


# Impact of Patient Communication Preferences on the Patient Trust in Physicians: A Cross-Sectional Study in Iranian Outpatient's Clinics

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## Abstract

There are widely emerging concerns that patient confidence in physicians is diminishing as physician–patient communication is threatened globally. This study aimed to assess patient communication preferences and their impact on patient trust in physicians. A cross-sectional study was conducted among outpatient clinics of 2 public and private hospitals in Tabriz, Iran. A total of 704 patients were selected conveniently. Of the 704 patients, 6.39% had low trust, 36.79% moderate trust, 35.37% had a high trust, and 21.45% had blind trust in physicians. Overall patient communication preference score was more in a private clinic rather than a public one ( $P = .008$ ). Patients of private hospitals and those who were living in rural areas have been shown to have more trust in physicians. Patients' trust in physicians showed a significant association with patient communication preference ( $B = 0.58$ ; 95% CI: 0.53-0.63,  $P < .001$ ).

## Keywords

communication, patient preference, trust, outpatient, physician

## Introduction

Healthcare is a dynamic social institution, and trust forms an integral part of human interactions with the healthcare system (1). Researchers have defined patient trust as a feeling of reassurance or confidence in the doctor (2). Patient trust in the physician is essential to reinforce health service delivery and improve care. The emerging concern regarding patient trust has led to triggering the realization that one should better understand the function of trust in the patient–physician relationship. In most healthcare environments worldwide, trust has worn amongst structural and social transformations (3).

The trust of patients in provisioners results from their faith in the overall health system, or because of their private relations and interplays with doctors (4). Although, the 2 types of trust may exist simultaneously. The definition of trust in physicians is a patient's confidence that the physicians will behave in the patient's best interest and will present proper therapy and medical care (5,6). Previously, it has been stressed to improve health via the betterment of patient–physician trust (7). Trust

in physicians is efficient on the health condition via continuous care, the inclination in seeking healthcare, and adhering to the therapeutic guidelines (6). The trust causes less feeling of vulnerability in patients, feeling of more effectiveness in clinicians,

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and diminishes the unbalances of information by enhancing the flow of information (1).

To provide the patient with high-quality care, there needs to be a healthy doctor–patient relationship. Poor quality doctor–patient communication has been found to be associated with patient dissatisfaction, reduced treatment adherence, and poor health outcomes (8).

Communication and trust are the key elements among the other factors in building a healthy relationship (9). In health-care settings, trust and communication are labeled a tool for better patient care and patient satisfaction. There is a necessity to have some degree of trust to build a climate in which honest communication can flourish. Effective and efficient communication is a predictor of medical practice and delivery of healthcare services (10).

Recent research has found the highest correlation between patient trust and their evaluation of the doctor’s communication (10). Tongue et al presume that the majority of complaints about physicians are about communication issues rather than clinical competency. Patients want doctors who can accurately diagnose and address their diseases while also communicating effectively with them. Even so, since patients’ interests may be different significantly, taking the patient’s interests into account is rather hard (1), which necessitates having a flexible behavioral repertory. Patient satisfaction and trust are positively connected to the quality of communication with patients (10). Studies have shown that trust is a strong predictor of a patient continuing with their provider (11).

Patient–physician trust has received considerable research interest. Nevertheless, despite the well-recognized significance of both patient–doctor trust and patient communication preferences for improving healthcare, the association between them has not been examined worldwide and especially in the context of the developing countries’ healthcare systems like Iran. Therefore, the purpose of this study is to fill this gap by exploring patient communication preferences and their impact on patient trust in physicians.

## Materials and Methods

### Study Design and Setting

This is a cross-sectional study conducted over 6 months from July to December 2019 at 2 specialized outpatient clinics associated to the public and private hospitals of Tabriz (Northwest Iran). The services offered by each type of clinic are varying widely, focuses on medical fields such as cardiology, dermatology, ear, nose, and throat (ENT), gastroenterology, gynecology and obstetrics, neurology, oncology, podiatry, and urology. A fee-for-service (FFS) system was the payment model of these clinics and about 1000 patients per month were the average number of patients at each clinic.

### Participants and Data Collection

Participants included outpatients who provided the “cardiology, obstetrics and gynecology, and oncology” services at

selected clinics. All outpatients were eligible to participate in this study if they were aged 18 years and above, and had the wellness and ability to participate. Severely diseased patients were not capable of giving information, with an acute neuropsychiatric condition or language deficit that would prevent informed consent or accurate evaluation were omitted. The sample size (SS) was measured clinically. The infinite SS equation ( $SS = (z^2 \times p \times q) / d^2$ ) was used according to the entire patient population at the contributing clinics, with a confidence interval of 95% ( $\alpha = 0.05$ ), therefore a z-score of 1.96 and an absolute precision of  $d = 0.05$ . A SS was calculated to be 380 patients in each clinic. However, given an attrition rate of 10%, the sample size was raised to 420 patients in each clinic. A total of 840 patients were invited for this study using convenience sampling from the clients waiting for their doctors’ visits at the clinics. A trained research assistant performed personal interviews using a structured questionnaire shortly after the patient’s visit with the doctor was over.

