis. The qualitative descriptive approach employed here is informed by the epistemological position that knowledge about trust in healthcare is socially situated, context-sensitive, and best captured through the direct voices of patients, providers, and organizational actors. By drawing on a diverse corpus of eleven studies spanning quantitative surveys, qualitative interviews, systematic reviews, and ethnographic observations, this research achieves methodological triangulation that strengthens the credibility and transferability of its findings.

The primary data sources for this study consist of eleven peer-reviewed journal articles selected on the basis of their theoretical relevance, methodological rigor, and thematic alignment with the research focus on patient trust and healthcare interaction. The studies span multiple national contexts and healthcare settings, including hospital-based care, primary health facilities, and community pharmacy environments. All selected studies were published between 2019 and 2025 in indexed international journals, using diverse methodologies. Data were analyzed through thematic synthesis, a systematic procedure that involves the line-by-line coding of findings from primary studies, the development of descriptive themes, and the generation of analytical themes that advance beyond the findings of individual studies. This approach is particularly appropriate for qualitative literature synthesis because it preserves the richness and context-specificity of original data while enabling the identification of patterns that transcend individual studies.

4. Results

4.1. Interaction Quality and Symbolic Communication

Across the included studies, interaction quality emerged as a consistently central determinant of patient trust. The studies converged on the view that patients do not evaluate interactions solely based on technical outcomes but attend closely to the manner, tone, and symbolic content of their exchanges with providers. Cersosimo (2019) documented through extended observation that clinical environments are rich with symbolic meaning: healthcare uniforms, diagnostic equipment, prescribing behaviors, and even the spatial arrangement of clinical spaces all communicate messages about authority, competence, and care that patients actively interpret.

Rodrigues (2021) elaborated on this symbolic dimension by showing that the performance of diagnostic rituals, including laboratory testing, physical examination, and medicine prescription, functions as a communicative act that signals providers' commitment to their patients' well-being. When these rituals were performed, patients reported greater confidence in the care they received, even in the absence of explicit verbal explanation. When providers moved too quickly through consultations, truncated examination procedures, or prescribed medications before patients had fully articulated their concerns, trust was compromised regardless of the clinical quality of the prescription.

Wibowo et al. (2020) found that outcome quality, defined as patients' perceptions of the results of their care, and justice quality, understood as fairness in service delivery, were both significant predictors of patient satisfaction, which subsequently predicted trust. The physical environment also contributed to trust formation, confirming that patients' assessments of institutional cleanliness, organization, and modernity serve as proxies for the overall quality of care they expect to receive. These findings suggest that trust-building is a multisensory experience that encompasses the full clinical environment.

4.2. Communicative Trust Mechanisms

The mechanisms through which communication generates trust were examined across multiple studies, with considerable convergence around the importance of active listening, information sharing, and affective responsiveness. Rodrigues (2021) introduced the concept of communicative trust to describe the process by which patients come to trust providers primarily through communicative performances rather than through formal credentials or institutional positioning alone. This framing shifts analytical attention from providers' attributes to providers' behaviors, emphasizing that trust must be continuously enacted rather than simply assumed. Waddell et al. (2021) identified specific barriers to trust-enabling communication in hospital settings, including a lack of private consultation spaces, noisy ward environments, time pressures on clinicians, and uncertainty about patients' willingness to participate in shared decision-making. These structural factors constrain even well-intentioned providers from achieving the quality of communication that research consistently associates with trust formation. Addressing these barriers requires systemic intervention rather than individual skill development alone.

Yuan (2022) contributed an important perspective on the role of interpreters in communicative trust, demonstrating through interpretive phenomenological analysis that professional interpreters navigate complex identity tensions when facilitating healthcare communication. Rather than adopting purely neutral stances, interpreters engage in identity integration strategies that allow them to draw on multiple professional and personal identities simultaneously, thereby enhancing the empathic quality of mediated communication. This finding underscores that trust-enabling communication is not a simple information transfer but a complex relational achievement. Gavurova et al. (2024) operationalized the communicative dimensions of trust through an intellectual model incorporating empathy, quality of medical services, accessibility, and security as four interrelated trust criteria. Their application of fuzzy set theory across multiple healthcare systems demonstrated that these criteria, while consistent in their theoretical significance, vary in their relative importance depending on regional context, a finding with important implications for the design of culturally sensitive trust-building interventions.

