The Trust in Doctors' Dilemma: Investigating the Role of Patients' Perceived Communication

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ABSTRACT

Trust in physicians and effective communication are central to high-quality healthcare, yet public confidence continues to decline amid concerns about unethical practices and communication breakdowns. Despite extensive scholarship in healthcare ethics, limited attention has been given to how patients subjectively perceive and assess ethical behavior through their lived experiences. This qualitative study examines how perceived communication shapes patient trust and evaluations of physicians' ethical conduct within the Tunisian healthcare context, focusing on the relational mechanisms that inform ethical judgments. An inductive thematic analysis was conducted using semi-structured interviews with 23 adult patients (12 men, 11 women; aged 19–68 years) recruited from several hospitals between April and June 2025. Interviews lasted 40–80 minutes, were audio-recorded, transcribed verbatim, and analyzed. Three major themes emerged: (1) general healthcare experiences, highlighting marked contrasts between private services, whereas perceived as professional yet financially burdensome, and public services, characterized by overcrowding, limited resources, and staff negligence; (2) trust in doctors, comprising four components, such as empathy, knowledge, dependability, and reputation, that collectively shape trust formation; and (3) doctor–patient communication, encompassing seven subthemes including respect, transparency, humanizing rapport, simplification of information, honesty, communicative style, and comforting behavior. Participants emphasized that trust is not solely grounded in clinical competence but is deeply rooted in emotional connection, moral character, and the quality of interpersonal communication. Perceived communication thus functions as a decisive influence on trust in doctors. The findings suggest the imperative for healthcare institutions to enhance communication training and relational competencies alongside technical expertise, while underscoring the value of integrating communicative dimensions into ethical frameworks and quality-of-care assessments.

Keywords: Patient trust, doctor-patient communication, healthcare ethics, thematic analysis, Tunisia

INTRODUCTION

The physician-patient relationship has long been regarded as the cornerstone of effective healthcare delivery, founded upon principles of trust, competence, and ethical responsibility (Pellegrini, 2017). Throughout history, healthcare professionals have been guided by rigorous ethical codes and professional standards that emphasize moral integrity, compassionate care, and unwavering commitment to patient welfare. However, contemporary healthcare systems face an unprecedented paradox: despite the profession's enduring reputation for trustworthiness, public confidence in physicians continues to erode across diverse global contexts (Alanazi et al., 2024; Udow-Phillips et al., 2025). This erosion is not merely a transient phenomenon but reflects profound systemic challenges, including communication breakdowns, perceived unethical practices, financial exploitation, and inadequate cultural sensitivity (Lazarus et al., 2024; Liu et al., 2024).

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Recent empirical evidence documents a steady decline in public trust in physicians, particularly following the COVID-19 pandemic. Udow-Phillips et al. (2025) reported that public trust in physicians dropped from 71.5% at the pandemic's outset to significantly lower levels in subsequent years, signaling widespread disillusionment with healthcare institutions and providers. Similarly, international research demonstrates that patients increasingly prioritize not only technical competence but also moral integrity, relational transparency, and effective communication when evaluating their healthcare experiences (Lazarus et al., 2024; Jameel et al., 2025). This shift underscores that trust formation is fundamentally relational, shaped by patients' subjective perceptions of how physicians communicate, demonstrate empathy, and embody ethical principles in clinical encounters (Bai et al., 2025; Zhang et al., 2025).

The significance of this trust crisis extends beyond individual patient-provider relationships to threaten the broader social fabric of healthcare delivery. Trust serves as a decisive mediator of patient satisfaction, treatment adherence, health outcomes, and healthcare system legitimacy (Hall et al., 2001; Wu et al., 2022). When trust deteriorates, patients exhibit reduced compliance with medical recommendations, increased healthcare-seeking delays, heightened anxiety, and diminished confidence in medical interventions (Gopichandran & Sakthivel, 2021; Petrocchi et al., 2019). Furthermore, declining trust exacerbates health disparities, particularly among vulnerable populations who already face systemic barriers to quality care (Ostrom et al., 2015; Huang et al., 2018). Understanding how patients perceive and evaluate ethical behavior through their lived experiences is therefore essential for restoring confidence in healthcare systems and ensuring equitable, high-quality care for all populations.

Existing scholarship has extensively documented the central role of trust in physician-patient relationships. Hall et al.'s (2001) seminal conceptual model identifies trust as a multidimensional construct encompassing competence (technical skill and expertise), fidelity (patient-centered commitment and loyalty), honesty (truthfulness and transparency), and global trust (overall confidence in the physician). This framework has profoundly influenced subsequent research, demonstrating that trust is not a singular attribute but rather emerges through the dynamic interplay of cognitive, affective, and behavioral dimensions (Hall et al., 2002; Thom et al., 2004). Empirical studies have consistently confirmed that trust positively influences patient satisfaction, treatment adherence, health outcomes, and willingness to disclose sensitive information (Dugan et al., 2005; Wu et al., 2022).

Communication has been identified as the primary vehicle through which trust is constructed, maintained, and potentially eroded in clinical encounters (Honavar, 2018; Ward, 2018). Effective physician communication—characterized by active listening, empathetic engagement, clear information provision, and respectful dialogue—has been shown to enhance patient trust, reduce perceived interpersonal threat, and foster secure therapeutic alliances (Gu et al., 2022; Li & Street, 2025). Conversely, communication failures such as withholding information, using overly technical jargon, demonstrating indifference, or lacking cultural sensitivity are frequently perceived as ethical breaches that undermine trust and patient satisfaction (Petrocchi et al., 2019; Çakmak & Uğurluoğlu, 2024). Recent research further emphasizes that perceived communication quality—patients' subjective evaluations of clarity, empathy, and responsiveness—serves as a decisive determinant of trust formation and ethical perceptions (Jameel et al., 2025; Liu et al., 2024).

