

Patient Trust and Satisfaction in Healthcare Services: Distinguishing Clinician and Institutional Drivers

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[Abstract] Patient trust is a central healthcare-management concern because patients evaluate care through both clinician-level and organization-level signals. This cross-sectional study examines associations between six trust dimensions and two satisfaction outcomes among 200 female breast cancer survivors receiving continuing care at an urban U.S. oncology center. A structured questionnaire measured technical competence, caring behaviors, cooperation, hospital reputation, vulnerability/dependence, reduced distrust/fear, satisfaction with physicians, and satisfaction with the physician-nurse team. Descriptive statistics, reliability analysis, correlations, and exploratory stepwise multiple regression were used. Technical competence ($\beta = .446$) and caring behaviors ($\beta = .332$) had the strongest standardized associations with physician satisfaction; hospital reputation had the strongest association with team satisfaction ($\beta = .494$). The results distinguish interpersonal from institutional sources of patient evaluation and indicate why managers should not treat trust or satisfaction as unitary indicators. The contribution is deliberately bounded to cross-sectional associations.

[Keywords] patient trust; patient satisfaction; healthcare management; oncology; institutional trust; patient experience

1. Introduction

Healthcare organizations compete on clinical outcomes and on the consistency of the patient experience. Patients encounter physicians, nurses, scheduling and administrative systems, digital interfaces, and organizational policies. Trust is therefore a management concern shaped by both interpersonal encounters and institutional signals (Hall et al., 2001; Ozawa & Sripad, 2013). It is especially important when patients make consequential decisions under uncertainty, vulnerability, and information asymmetry. Unable to evaluate technical quality directly, patients use cues such as clear explanations, empathy, responsiveness, professional conduct, and reputation to judge whether care is competent and patient oriented (Ye et al., 2025; Tan et al., 2026).

Cancer survivorship makes these judgments especially salient. Continuing care involves repeated clinical, emotional, and administrative demands and permits patients to evaluate both individual clinicians and the larger care system. Prior research links trust with communication, patient-centered care, and satisfaction, while service-quality research distinguishes technical quality from the manner in which care is delivered (Donabedian, 1988; Keshtkar et al., 2024). Yet managers

still need to know whether the trust dimensions associated with satisfaction with a physician differ from those associated with a multidisciplinary team. The distinction changes the managerial response. Physician dissatisfaction tied to competence or caring calls for clinical assurance, communication, and professional development; team dissatisfaction tied to institutional reputation calls for better coordination, reliability, transparency, and consistency across touchpoints. This study compares six trust dimensions with satisfaction with physicians and with the physician-nurse team among 200 breast cancer survivors. It contributes evidence from a repeated, high-stakes service setting; separates interpersonal and institutional trust profiles; and translates those profiles into distinct management priorities.

Although prior studies have established a relationship between patient trust and satisfaction, much of this research treats trust and satisfaction as global patient evaluations. Such aggregated measures provide limited guidance about whether healthcare managers should intervene at the clinician, team, or institutional level. The present study addresses this gap by comparing the trust dimensions associated with physician-specific satisfaction with those associated with satisfaction involving the broader physician–nurse team.

The management contribution of this study is therefore not simply that trust is associated with satisfaction, but that the dimensions of trust can identify the organizational level at which managerial intervention may be required. Competence, caring, and communication are experienced primarily through clinician–patient interaction and therefore point toward clinician-level management practices such as professional development, communication support, and continuity of care. By contrast, coordination, reliability, and institutional reputation reflect experiences extending across professionals and organizational processes and therefore point toward team- and organization-level interventions. This multilevel perspective converts patient-trust measurement from a general attitudinal indicator into a more diagnostic management tool.

2. Literature Review and Hypotheses

2.1 Patient Trust, Service Quality, and Satisfaction

Patient trust permits individuals to accept vulnerability and rely on professionals whose expertise they cannot independently verify (Hall et al., 2001; Thom et al., 2004). Interpersonal trust concerns clinicians' perceived competence, benevolence, honesty, and responsiveness; institutional trust concerns the reliability, standards, coordination, and reputation of the organization. Patients form both judgments because clinicians work within visible systems and routines (Schoorman et al., 2007).