Table 1. Summary of Key Themes and Supporting Evidence

Theme	Core Insight	Supporting Studies
Interaction Quality & Symbolic Communication	Trust formation is shaped by symbolic elements in the clinical environment, such as uniforms, technology, rituals, and spatial settings, that patients actively interpret as signals of provider competence and commitment.	Cersosimo (2019), Wibowo et al. (2020), and Rodrigues (2021)
Communicative Trust Mechanisms	Providers' communicative performance, including active listening, information sharing, empathy, and diagnostic rituals, is the primary mechanism through which trust is cultivated or eroded during therapeutic encounters.	Rodrigues (2021), Waddell et al. (2021), Yuan (2022), and Gavurova et al. (2024)
Organizational & Administrative Determinants	Institutional governance, administrative responsiveness, and the quality of staff services create structural conditions that either support or undermine interpersonal and institutional trust across the patient journey.	AlOmari and Hamid (2021), Bhati et al. (2023), and Hussain et al. (2025)
Continuity of Care & Longitudinal Trust	Repeated, consistent interactions with the same providers over time are essential for deepening trust; care fragmentation and one-off encounters inhibit the relational depth necessary for therapeutic trust to develop.	Rodrigues (2021), Liu et al. (2021), and Khatri et al. (2023)

Table 1 shows that patient trust is multidimensional, shaped by both interpersonal and systemic factors. Interaction quality and symbolic communication highlight how patients interpret environmental cues, rituals, and provider behaviors as signals of competence and commitment (Cersosimo, 2019; Wibowo et al., 2020). Communicative trust mechanisms emphasize the role of active listening, empathy, information sharing, and diagnostic practices in building or undermining trust during encounters (Waddell et al., 2021; Yuan, 2022; Gavurova et al., 2024). Organizational and administrative determinants show that institutional governance, responsiveness, and service quality create structural conditions that support or hinder trust (AlOmari & Hamid, 2021; Bhati et al., 2023; Hussain et al., 2025). Continuity of care underscores that repeated and consistent interactions strengthen longitudinal trust, whereas fragmented or one-off encounters limit relational depth (Rodrigues, 2021; Liu et al., 2021; Khatri et al., 2023).

4.3. Organizational and Administrative Determinants of Trust

Organizational factors were identified across multiple studies as critical structural determinants of patient trust. Bhati et al. (2023) articulated a comprehensive model of hospital administration in which effective governance, financial management, human resource development, and quality improvement systems collectively constitute the institutional foundation for trustworthy care. Their analysis identified patient-centered care, interdisciplinary collaboration, and systematic performance measurement as three organizational strategies with the greatest potential to enhance patient trust outcomes.

Hussain et al. (2025) provided empirical evidence for the trust-generating effects of high-quality administrative procedures, demonstrating a significant positive relationship between administrative process quality and patient trust that operated both directly and through the mediating pathways of medical staff service quality and patient satisfaction. Importantly, the moderating effect of electronic health knowledge suggests that administrative trust is increasingly mediated by patients' digital capabilities, with more digitally engaged patients benefiting more substantially from high-quality administrative interactions. AlOmari and Hamid

(2021) demonstrated that trust in three dimensions of hospital care, physician competence, nursing care quality, and administrative efficiency significantly predicted patients’ propensity to recommend the hospital to others. This finding frames trust not merely as a psychological state but as a behavioral disposition with tangible organizational consequences, linking patient trust to institutional reputation, service utilization, and community health outcomes.