Despite this robust body of literature, significant gaps remain in our understanding of how patients subjectively perceive and assess physicians' ethical behavior through their lived experiences. First, much of the existing research has focused on normative ethical frameworks and professional codes of conduct, which often fail to capture the nuanced, context-dependent ways in which patients evaluate ethical behavior in real-world clinical encounters (Fleisje, 2024; Tomaselli et al., 2020). Second, while communication has been recognized as important, it has frequently been treated as an adjunct factor rather than a central, decisive variable that mediates trust formation and ethical perceptions (Bai et al., 2025). Third, limited attention has been given to how institutional contexts—particularly disparities between private and public healthcare sectors—shape patients' ethical evaluations and trust (Ewunetu et al., 2023; Pérez-Arechaederra et al., 2025). Fourth, cross-cultural research exploring these dynamics in non-Western contexts, such as North Africa and the Middle East, remains notably scarce, despite growing recognition that cultural, religious, and socioeconomic factors profoundly influence patient expectations and perceptions (Doubova et al., 2016).

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Specifically, existing ethical decision-making models—such as the Theory of Planned Behavior and the Hunt and Vitell General Theory of Marketing Ethics—tend to emphasize rational evaluations of norms and consequences while underestimating the roles of relational dynamics, emotional connection, and communicative quality in shaping ethical judgments (Consolandi, 2024). This theoretical gap limits both scholarly understanding and practical applications, perpetuating a disconnect between normative ethical standards and patients' actual experiences. Furthermore, while empathy has been acknowledged as valuable, its specific mechanisms and interactions with other trust dimensions (competence, dependability, reputation) remain insufficiently theorized and empirically explored (Efthymiou, 2024; Wang et al., 2025).

This qualitative study addresses these critical gaps by investigating how perceived communication shapes patient trust in doctors and evaluations of physicians' ethical conduct within the Tunisian healthcare context. Specifically, this research examines the relational mechanisms through which patients form trust, assess ethical behavior, and navigate institutional disparities between private and public healthcare sectors. The central research questions guiding this inquiry are: (1) What are patients' general experiences and perceptions of the private versus public healthcare sectors in Tunisia? (2) What dimensions of trust emerge as most salient in-patient narratives, and how are they constructed? (3) What role does perceived communication play in shaping patient trust in doctors and evaluations of their ethical conduct?

RESEARCH METHODOLOGY

Research Design

A qualitative research design was employed, utilizing an inductive thematic analysis approach, as outlined by Braun and Clarke (2006, 2019). This methodology was selected for its utility in identifying, analyzing, and reporting patterns (themes) within qualitative data, and for its flexibility in interpreting various aspects of the research topic. The study was conducted within a constructivist paradigm, acknowledging that patients' perceptions of ethical behavior are constructed through their personal experiences and social contexts.

Participant Selection and Recruitment

A purposive sampling strategy was used to recruit participants who could provide rich, relevant, and diverse insights into the research question (Palinkas et al., 2015). Participants were eligible if they were: (a) adult patients (aged 18 years or older), (b) had attended at least two or more consultations with a doctor in the 6 months, and (c) were able to provide informed consent.
Recruitment took place several hospitals in Tunisia between 2nd of April 2025 and 25th of June. Potential participants were approached in waiting rooms by a research assistant or identified by their treating physician and referred to the researcher. All participants received both verbal and written information about the study's aims and provided written informed consent before participating. Recruitment continued until data saturation was achieved, which was determined when subsequent interviews yielded no new thematic information relevant to the research question.

Sample Characteristics

Table 1: Sample characteristics

NUM	Abb.	Age	Gender	MTU (/10)	Place of Residence	Profession	Level of Education
1	AS	23	Male	4	Nabeul	Student	UUE
2	HS	20	Male	2	Nabeul	Student	SS
3	SB	48	Male	4	Tunis	Professor	CUE
4	AA	29	Female	5	Sousse	PhD student	CUE
5	HA	28	Female	5	Tunis	Student	UUE
6	SH	20	Female	2	Sousse	Student	SS
7	AG	24	Male	4	Sousse	Student	CUE

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8	BA	23	Male	5	Nabeul	Student	UUE
9	SA	22	Female	5	Sousse	Student	CUE
10	ZBZ	47	Female	7	Nabeul	Professor	CUE
11	FBA	33	Female	8	Sousse	Clinical Research	CUE
12	SEM	23	Male	3	Nabeul	Student	UUE
13	IN	47	Male	3	Sousse	Professor	CUE
14	LA	68	Female	1	Mahdia	Housewife	PS
15	HM	47	Male	1	Mahdia	Farmer	SS
16	AM	28	Male	6	Monastir	Architect	CUE
17	GB	35	Female	9	Monastir	Clinical Research	CUE
18	ABA	56	Male	1	Monastir	Employee	UUE
19	TA	19	Female	3	Tunis	Student	UUE
20	JJ	54	Female	3	Tunis	Entrepreneur	CUE
21	SED	24	Male	3	Kef	Student	UUE
22	AM	30	Male	8	Nabeul	Entrepreneur	SS
23	CB	24	Female	6	Tunis	Student	CUE