Communication is a principal mechanism through which these judgments form. Clear information, active listening, empathy, and partnership-oriented communication are associated with greater trust, although effects vary by setting (Keshtkar et al., 2024; Ye et al., 2025; Tan et al., 2026). Shared decision making combines clinical evidence with patient preferences and is especially relevant when oncology decisions involve trade-offs among longevity, side effects, function, and quality of life. Trust supports participation but should not be equated with passive compliance. Healthcare quality includes technical quality and functional delivery (Donabedian, 1988). Technical competence reflects perceived expertise; caring and cooperation reflect relational delivery; and hospital reputation summarizes accumulated institutional signals from staffing,

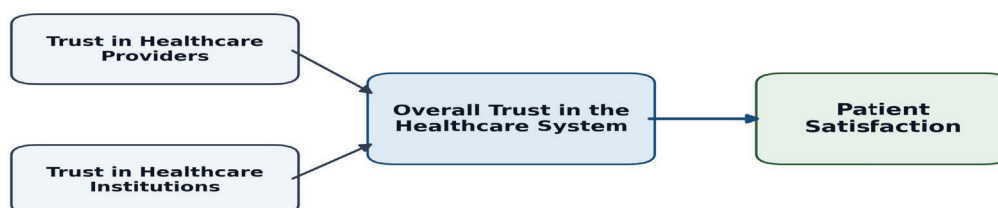
coordination, communication, and follow-up. Satisfaction is an evaluation of received care. Although useful for management, an overall score can obscure which trust dimension produced the evaluation. Trust should be positively associated with satisfaction because it reduces perceived relational risk and increases confidence that care is credible and patient oriented (Platt et al., 2021). Institutional trust becomes more visible when care crosses professional and departmental boundaries. Scheduling, nursing responsiveness, exchange of information, navigation, complaint resolution, and follow-up all communicate whether an organization is dependable. Reputation may condense these experiences into a general judgment, but it remains a perception rather than direct proof of clinical performance. For management purposes, reputation is most useful when interpreted beside operational quality and patient-safety evidence rather than as a stand-alone brand measure (Mayer et al., 2021).

Satisfaction and trust are conceptually distinct. Satisfaction evaluates whether a completed encounter met expectations, whereas trust concerns confidence under future vulnerability and uncertainty. A patient can be satisfied with a courteous encounter yet retain doubts about competence or trust a clinician while being dissatisfied with administrative delays. Measuring the constructs separately therefore gives managers more diagnostic information than treating one as a proxy for the other.

Figure 1 summarizes the general relationship identified in existing research among trust in healthcare providers, trust in healthcare institutions, overall healthcare-system trust, and patient satisfaction. Consistent with recent evidence, trust in healthcare providers and trust in healthcare institutions contribute to patients' broader confidence in the healthcare system, which is positively associated with patient satisfaction (Wang et al., 2024; Hussain et al., 2025; Mainous et al., 2025; Topuz et al., 2025; Gao & Cham, 2026).

Figure 1

Summary of Existing Research on Trust and Patient Satisfaction



Building on this general evidence, the present study moves beyond overall trust and satisfaction by examining whether six specific trust dimensions have different associations with physician-specific and team-level satisfaction.

This paper integrates relationship marketing, service quality, and patient-centered care in the context of healthcare services provided to women with breast cancer in an urban oncology center. Service-quality theory suggests that competence and caring should be prominent in physician evaluation, whereas reputation should gain importance when patients evaluate a team embedded in an organizational system. Trust is modeled here as a multidimensional patient perception, not as a demonstrated organizational capability.

These three theoretical perspectives are complementary rather than competing explanations. Relationship marketing explains why trust becomes especially important in continuing healthcare relationships characterized by uncertainty and repeated interaction. Service-quality theory distinguishes the technical and functional cues through which patients evaluate those relationships: perceived competence reflects technical quality, whereas caring and communication reflect functional or relational quality. Patient-centered care explains how these qualities become observable to patients through understandable information, empathy, participation, responsiveness, and continuity. At the organizational level, repeated interactions across physicians, nurses, administrative processes, and follow-up systems generate broader judgments about reliability and reputation. Accordingly, the expected importance of a trust dimension should depend partly on the target being evaluated: clinician-centered cues should be particularly salient for physician satisfaction, whereas organizational signals should become more salient when patients evaluate a multidisciplinary care team.