4.4. Continuity of Care and Longitudinal Trust Development

Continuity emerged as a recurring and powerful theme across the included studies, consistently linked to deeper and more durable forms of patient trust. Khatri et al. (2023) developed a multilevel framework distinguishing between individual-level continuity, characterized by sustained relationships with known providers; organizational-level continuity, supported by interprofessional teamwork and integrated service delivery; and system-level continuity, enabled by multisectoral coordination across health and social care. Each level contributed independently and cumulatively to the maintenance of patient trust across care transitions. The temporal dimension of trust was further illuminated by Rodrigues (2021), whose ethnographic analysis revealed that repeated contact with familiar pharmacy staff generated qualitatively different trust experiences compared to sporadic encounters with rotating hospital providers. The familiarity cultivated through continuity allowed patients not only to assess provider competence more accurately over time but also to feel more confident in raising concerns, reporting side effects, and negotiating treatment options. This finding aligns with broader evidence that relational continuity functions as a protective factor against adverse outcomes by enabling more thorough and honest patient-provider communication.

Liu et al. (2021) contributed important quantitative evidence for the mediating role of trust in sustaining patient loyalty over time. Their finding that patient satisfaction does not independently predict loyalty but instead operates through the mediating variable of patient trust implies that health systems focused exclusively on satisfaction improvement are likely to underinvest in the trust-building processes that generate long-term patient retention. This has direct implications for healthcare quality improvement strategies and for the metrics used to evaluate organizational performance.

Table 2. Trust Barriers and Enablers Identified Across Studies

Domain	Trust Enablers	Trust Barriers
Interpersonal Communication	Active listening, empathy, voluntary information sharing, diagnostic rituals, warmth, and affective responsiveness	Rushed consultations, incomplete examination, one-way communication, lack of empathy, poor listening
Symbolic & Environmental	Professional attire, diagnostic technology, organized facilities, appropriate clinical rituals, and recognizable medicine packaging	Absence of diagnostic procedures, unfamiliar environments, and missing symbolic markers of professional competence
Organizational & Administrative	Effective governance, streamlined administrative processes, responsive staff, digital health integration, and patient-centered policies	Fragmented administration, poor records management, long waiting times, and staff unresponsiveness
Care Continuity & Coordination	Consistent provider relationships, interprofessional collaboration, integrated care pathways, smooth care transitions	Provider rotation, lack of information continuity, siloed services, and inadequate handover practices

Table 2 indicates that patient trust is influenced by factors at multiple levels. At the interpersonal level, trust is enabled by active listening, empathy, information

sharing, diagnostic rituals, and warmth, while it is undermined by rushed consultations, poor listening, and a lack of empathy. Symbolic and environmental cues, such as professional attire, organized facilities, clinical rituals, and recognizable medicine packaging, strengthen trust, whereas their absence erodes confidence. Organizational and administrative support, including effective governance, responsive staff, streamlined processes, digital health integration, and patient-centered policies, facilitates trust, while fragmented administration, long waits, and poor records management act as barriers (Alsharar et al., 2025). Continuity and coordination of care further enable trust through consistent provider relationships and integrated care pathways, whereas provider rotation, siloed services, and inadequate handovers impede longitudinal trust.

5. Discussion

The findings of this study collectively affirm that patient trust is a multidimensional construct that cannot be adequately explained by any single theoretical framework or addressed through any single intervention. The four themes identified, interaction quality, communicative trust, organizational determinants, and care continuity, are deeply interconnected, forming a dynamic system in which deficiencies in one domain tend to undermine gains in others. Understanding these interdependencies is essential for designing healthcare improvement strategies that are both theoretically grounded and practically effective. From a symbolic interactionist perspective, the findings illuminate how healthcare environments are saturated with meaning that patients continuously interpret and reinterpret in light of their own cultural frameworks, previous experiences, and current health anxieties. Cersosimo's (2019) observation that even mundane clinical objects, such as a white coat, a stethoscope, and an imaging machine, carry profound symbolic weight is corroborated by Rodrigues's (2021) finding that the performance of biomedical rituals communicates care and competence in ways that verbal reassurance alone cannot replicate. This implies that healthcare organizations must attend not only to the verbal skills of their staff but to the broader symbolic ecology of clinical practice, including the physical environment, the availability of diagnostic technologies, and the consistency with which care rituals are performed.