MTU: Medical Terms Understanding. UUE: Uncompleted University Education. CUE: Completed University Education or higher. SS: Secondary School. PS: Primary School

Table 2: Summary of interviewees

Characteristic	**Categories**	**Frequency (n = 23)**
Gender	Male (12), Female (11)	12 ♂ / 11 ♀
Age (years)	Range: 19 – 68, Mean ≈ 34.7	–
Education Level	UUE (6), CUE (11), SS (5), PS (1)	
Profession	Students (11), Professors (3), Clinical Research (2), Entrepreneur (2), Architect (1), Farmer (1), Housewife (1), Employee (1), PhD Student (1)	
Place of Residence	Nabeul (7), Sousse (6), Tunis (5), Monastir (3), Mahdia (2), Kef (1)	
MTU (/10)	Range: 1 – 9, Mean ≈ 4.2	–

The qualitative sample consisted of 23 participants, with a balanced gender distribution (12 males and 11 females) and ages ranging from 19 to 68 years, with an average of approximately 35 years. The majority were students (n = 11), while others included professors (n = 3), clinical researchers (n = 2), entrepreneurs (n = 2), and smaller groups such as an architect, farmer, housewife, employee, and one PhD student. In terms of education, ten participants had completed university education or higher, six had incomplete university education, five had secondary school education, one had only primary school education, and one was a doctoral student. The medical terms understanding scores (measured on a scale from 1 to 10) ranged between 1 and 9, with an overall mean of approximately 4.2.

Data Collection

Data was collected through semi-structured, in-depth interviews. This method allows for deep exploration of personal perspectives while ensuring key topics are covered across all interviews (Brinkmann & Kvale, 2015). An interview guide was developed based on a comprehensive review of the literature and the study's objectives. The guide explored several key domains:

- General experiences and expectations with doctors.

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- Factors that build trust in the doctor-patient relationship.
- Perceived communication and its impact on trust.

All interviews were conducted by the primary researcher FBA in a private room at the clinic. Interviews lasted between 32 and 86 minutes, with a mean duration of 64 minutes. With permission, all interviews were audio-recorded digitally. Field notes were taken immediately after each interview to capture initial impressions and contextual observations. The audio recordings were transcribed verbatim by the researcher and then checked for accuracy by a second researcher who was familiar with the subject. All transcripts were de-identified by removing names and any identifying details to ensure participant confidentiality.

Data Analysis

The data were analyzed using the six-phase framework for thematic analysis as described by Braun and Clarke (2006, 2019). First, to familiarize themselves with the data, the research team immersed themselves in the data by actively reading and re-reading the transcripts and listening to the audio recordings. Then, line-by-line coding was performed across the entire dataset using Atlas.ti 9 software. Codes identified meaningful features relevant to the research question. Subsequently, the codes were collated and sorted into potential themes. This involved gathering all data relevant to each potential theme. The potential themes were checked against the coded data and the entire dataset to ensure they formed a coherent pattern. This phase involved refining the themes, which sometimes involved splitting, combining, or discarding them. The essence of each theme was articulated, and clear definitions and concise names were generated for each theme. Finally, the analysis was woven into a narrative, selecting vivid, compelling extract examples to illustrate each theme.

RESULTS

The findings are presented through a primary lens of inductive thematic analysis. To enhance the robustness and analytical depth of our qualitative insights, we employed Atlas.ti 9 software to conduct a supplementary quantitative analysis of the coded data. This involved two procedures: first, a frequency analysis of codes across the 23 interview transcripts to identify the most prevalent concepts; and second, a cross-code co-occurrence analysis to explore relationships between concepts (e.g., how often codes for "empathy" and "trust" appeared together). These quantitative techniques were used not to test hypotheses but to systematically validate and illuminate the patterns emerging from the thematic analysis, ensuring that our interpretations were firmly grounded in the entire dataset. The following sections present the qualitative themes, enriched with observations from these frequency and co-occurrence analyses, as well as comparative analysis across participant sociodemographic characteristics.

Themes Results

Theme 1: General Healthcare Experiences

An analysis of participant interviews revealed that healthcare experiences were strongly influenced by the institutional sector, public or private. Three sub-themes emerged: positive private sector experiences, negative private sector experiences, and negative public sector experiences. These themes highlight the interplay between perceptions of service quality, ethical conduct, and institutional conditions.

Positive Private Sector Experience

Most respondents described positive experiences in private healthcare facilities. These were consistently associated with professionalism, respectful interpersonal treatment, and patient-centered care. Female participants in particular emphasized the importance of respectful communication. One respondent stated: “They’re always polite, smiling, and treat each person respectfully and in their own time.” Respect was repeatedly cited as a cornerstone of quality care. Another participant reflected:

“I was impressed by the doctor’s consideration for the patient and his respect.” Beyond interpersonal kindness, participants highlighted the coordinated nature of care in private institutions. A respondent who underwent

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surgery recalled: “They prepared me very well... A nutritionist came... The anesthesiologist came to explain... They even brought a psychologist to prepare me mentally.” Such accounts emphasized the comprehensive and multidisciplinary approach of private institutions, especially in pre-operative contexts. While financial concerns occasionally tempered these positive views, participants generally described private care as superior in clinical and interpersonal terms.