2.2 Hypotheses

The two satisfaction targets create a direct empirical comparison. Satisfaction with physicians is anchored mainly in encounters with an identifiable professional, whereas satisfaction with physicians and nurses makes coordination and the institutional setting more salient. The model does not assume that each trust dimension operates exclusively at one level; it instead anticipates different relative weights across the two evaluations.

Patient-centered care further clarifies why these distinctions matter. Respect for preferences, understandable information, emotional support, and participation in decisions are expressed through clinician behavior but depend on organizational conditions that make continuity and coordination possible (Agency for Healthcare Research and Quality [AHRQ], 2023; World Health Organization [WHO], 2023). The framework therefore treats interpersonal and institutional trust as connected evaluations while preserving their different managerial levers.

H1: Patient trust dimensions are positively associated with patient satisfaction.

H2: Technical competence is positively associated with satisfaction with physicians.

H3: Caring behaviors are positively associated with satisfaction with physicians beyond technical competence.

H4: Hospital reputation is positively associated with satisfaction with the physician-nurse team.

3. Methods

3.1 Design, Setting, and Sample

A cross-sectional survey examined trust and satisfaction among breast cancer survivors receiving

specialty care at a major urban oncology center and affiliated Midwestern U.S. hospitals. The purposive sample comprised 200 women in continuing follow-up after primary treatment. Eligibility required a breast cancer diagnosis, completion of primary treatment, current follow-up care, ability to complete the questionnaire, and voluntary participation. The individual patient was the unit of analysis. Participation was voluntary. Respondents were informed of the study purpose, confidentiality, and their right to decline without affecting care. No personally identifying information was collected; questionnaires were anonymous, and completion constituted informed consent.

3.2 Measures

Items were adapted from healthcare-trust and satisfaction literature to the survivorship context (Hall et al., 2001; Thom et al., 2004; Ozawa & Sripad, 2013). Trust used 20 items across six dimensions; satisfaction used 9 items across two outcomes. Responses ranged from 1 (Strongly Disagree) to 5 (Strongly Agree). Negatively worded trust items were reverse coded before composite scores were calculated.

Table 1

Trust and Satisfaction Measures

Construct	Items	Illustrative content	Alpha
Technical competence	1–3	Skills, decisions, and sincerity	.90
Cooperation	4–6	Listening, cooperation, and following advice	.81
Reduced distrust/fear	7–11	Lower fear, hesitation, and distrust	.74
Hospital reputation	12–14	Staff quality, comfort, and reputation	.77
Vulnerability/dependence	15–17	Dependence on expertise and confidence	.73
Caring behaviors	18–20	Priority to needs, sensitivity, and caring	.73
Satisfaction with physicians	6	Bonding, teamwork, recommendation, overall satisfaction	.88
Satisfaction with physicians and nurses	3	Dignity and satisfaction with the full team	.73

3.3 Reliability, Validity, and Analysis

Cronbach's alpha ranged from .73 to .90, meeting the conventional .70 guideline (Nunnally & Bernstein, 1994). Literature and pilot review supported content and face validity. Descriptive statistics summarized construct levels, and Pearson correlations described bivariate associations. Two stepwise multiple regression analyses were conducted, one for satisfaction with physicians and one for satisfaction with physicians and nurses. All six trust dimensions were eligible for entry into each model. The stepwise procedure retained only predictors meeting the statistical entry and retention criteria; consequently, trust dimensions not meeting these criteria are not shown in the final reported models. The purpose of the stepwise analysis was exploratory and diagnostic—to identify a parsimonious subset of trust dimensions providing incremental explanatory information for each satisfaction outcome—rather than to estimate a structural causal model or establish the relative causal importance of the six dimensions. Tests used a .05 threshold. The resulting

coefficients are therefore interpreted as sample-specific associations rather than causal effects.