The framework of communicative action provides a complementary lens through which to interpret the barriers to trust identified in the literature. Waddell et al.'s (2021) documentation of structural impediments to shared decision-making in hospitals resonates with the Habermasian notion that genuine communicative action oriented toward mutual understanding rather than strategic goal achievement is systematically distorted by institutional pressures. Time constraints, hierarchical role expectations, and physical environment limitations prevent providers and patients from achieving the kind of reciprocal, open communication through which trust most effectively develops. Addressing these barriers requires not only interpersonal skill training but organizational redesign that creates the temporal, spatial, and cultural conditions for authentic dialogue.

The organizational findings of this study contribute to a growing recognition that institutional trust cannot be separated from interpersonal trust in healthcare. Hussain et al.'s (2025) demonstration that administrative procedures influence patient trust through both direct and mediated pathways challenges the traditional view of administration as a support function peripheral to clinical care quality. Instead, administrative processes constitute a distinct dimension of the patient experience, with their own trust-generating potential. Similarly, AlOmari and Hamid's (2021) finding that administrative trust significantly predicts word-of-mouth behavior indicates that organizational reputation is itself a trust outcome, with implications for how health systems communicate their value to communities.

The mediating role of trust in the satisfaction-loyalty pathway identified by Liu et al. (2021) has significant strategic implications. Health systems that invest in patient satisfaction improvement without simultaneously cultivating the interpersonal and institutional conditions for trust are likely to find that satisfaction gains do not translate into the behavioral loyalty, sustained service engagement, recommendations to others, and treatment adherence that constitute the ultimate purpose of quality improvement. This finding suggests that patient trust should be treated as a primary outcome measure in healthcare quality frameworks, rather than an assumed consequence of satisfaction.

The role of digital health technologies in mediating and moderating trust relationships warrants particular attention in light of Hussain et al.'s (2025) finding regarding e-health knowledge as a positive moderator of the staff service-trust pathway. As telehealth, electronic health records, and AI-assisted diagnosis become more prevalent, the conditions under which patients trust digitally mediated care are becoming increasingly important. To build patient trust, healthcare systems must address multiple levels simultaneously: strengthen communication skills, optimize symbolic and physical environments, improve organizational processes, and ensure continuity of care. Targeted staff training, workflow redesign, and digital health integration should align with these dimensions, as isolated interventions are insufficient. Prioritizing trust as a key outcome enhances patient engagement, adherence, satisfaction, and loyalty.

6. Conclusion

This study synthesizes eleven peer-reviewed studies to develop a thematic understanding of patient trust in healthcare that is theoretically grounded, empirically supported, and practically relevant. The findings indicate that patient trust emerges from the interaction of multiple factors, including the quality of interactions, healthcare providers' communicative competence, institutional responsiveness, and continuity of care relationships. No single factor is sufficient; rather, trust is constructed through the integration of relational, symbolic, administrative, and temporal conditions. This study integrates symbolic interactionism and communicative action perspectives, demonstrating that trust is both a micro-level process of meaning-making and a macro-level outcome shaped by institutional structures. The practical implications highlight the need to strengthen providers' communication skills, evaluate administrative processes and service environments, and promote policies that support sustained patient-provider relationships.

However, this study has several limitations, including the relatively small number of studies, potential publication bias, and contextual variations across healthcare systems that may limit generalizability. Additionally, the thematic synthesis approach may simplify the complexity of trust dynamics in real-world settings. Therefore, future research should expand the scope of analysis by incorporating cross-cultural contexts, employing longitudinal designs to capture the evolution of trust over time, and integrating qualitative and quantitative approaches for a more comprehensive understanding. Further studies are also encouraged to examine the role of digital health technologies and evolving policy frameworks in shaping patient trust within the context of ongoing healthcare transformation.

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Data Disclosure Statement

The data that support the findings of this study are available from the corresponding author upon reasonable request.



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