Negative Private Sector Experience

Despite widespread appreciation of clinical care, many respondents reported concerns about financial misconduct and unethical practices in private healthcare settings. These experiences were more frequently reported by male participants and those with higher education levels. One respondent described: “He charged fees for procedures and check-ups he didn’t perform.” The same individual also reported falsified records: “The doctor was recording three visits per day in the medical log, while in reality, he only came to see me once.” Other respondents indicated that doctors sometimes refused formal payment methods or documentation. As one participant stated:

“The doctor refused to be paid by cheque and demanded cash... he refused to provide [a report].” Such practices were particularly noted in smaller clinics rather than in larger hospitals. Across accounts, a sense of distrust emerged toward the profit-driven motives of private institutions. A participant summarized: “They’re greedy... They might keep you overnight just to charge more money... They don’t work ethically; they only care about money.” These findings reveal a complex dynamic in which private healthcare was praised for clinical excellence but simultaneously criticized for financial exploitation.

A comparative analysis revealed that reports of financial exploitation were more frequent and vehement among participants with higher education levels (CUE) and those with higher Medical Terms Understanding (MTU scores ≥ 5). These participants often used more specific terminology (e.g., "falsified records," "unjustified procedures") and appeared more equipped to identify deviations from expected ethical billing practices. In contrast, participants with lower educational attainment or MTU scores, while still expressing a sense of being overcharged, described it in more general terms, such as "it was expensive" or "they care about money."

Negative Public Sector Experience

In contrast, experiences with public healthcare facilities were overwhelmingly negative. Respondents across all demographic groups reported severe overcrowding, inadequate infrastructure, and staff negligence. One participant provided a striking account of her father’s treatment: “He even went into the OR wearing his personal clothes... the floor was bloody... without any cleaning or sterilization.” This theme was reinforced by repeated references to staff indifference. The same respondent remarked: “You stay alone feeling pain while they sit in another room laughing and talking... They don’t care about their job.” Another participant described a lack of urgency even in relatively quiet conditions: “The hospital [was] completely empty... Only one doctor... she was so cold, showing no concern at all for the patients.” Physical conditions of public facilities were also a recurring concern. One participant noted: “You see a lot of strange things... impolite doctors... broken equipment... windows are shattered.” Younger respondents particularly emphasized outdated equipment, while older participants expressed concern about basic safety standards. Across accounts, public institutions were portrayed as an option of last resort. The convergence of poor infrastructure, staff disengagement, and inadequate resources fostered a strong preference for private healthcare, even among individuals with limited financial means.

While negative perceptions of public healthcare were universal across the sample, the framing of these criticisms varied. Younger participants (e.g., students) more frequently cited outdated equipment and a lack of modernity, whereas older participants and those with lower MTU scores focused overwhelmingly on staff negligence and a perceived lack of basic humanity and care. This suggests that while the institutional failures are universally recognized, the aspects that are most salient to patients may be influenced by age and health literacy.

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Theme 2: Trust in Doctors

The theme Trust in Doctors explores the multidimensional processes through which patients develop or withhold confidence in their healthcare providers. Trust represents a cornerstone of the doctor–patient relationship, shaping adherence to treatment, satisfaction with care, and overall health outcomes. Findings reveal that trust is not solely derived from clinical competence but also from emotional connection, moral character, and social reputation. The four key trust dimensions that emerged were Physician's Empathy, Physician's Knowledge, Physician's Dependability, and Physician's Reputation.

Physician's Empathy

Empathy emerged as a critical driver of trust, with participants consistently highlighting the value of emotional sensitivity, compassion, and humane treatment. Empathy was not seen as an optional quality but as a prerequisite for ethical care and psychological reassurance.

One participant described the dual role of emotional and professional presence: "When a doctor is emotional, he gains kindness and love from people, but when he is honest and professional, he earns trust." This statement illustrates how empathy complements honesty, functioning as a relational catalyst that strengthens confidence in medical care.

Participants also linked empathy with moral responsibility, particularly in resource-constrained contexts. As one explained: "If a poor patient comes in and is dying, maybe he treats him for free... Either treat the patient or kindly refer him to another doctor." Here, empathy was framed not as sentiment alone but as concrete, compassionate action.

Another participant reflected on empathy's role in reducing hierarchical distance: "If the doctor... treats me like a friend or family... I develop strong trust in him." In contrast, others criticized rigid and depersonalized practice: "Some doctors give you hope... Others are completely devoid of humanity and stick rigidly to scientific protocols..." These perspectives highlight how empathy mitigates the dehumanizing effects of mechanistic treatment.

Finally, one participant captured empathy's psychological significance in one sentence: "If he shows empathy, I feel safe." Trust was thus perceived as inseparable from a doctor's ability to provide emotional security and comfort.

Taken together, the data suggest that empathy is regarded as a decisive factor in trust-building. It provides reassurance, fosters closeness, and frames the physician not only as a medical expert but also as a humane companion in the healing process.

The emphasis on empathy was notably stronger in narratives from female participants. They more frequently provided detailed examples of empathetic or dismissive interactions and linked these directly to their emotional security. One female participant's statement, "If he shows empathy, I feel safe," encapsulates this gendered emphasis. While male participants also valued empathy, their narratives often connected it to perceptions of professional competence and dependability, stating, for instance, that an empathetic doctor was also seen as more thorough and reliable.