All focal variables came from the same questionnaire and respondent, so common-method covariance cannot be ruled out. Procedural protections included anonymity, separation of construct content within the instrument, reverse coding of negatively phrased trust items, and use of multiple-item scales. These steps reduce some response pressures but do not replace temporal separation, independent data sources, or a formal latent-method analysis. The results are therefore presented conservatively.

Internal consistency provides evidence of reliability but does not by itself establish the proposed multidimensional factor structure. Because the available analysis did not include confirmatory or exploratory factor analysis, convergent and discriminant validity among the six proposed trust dimensions cannot be established conclusively. The dimensions are therefore treated as conceptually differentiated scale groupings derived from the questionnaire and prior literature rather than as independently validated latent constructs

4. Results

4.1 Descriptive Results and Correlations

All scales demonstrated acceptable internal consistency. Mean scores were high, indicating favorable evaluations and a restricted upper range. Technical competence had the highest trust mean ($M = 4.88$), followed by cooperation ($M = 4.85$) and caring behaviors ($M = 4.73$). The ceiling pattern should temper generalization to settings with less favorable experiences.

Table 2

Descriptive Statistics

Variable	Mean	Alpha
Technical competence	4.88	.90
Cooperation	4.85	.81
Reduced distrust/fear	4.36	.74
Hospital reputation	4.55	.77
Vulnerability/dependence	4.50	.73
Caring behaviors	4.73	.73
Satisfaction with physicians	4.79	.88
Satisfaction with physicians and nurses	4.77	.73

Note. Five-point response scales.

All trust dimensions correlated positively with both outcomes ($p < .01$). Technical competence had the largest correlation with physician satisfaction ($r = .72$), followed by caring behaviors ($r = .66$). Hospital reputation had the strongest correlation with team satisfaction ($r = .65$). Concurrent measurement precludes conclusions about temporal order.

Table 3*Correlations of Trust Dimensions with Satisfaction*

Trust dimension	Physicians	Physicians/Nurses
Technical competence	.72	.53
Cooperation	.35	.29
Reduced distrust/fear	.46	.28
Hospital reputation	.54	.65
Vulnerability/dependence	.41	.39
Caring behaviors	.66	.47

Note. All correlations are significant at $p < .01$.

4.2 Multiple Regression Results

The stepwise procedure began with all six trust dimensions eligible for entry into each satisfaction model. The final physician-satisfaction model retained four trust dimensions, whereas the final physician–nurse satisfaction model retained three. Accordingly, Tables 4 and 5 report the predictors retained in the respective final stepwise models rather than coefficients for all six candidate predictors.

In the physician model, technical competence had the largest standardized coefficient ($\beta = .446$, $p < .001$), followed by caring behaviors ($\beta = .332$), hospital reputation ($\beta = .224$), and reduced distrust/fear ($\beta = .160$). Physician satisfaction thus reflected direct clinician evaluation and the institutional context.

Table 4*Predictors of Satisfaction with Physicians*

Predictor	Standardized β	t	p
Technical competence	.446	10.445	< .001
Caring behaviors	.332	7.689	< .001
Hospital reputation	.224	5.454	< .001
Reduced distrust/fear	.160	4.026	< .001

In the team model, hospital reputation had the largest coefficient ($\beta = .494$, $p < .001$), followed by technical competence ($\beta = .269$) and caring behaviors ($\beta = .172$). The principal result is the shift in emphasis: technical competence dominated physician satisfaction, whereas hospital reputation dominated evaluation of the broader team.

Table 5*Predictors of Satisfaction with Physicians and Nurses*

Predictor	Standardized β	t	p
Hospital reputation	.494	9.327	< .001
Technical competence	.269	4.790	< .001
Caring behaviors	.172	3.068	.005

H1 was supported by positive correlations between all trust dimensions and satisfaction. H2 and H3 were supported by the positive competence and caring coefficients in the physician model. H4 was supported because hospital reputation was positively associated with physician-nurse team satisfaction and, among the predictors retained in the final stepwise model, had the largest standardized coefficient.

5. Discussion

The trust profile associated with satisfaction depended on the target of evaluation. Technical competence and caring were most prominent for physicians, whereas hospital reputation was most prominent for the physician-nurse team. Patients therefore evaluate care through interpersonal and institutional signals, and a single global score can conceal actionable differences.