Physician's Knowledge

Medical expertise was another decisive dimension of trust. Participants emphasized formal education, clinical experience, diagnostic accuracy, and professional recognition as markers of reliability and authority.One participant explained that knowledge formed the very basis of legitimacy: "I trust him because he studied and knows more than me. If I'm going to the doctor, it means I'm looking to heal, not that I know better than him." This acknowledgment of epistemic asymmetry reflects how patients defer to the physician's superior knowledge as an essential foundation of trust.

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Experience was also considered vital. As another participant stated: “If the doctor is experienced and has worked in the public sector, they tend to be better.” Similarly, one explained: “When a doctor is older and has the title of full professor... I trust them... They’re even teaching medicine to interns.” Both perspectives suggest that cumulative expertise, professional title, and teaching responsibilities serve as proxies for competence and credibility.

A striking example of diagnostic precision was also shared: “The doctor... made the right diagnosis and gave an injection... Later, the specialist said, ‘That doctor saved your life.’” This account illustrates how accurate and timely clinical judgment can translate directly into trust.

Knowledge was also linked with ethics. As one participant remarked: “Her knowledge in dental care, her kindness, and the good treatment she gave me influenced my opinion... professional ethics influence the patient’s behavior.” This reinforces the idea that knowledge gains trust when it is ethically applied and paired with humane treatment.

Overall, participants regarded knowledge as a core driver of trust, grounded not only in medical authority but also in its ethical and compassionate use.

Physician’s Dependability

Dependability referred to the doctor’s attentiveness, consistency, and reliability in clinical interactions. Patients described how inattentiveness, rushing, or lack of engagement eroded their confidence, while careful listening and patience reinforced trust.

One participant recalled dismissive encounters: “There are doctors you just don’t feel comfortable with... you feel like they’re dodging your questions.” In another case, the same participant added: “You’re focused on your phone, cutting the consultation short... You make me feel even more stressed.” These accounts highlight how distractions and divided attention compromise the perception of dependability.

Another participant expressed a similar frustration: “I was talking, and he wasn’t even listening.” For this respondent, active listening was a critical test of a physician’s commitment.

By contrast, a different participant recalled a reassuring experience: “She took the time to clearly explain my condition... didn’t rush me, answered all my questions with patience.” This interaction underscored how dependability is conveyed through time investment, clear explanations, and sustained attentiveness.

Thus, dependability emerged as a defining element of trust, with patients expecting physicians to be fully present, responsive, and consistent in their commitment.

Physician’s Reputation

Finally, reputation functioned as a socially constructed dimension of trust. Patients frequently relied on community narratives, family recommendations, and word-of-mouth to guide their choice of doctors.

One participant explained: “Go to someone you hear a name repeated more than once, then you go and see with your own eyes if the doctor is ethical... It also depends on how he communicates with the patient, you know?” This illustrates how reputation acts as an entry point that is then validated through personal experience.

Another participant elaborated on the moral dimension: “He fears God, does his job well, doesn’t cheat people... He analyzes the patient’s condition more thoroughly to give the right treatment.” Here, technical competence and ethical conduct were intertwined in shaping reputation.

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Community belonging also played a role. One patient observed: “The doctor I see now is from my neighborhood. I don’t know him personally, but I heard people talking about him.” This suggests that social familiarity and collective endorsement can substitute for direct prior experience.

In addition, alignment of values was critical. As one participant noted: “If their general behavior seems to clash with my moral values, I change doctors.” Reputation was therefore not only collective but also filtered through personal moral expectations.

Another respondent provided a comprehensive account: “My trust toward doctors varies through... recommendations from loved ones, perceived professionalism... transparency, empathy, listening, and concrete results.” This confirms that reputation is multidimensional, combining social testimony with observed professional and ethical behaviors.

The reliance on reputation as a trust heuristic was particularly pronounced among participants with lower MTU scores and those with only secondary school education. This group was more likely to state they "go to someone you hear a name repeated," suggesting that social testimony serves as a crucial risk-reduction strategy when personal ability to evaluate clinical competence is perceived to be limited.

Theme 3: Doctor–Patient Communication

Interviews revealed that the quality of doctor–patient communication was a decisive factor shaping overall healthcare experiences. Beyond the transfer of medical information, communication was described as fundamental to trust, emotional well-being, and perceptions of ethical care. Seven sub-themes emerged: respect, transparency, humanizing rapport, simplifying information, honesty, style of communication, and comforting.

Respect

Respect was consistently identified as the foundation of effective doctor–patient communication. Respondents emphasized demeanor, patience, and acknowledgment of dignity as central expectations in any clinical interaction. One participant explained: “Having a kind and respectful way of speaking... and patience which I always repeat is key.” Several participants described respectful communication as transformative, moving encounters beyond clinical routines. One respondent reflected: “He made you feel like you weren’t even sick. It felt like you were with a friend, not a doctor.” Respect was also framed as a universal, egalitarian principle, extending across social, linguistic, and cultural differences. A participant summarized: “The first rule should be treating everyone with the same care and respect, no matter where they come from or how they speak.”

Transparency

Transparency emerged as another vital quality, strongly tied to patients’ perceptions of trust and ethics. Respondents valued physicians who provided clear, complete, and unbiased information. One participant noted: “Cheerfulness, honesty, trust, transparency are essential to judge a doctor.” The expectation of informed consent was repeatedly emphasized. As one participant explained:

“The patient should receive all the necessary information: diagnosis, treatment options, risks and benefits.” Transparency was also considered important for family communication. A respondent highlighted: “They should explain everything clearly and gently to the family. It’s not only about the medical side, but about how they communicate.” These findings suggest that transparency was not only a matter of disclosure but also of delivery—clarity, gentleness, and respect for autonomy.