This contrast is substantively more useful than simply showing that overall trust and satisfaction are related. If the same trust score had predicted both outcomes in the same manner, a uniform improvement program might be defensible. Instead, the coefficient pattern points to two connected but distinct management domains: the clinical relationship and the organizational environment supporting team care.

The findings suggest that patient trust should be interpreted not only as a multidimensional perception but also as a multilevel management signal. Different trust dimensions may direct managerial attention toward different loci of intervention. Physician-related dimensions such as perceived competence and caring are most directly addressed through clinician selection, development, communication, and professional support, whereas institution-related perceptions call for management of coordination, reliability, handoffs, service recovery, and organizational consistency.

Competence remained central, but caring provided additional explanatory value. Patients evaluate both what physicians appear capable of doing and how they relate to patients, consistent with contemporary evidence on empathic and patient-centered communication (Keshtkar et al., 2024; Ye et al., 2025; Tan et al., 2026). Warmth cannot substitute for clinical competence; rather, communication makes expertise, attention, and responsiveness visible to patients.

Reputation's dominance in the team model suggests that it serves as a summary signal of reliability across clinicians, nursing, coordination, and administration. Because reputation was a patient perception, this result supports an institutional component of trust but does not establish an organization-level capability. Independent measures of routines and performance are required for that claim.

The findings refine relationship marketing and service-quality theory. Continuing care creates repeated opportunities for trust and cooperation, but the object of trust matters. Competence aligns with technical quality, caring with functional quality, and reputation with an institutional signal spanning multiple encounters. The contribution is a differentiated account of trust and satisfaction, not evidence for downstream loyalty, adherence, or health outcomes, which were not measured. The survivorship context strengthens the relevance of this distinction. Repeated visits allow patients to observe whether messages are consistent across professionals, whether concerns are remembered, and whether follow-up obligations are fulfilled. At the same time, the specialized and high-stakes setting may make competence and institutional reputation more salient than they would be in routine or episodic care. Replication is therefore needed before assuming the same hierarchy of coefficients elsewhere.

This study extends healthcare-management research by demonstrating that patient trust is not only multidimensional but also target dependent. Technical competence and caring behaviors were most prominent when patients evaluated physicians, whereas hospital reputation was most prominent when they evaluated the broader physician–nurse team. This distinction connects patient-experience measurement to the organizational level at which corrective action must occur and explains why global trust or satisfaction scores may provide insufficient guidance for healthcare managers.

6. Managerial Implications

The findings support a two-level trust-management framework. Clinician-level trust should be managed through competence assurance, understandable communication, empathy, and continuity. Institution-level trust should be managed through dependable coordination, consistent handoffs, timely information, effective service recovery, and transparent follow-up.

6.1 Manage Trust Alongside Satisfaction

Patient-experience dashboards should pair satisfaction with separate measures of competence, caring, distrust/fear, and reputation and report physician and team evaluations separately. Repeated measurements by service unit and patient group can reveal whether deterioration is concentrated in clinician interaction, coordination, or institutional reliability. Given the cross-sectional evidence, the coefficients should guide diagnosis and improvement, not clinician rankings or compensation. Managers can use simple escalation logic. A decline confined to physician trust warrants review of communication, continuity, and confidence in clinical judgment. A decline in team trust warrants review of handoffs, response times, role clarity, and cross-unit consistency. Broad deterioration across both levels calls for joint clinical and operational inquiry. Narrative comments and complaints should be reviewed with the numerical trends to reveal causes that scale averages may hide.

6.2 Reinforce Competence and Compassion

Organizations should protect the technical foundation of trust through credentialing, peer review, continuing development, evidence-based protocols, and quality monitoring. Because patients infer competence from observable signals, clinicians also need time and systems to explain recommendations, alternatives, risks, uncertainty, and follow-up responsibilities clearly. Competence should be communicated without creating false certainty. Standardized after-visit

summaries, plain-language explanations, teach-back, and timely access to results can make clinical reasoning more understandable while preserving honesty about uncertainty. Consistency among physician, nursing, and digital messages is especially important: contradictory guidance can weaken confidence even when the underlying care is technically sound.