Humanizing Rapport

Participants highlighted the importance of doctors who connected on a human level. Positive encounters were often described in relational terms, such as friendship or empathy. One participant explained: “I felt like the

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doctor was a friend who cared about my health and was advising me out of concern." The absence of this human connection was experienced as dehumanizing. For example, a parent recounted: "My son smiled at him, and the doctor showed no reaction—he treated him like a doll." Respondents often equated human qualities with ethical practice. One participant stated: "The signs that make me think a doctor is acting ethically are when he shows empathy, humanity, and patience." This theme underscores the perception that technical skill alone is insufficient without emotional intelligence.

Simplifying Information

Another strong expectation was that doctors adapt explanations to patients' levels of understanding. Language barriers were identified as a major obstacle. A participant noted: "He should explain it in Arabic... If the person doesn't understand, then explain it in an easy way." Others criticized the routine use of technical or foreign-language terminology. As one respondent put it: "Sometimes doctors speak in a complicated language that only they understand... Not everyone is educated or literate." This practice was viewed as disrespectful and exclusionary, particularly for elderly or less-educated patients. Another participant summarized: "Many doctors speak in French and use technical terms... They don't even try to translate or explain things clearly." Simplifying information was thus regarded as both a communicative and an ethical obligation.

The sub-theme of simplifying information was, unsurprisingly, directly correlated with participants' stated level of Medical Terms Understanding (MTU). Those with lower MTU scores (≤ 3) and lower educational attainment provided the most forceful critiques of doctors using French or technical jargon, often describing it as a deliberate barrier or a sign of disrespect. Participants with higher MTU scores (≥ 7), while still appreciating clear explanations, were less likely to view the use of technical language as an ethical breach and more as a minor communication inefficiency.

Honesty

Honesty was described as a moral virtue essential to trust. Participants emphasized straightforwardness, tempered by empathy. A respondent explained: "An honest doctor means he has empathy... you can feel that they're sad when delivering bad news." Honesty was also tied to evidence-based practice. One participant recalled: "Explaining the risks of resistance. I appreciated his honesty and ethical decision-making, even though I was hoping for a quick fix." Finally, honesty about a doctor's own role and qualifications was seen as critical. As one participant argued: "A doctor should never lie or pretend to be something they are not... the patient should be informed [if a trainee is involved]."

Style of Communication

Participants closely observed doctors' tone, gestures, and demeanor, interpreting these as indicators of professional character and ethical integrity. One respondent remarked: "Their tone, gestures, and overall non-verbal communication play an enormous role in detecting whether or not the doctor is acting ethically." Confidentiality was also framed as part of communicative style. As a participant emphasized: "Doctors must have a good communication with the patient and not disclosing the patient's personal information." Others noted the therapeutic power of communication style itself. One participant summarized: "It's about how you talk to people, how you treat them, and how you make them feel. Sometimes, even more than medicine, a kind word and a bit of time can make all the difference."

Comforting

Finally, participants valued communication that offered comfort and reassurance. Expressions of hope and encouragement were described as critical to sustaining morale. A respondent stated: "Some doctors give you hope, even if it's small, and they encourage you to keep trying." Simple offers of availability were also perceived as highly meaningful. One participant recalled: "Come back anytime, and if you need anything, I'm here." This approach combined emotional and informational support. As one respondent explained: "He talked to me, reassured me, and explained everything in detail before doing anything. He even asked for my consent

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first." Such accounts underline that comfort, reassurance, and openness are not secondary to medical practice but integral to ethical and effective doctor–patient communication.

DISCUSSION

This This qualitative study explored patient trust and ethical evaluations within the Tunisian healthcare context through three central research questions. The findings provide clear and coherent answers to each. First, regarding patients' general experiences (RQ1), the analysis revealed a stark institutional duality that fundamentally shapes perceptions: private care is associated with clinical professionalism yet financial ethical risks, while public care is characterized by systemic neglect. Second, concerning the dimensions of trust (RQ2), our findings confirm that trust is a multidimensional construct, with empathy, knowledge, dependability, and reputation serving as its core, interrelated pillars. Third, and most significantly, the study demonstrates that perceived communication (RQ3) is the primary mechanism through which these trust dimensions are expressed and evaluated, acting as a decisive mediator of ethical perceptions.

Furthermore, our analysis across sociodemographic groups adds crucial depth to these findings. The heightened sensitivity to financial exploitation among more highly educated patients suggests that health literacy influences not only medical understanding but also the ability to detect ethical infringements in billing. The gendered emphasis on empathy—with women linking it more to emotional security and men to professional dependability—warrants further investigation into how trust-building is navigated differently. Finally, the greater reliance on reputation among those with lower health literacy underscores its role as a vital, socially-based trust heuristic in the face of informational asymmetry.

General Healthcare Experiences: Institutional Context Matters

The first major finding concerns the stark contrast between private and public healthcare experiences. Participants consistently praised private healthcare facilities for professionalism, respectful treatment, and patient-centered care, aligning with literature emphasizing the role of service quality in building trust (Hall et al., 2001; Gu et al., 2022). However, these positive perceptions were tempered by concerns about financial exploitation, unethical billing practices, and profit-driven motives. Participants reported instances of falsified records, unjustified procedures, and resistance to formal payment documentation—practices that eroded trust despite clinical excellence. This duality, in which technical competence alone cannot sustain trust when ethical integrity is compromised (Ostrom et al., 2015; Huang et al., 2018).