Compassion should be an organizational expectation reinforced through recruitment, orientation, coaching, and development in listening, empathy, cultural responsiveness, shared decision making, and health-literacy-sensitive communication (Keshtkar et al., 2024; Tan et al., 2026). Workload, scheduling, and documentation burdens that constrain compassionate interaction also deserve attention. Effects should be evaluated with repeated trust measures, narrative feedback, complaints, and longitudinal data.

6.3 Strengthen Institutional Consistency

Leaders should map the patient journey; assign accountable owners; and set standards for scheduling, handoffs, test-result communication, navigation, billing, complaint resolution, and follow-up. Trust data should be reviewed with operational and safety indicators because poor communication across clinical relationships and professional groups can contribute to safety incidents (Keshtkar et al., 2025). External reputation-building should follow verified improvements in quality, transparency, coordination, and reliability rather than substitute for them. A practical review cycle would combine trust and satisfaction scores with wait times, unresolved messages, delayed results, repeated contacts, complaints, and safety reports. Leaders can then identify where a reputation problem reflects a recurring process failure rather than a communication problem. Visible corrective action and transparent follow-up are likely to be more credible than promotional claims unsupported by patients' day-to-day experience.

7. Limitations and Future Research

The cross-sectional, single-system design does not establish temporal order or causality and limits organizational generalization. Purposive sampling may reduce representativeness. The available data do not report the sampling frame, number approached, response rate, data-collection period, or detailed demographic and treatment characteristics. Concurrent self-report measurement creates common-method risk, and high means suggest ceiling effects.

The stepwise regression procedure is also data dependent, and the variables retained in the final models may therefore be sample specific. The models should be interpreted as parsimonious exploratory summaries of associations in the present sample and replicated in independent samples rather than as definitive rankings of predictor importance.

Future research should validate the multidimensional measurement structure using exploratory and confirmatory factor analysis and assess convergent and discriminant validity before stronger claims are made regarding the empirical distinctiveness of the six dimensions.

Future studies should consider longitudinal, multisite, and multilevel designs. Organizational practices, including communication standards, continuity systems, complaint resolution, leadership behavior, and digital governance, should be measured independently from patient perceptions. Researchers can then test whether these practices precede changes in interpersonal, institutional, and digital trust and whether satisfaction subsequently relates to loyalty, adherence,

and clinical or quality-of-life outcomes. Research should also examine whether the pattern varies by disease stage, treatment burden, health literacy, race and ethnicity, age, insurance status, and prior experience with the health system. Digital portals, telehealth, and AI-supported communication introduce another possible object of trust that may alter both clinician and institutional evaluations. Larger samples should test measurement invariance, competing factor structures, and interaction effects, while linkage to independently observed process and outcome indicators would clarify the practical meaning of patient-reported trust.

Qualitative interviews could complement scale-based evidence by showing how patients interpret competence, caring, and reputation in their own words and which specific encounters cause confidence to rise or fall. Experimental or quasi-experimental evaluations of communication training, redesigned handoffs, and service-recovery programs could then determine whether targeted managerial changes improve the corresponding trust dimension over time.

8. Conclusion

The dimensions of trust most strongly associated with satisfaction change according to whether patients evaluate an individual physician or the broader physician–nurse team. Patient trust is not a uniform evaluation of healthcare. Among the breast cancer survivors studied, technical competence and caring behaviors were most strongly associated with physician satisfaction, whereas hospital reputation was most strongly associated with physician-nurse team satisfaction. Interpersonal and institutional trust therefore require different managerial responses. Healthcare organizations should sustain clinical competence and compassionate communication while ensuring coordination, reliability, and consistency across the patient journey. Despite limits on causal and organizational inference, measuring trust and satisfaction separately and at multiple levels can help leaders locate where patient confidence is strengthened or weakened.

Ethics Statement

Participation in this study was entirely voluntary. Prior to participation, respondents were informed of the purpose of the research and provided informed consent. To protect participant privacy, responses were collected anonymously; no personal identifiable information was obtained, and all data were kept confidential and analyzed only in aggregate form. The study procedures were designed to minimize risk and uphold accepted ethical standards for research involving human participants. IRB approval was obtained before data collection.

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