In contrast, public healthcare facilities were overwhelmingly characterized by overcrowding, inadequate infrastructure, staff negligence, and indifference. Participants described disturbing experiences of unsanitary conditions, broken equipment, and emotional coldness from healthcare providers, echoing concerns about systemic trust erosion documented in contemporary healthcare literature (Udow-Phillips et al., 2025; Lazarus et al., 2024; Alanazi et al., 2024). The convergence of resource constraints and perceived staff disengagement positioned public institutions as options of last resort, even among economically vulnerable participants. These findings underscore that institutional conditions significantly shape ethical perceptions, suggesting that systemic reforms addressing infrastructure, staffing, and organizational culture are essential complements to individual provider training (Ewunetu et al., 2023; Pérez-Arechaederra et al., 2025).

Trust in Doctors: A Multidimensional Relational Construct

The second theme revealed that trust in doctors emerges through four interrelated dimensions: empathy, knowledge, dependability, and reputation. This multidimensional structure aligns with Hall et al.'s (2001) conceptual model of trust, which identifies competence, fidelity, honesty, and global trust as interconnected elements. However, our findings extend this framework by highlighting the centrality of empathy and its role in reducing hierarchical distance and providing psychological security.

Empathy was consistently identified as a prerequisite for ethical care, not merely as an optional interpersonal quality but as a moral responsibility. Participants emphasized that empathy fosters emotional safety,

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humanizes medical encounters, and mitigates the dehumanizing effects of mechanistic treatment protocols. This finding resonates with research showing that emotional sensitivity and compassionate action are decisive drivers of trust and patient satisfaction (Wu et al., 2022; Bai et al., 2025). One participant's statement "If he shows empathy, I feel safe" which captures the psychological significance of empathy as a trust-building mechanism, suggesting that technical competence gains legitimacy only when paired with humane treatment (Efthymiou, 2024; Wang et al., 2025).

Knowledge and expertise formed the epistemic foundation of trust. Participants deferred to physicians' superior medical knowledge while emphasizing that experience, diagnostic accuracy, and professional recognition serve as credibility markers. This finding supports literature emphasizing competence as a core trust dimension (Hall et al., 2001; Thom et al., 2004). However, participants also linked knowledge with ethical application, indicating that expertise gains trust when exercised with moral integrity and compassionate intent. This integration of technical and moral dimensions suggests that patients evaluate competence not in isolation but within a broader ethical framework (Pellegrini, 2017; Fleisje, 2024).

Dependability manifested through attentiveness, consistency, and active listening. This sub-theme emerged as a critical test of physicians' commitment. Participants described how distractions, rushed consultations, and dismissive behaviors eroded confidence, while patient explanations and sustained engagement reinforced trust. These findings align with research on physician communication behaviors and their impact on patient perceptions (Petrocchi et al., 2019; Liu et al., 2024; Street et al., 2007). The emphasis on "being present" suggests that dependability functions as a behavioral signal of fidelity, one of Hall et al.'s (2001) core trust dimensions.

Reputation, the fourth dimension, functioned as a socially constructed trust indicator. Patients relied on community narratives, family recommendations, and word-of-mouth endorsements to guide healthcare choices. This finding highlights the role of social testimony in reducing uncertainty and establishing initial confidence, consistent with research on trust formation in service contexts (Hall et al., 2002; Gu et al., 2022). Importantly, reputation was not static but continuously validated through personal experience and alignment with individual moral values, suggesting a dynamic interplay between collective endorsement and subjective evaluation (Zhang et al., 2025).

Patient Perceived Communication: A Decisive Variable of Trust in Doctors

The third and most extensive theme revealed that communication quality is specifically, patient-centered communication characterized by respect, transparency, and humanizing rapport, which is the primary mechanism through which the identified trust dimensions are expressed and evaluated.

Respect was identified as the foundational expectation, encompassing demeanor, patience, dignity, acknowledgment, and egalitarian treatment across social and cultural differences. Participants framed respectful communication as transformative, moving encounters beyond transactional routines to relational partnerships. This finding resonates with patient-centered communication frameworks emphasizing dignity and autonomy as ethical imperatives (Tomaselli et al., 2020; Çakmak & Uğurluoğlu, 2024; Epstein & Street, 2007). On the other hand, transparency emerged as a trust-building quality strongly tied to ethical perceptions. Participants valued complete, unbiased information, informed consent, and clarity in family communication. Transparency was perceived not merely as disclosure but as a manner of delivery characterized by gentleness, respect for autonomy, and emotional sensitivity. This aligns with literature linking transparency to reduced distrust and enhanced patient empowerment (Hall et al., 2001; Jameel et al., 2025).

Furthermore, humanizing rapport underscored the importance of relational connection beyond clinical roles. Participants equated friendliness, emotional intelligence, and empathetic engagement with ethical practice, while depersonalized interactions were experienced as dehumanizing. This finding supports research emphasizing the therapeutic value of relational presence and emotional attunement in medical encounters (Ward, 2018; Honavar, 2018). Simplifying information was framed as both a communicative and ethical obligation, particularly for patients with limited health literacy or education. Participants criticized the routine

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use of technical jargon and foreign-language terminology, viewing such practices as exclusionary and disrespectful. This finding aligns with health literacy research emphasizing the ethical imperative to adapt communication to patients' comprehension levels (Doubova et al., 2016; Consolandi, 2024).

Similarly, honesty, when tempered with empathy, was described as a moral virtue essential to trust. Participants appreciated straightforwardness in diagnosis, prognosis, and treatment risks, even when delivering difficult news. Honesty about physicians' roles and qualifications (e.g., trainee involvement) was also considered critical to informed consent and ethical integrity (Gopichandran & Sakthivel, 2021; Li & Street, 2025). Additionally, the style of communication, which includes tone, gestures, non-verbal cues, and confidentiality, was closely observed as an indicator of professional character. Participants noted that kind words and attentive demeanor could be as therapeutic as medical interventions, highlighting the affective dimension of communication (Petrocchi et al., 2019; Liu et al., 2024).

Finally, comforting was valued as a source of hope, reassurance, and emotional support. Simple expressions of availability and encouragement were perceived as highly meaningful, underscoring that comfort and openness are integral to ethical and effective care (Bai et al., 2025; Wang et al., 2025).

Theoretical and Practical Implications

These findings have important theoretical implications. First, they challenge normative ethical frameworks that treat ethical behavior as adherence to professional codes without accounting for patients' subjective experiences and cultural contexts. Our results suggest that patients' ethical evaluations are relational and context-dependent, shaped by communication quality, emotional attunement, and institutional conditions. This aligns with constructivist perspectives emphasizing the socially constructed nature of ethical perceptions.

Second, Our identification of distinct trust dimensions (empathy, knowledge, dependability, reputation) and their reliance on patient-centered communication provides a nuanced framework that can be directly integrated into medical training and patient satisfaction metrics. While Hall et al. (2001) identified competence, fidelity, and honesty as trust dimensions, our study reveals that these qualities are primarily expressed, interpreted, and evaluated through communicative behaviors. This positions communication not merely as a channel for conveying trust-related attributes but as the medium through which trust is actively constructed and maintained.

Third, the study highlights gaps in traditional ethical decision-making models, such as the Theory of Planned Behavior and the Hunt and Vitell General Theory of Marketing Ethics, which emphasize rational evaluations of norms and consequences while neglecting relational and cultural dimensions. Our findings suggest that integrating empathy, transparency, and cultural sensitivity into ethical frameworks is essential for capturing the complexity of patients' moral reasoning.

From a practical standpoint, the findings underscore the need for healthcare systems to prioritize communication training and relational competencies alongside technical skills. Medical education programs should incorporate empathy development, cultural sensitivity training, and health literacy adaptation as core curricular components. Healthcare institutions must also address systemic factors—infrastructure, staffing, organizational culture—that shape ethical perceptions and patient experiences.

Furthermore, the documented concerns about financial exploitation in private healthcare and systemic neglect in public healthcare call for regulatory oversight, transparency initiatives, and accountability mechanisms to restore and maintain public trust. Policymakers should consider patient feedback systems and community engagement strategies to continuously assess and improve ethical standards.

Limitations and Future Research Directions

Several limitations warrant consideration. First, the study was conducted exclusively in Tunisia, and findings may reflect specific cultural, religious, and institutional contexts that limit generalizability. Cross-cultural comparative studies would enhance understanding of how communication and trust function across diverse

healthcare systems. Second, the sample, while purposively selected for diversity, was relatively small (n = 23) and may not capture the full range of patient perspectives, particularly among marginalized or underrepresented populations. Future research should explore ethical perceptions among vulnerable groups, including patients with chronic illnesses, elderly populations, and those with limited health literacy. Third, while the study employed rigorous qualitative methods, quantitative studies should empirically test the relationships identified in this qualitative analysis, particularly the mediating role of communication in trust formation and ethical perception. Finally, the role of religion and spirituality, flagged in the introduction as an underexplored factor, did not emerge explicitly in participant narratives. This may reflect the interview guide's focus or participants' reluctance to discuss religious influences openly. Future studies should more directly investigate how religious beliefs and cultural values shape ethical evaluations in healthcare contexts.

CONCLUSION

This qualitative study demonstrates that perceived communication is a decisive mediator of patient trust and perceptions of ethical behavior in healthcare. Trust is not solely a function of clinical competence but emerges through multidimensional processes encompassing empathy, knowledge, dependability, and reputation. Communication quality—manifested through respect, transparency, humanizing rapport, information accessibility, honesty, communicative style, and comforting—serves as the primary medium through which ethical intentions are expressed, interpreted, and evaluated.

The findings reveal significant disparities between private and public healthcare experiences in Tunisia, with institutional conditions profoundly shaping ethical perceptions. While private facilities were praised for professionalism, concerns about financial exploitation underscored the tension between technical excellence and moral integrity. Conversely, public healthcare was characterized by systemic neglect, infrastructure deficits, and staff indifference, positioning these institutions as last-resort options.

These insights challenge traditional ethical frameworks that emphasize normative codes without accounting for patients' lived experiences and relational dynamics. The study underscores the need to integrate communication competencies, empathy development, and cultural sensitivity into medical education and healthcare policy. Beyond individual provider training, systemic reforms addressing infrastructure, organizational culture, and accountability mechanisms are essential for restoring and maintaining public trust.

Future research should extend these findings through cross-cultural comparative studies, quantitative validation of identified relationships, and exploration of perspectives among vulnerable populations and healthcare providers. By foregrounding communication and trust as central to ethical healthcare, this study contributes to a more comprehensive, patient-centered understanding of ethical conduct—one that recognizes the profound moral significance of how doctors talk, listen, and relate to those entrusted to their care.

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