### Measures

The questionnaire consisted of 2 parts. Part one: We utilized the KOPRA (communication preferences of chronically ill patients, “Kommunikationspraeferenzen,” in German), to measure the communication preferences of patients. KOPRA has been developed by Farin et al (12) and has 32 items in 4 sub-scales. “Patient participation and patient orientation” (PPPO, 11 items) measure patient communication interests regarding the patient’s participation in therapies and considerateness of their ideas and interests. “Effective and open communication” (EOC, 10 items) is a measure of interests in terms of effective collection, conveyance, and share of information and open communication concerning adverse occasions. “Emotionally supportive communication” (ESC, 6 items) assesses interests concerning emotionally supportive communication. “Communication about personal circumstances” (CPC, 5 items) evaluates interests about a personal communication manner that also comprises private facets. The PPPO and EOC scales typically concentrate on implemental aspects of communication, while the ESC and CPC scales deal with affectional elements of communication.

The items of KOPRA were categorized on a Likert scale ranging from 1 to 5 (1 = not so important and 5 = extremely important). The questionnaire has been utilized in multiple studies (13,14) and Cronbach’s  $\alpha$  had been computed previously for this scale, and the reliability coefficient for scale was between 0.80 and 0.92. The 1 to 5 metric of responses to questionnaire items was maintained through transforming the entire scores of the questionnaire and its dimensions into a 1 to 5 scale via dividing the scores by the number of the corresponding items. Then, the high total score is interpreted as an important communication preference.

Part two: The patient trust was measured using the trust in physician scale for a developing country setting developed by Gopichandran et al (1) with 12 items. The patients were

asked to rate the items on a 5-point Likert scale with scores ranging from 1 to 5 (1 = strongly disagree and 5 = strongly agree). The Cronbach's  $\alpha$  of the scale was 0.928. In the trust scale, the resultant scores were divided into 4 categories: low trust (scores < 3), moderate trust (average scores of 3-3.99), high trust (average scores of 4-4.99), and blind trust (scores averaging 5.0).

The patients' demographic information was gathered using a cover page comprising open-ended questions including age, gender, marital status, ethnicity, education status, employment status, place of residence, insurance coverage (yes/no), and hospital ownership.

### Data Analysis

Analyses were performed using IBM SPSS Statistics for Windows, Version 25, Armonk, NY: IBM Corp. Descriptive statistics were presented as frequency and percent for categorical variables and mean and standard deviation (SD) for continuous variables. Student's *t*-test was used to compare the mean of patients' groups at the public and private hospitals regarding their perception of patient-communication preference and trust. Linear regression analysis ( $R^2$ ) was used to test the association of the independent variable (patient-communication preference) with the dependent variable (trust) making adjustments for patients' socio-demographic characteristics.

### Ethical Considerations

Ethical clearance was sought from the Ethics Committee of Tabriz University of Medical Science (IR.TBZMED.REC.1397.541). Verbal consents were received from the contributors because the data were collected by using a questionnaire and thus did not involve any personal data. The Ethics Committee approved the use of verbal consent.

### Results

A total of 704 outpatients agreed to be interviewed and completed the questionnaires (response rate = 83.8%). Table 1 shows the characteristics of participants.

According to the hospital ownership, which the clinics were affiliated, mean scores and SD of total patient communication preferences and 4 dimensions were calculated and compared in Table 2. Overall patient communication preferences were (mean = 3.85, SD = 0.79) in both public and private clinics.

However, when comparing the mean value of patient communication preferences between the studied hospitals, overall patient communication preferences in a private clinic (mean = 3.95, SD = 0.77) were found to be more than in a public clinic (mean = 3.79, SD = 0.79). This difference was statistically significant ( $t = -2.66$ ,  $P = .008$ ). "Emotionally supportive communication" (mean = 4.15, SD

**Table 1.** Characteristics of Patients (n = 704).

Variables	Total n (%)	Public clinic (406) n (%)	Private clinic (296) n (%)
<b>Gender</b>			
Male	310 (44)	191 (47.0)	119 (39.9)
Female	394 (56)	215 (53.0)	179 (60.1)
<b>Marital status</b>			
Married	523 (74.3)	290 (71.4)	233 (78.2)
Single	181 (25.7)	116 (28.6)	65 (21.8)
<b>Age (in years)</b>			
≤ 25	151 (21.4)	90 (22.2)	61 (20.5)
26-35	190 (27)	97 (23.9)	93 (31.2)
36-45	153 (21.7)	79 (19.5)	74 (24.8)
≥ 46	210 (29.8)	140 (34.5)	70 (23.5)
<b>Ethnicity</b>			
Turk	574 (81.5)	332 (81.8)	242 (81.2)
Fars	22 (3.1)	4 (1.0)	18 (6.0)
Kurd	84 (11.9)	56 (13.8)	28 (9.4)
Lur	24 (3.4)	14 (3.4)	10 (3.4)
<b>Education status</b>			
Illiterate	27 (3.8)	10 (2.5)	17 (5.7)
High school or lower	109 (15.5)	71 (17.5)	38 (12.8)
College or more	568 (80.7)	325 (80.0)	243 (81.5)
<b>Employment status</b>			
Unemployed <sup>a</sup>	167 (23.7)	111 (27.3)	56 (18.8)
Self-employed	148 (21.0)	88 (21.7)	60 (20.1)
House wife	264 (37.5)	142 (35.0)	122 (40.9)
Worker	125 (17.8)	65 (16.0)	60 (20.1)
<b>Place of residence</b>			
Urban	596 (84.7)	336 (82.1)	230 (77.2)
Rural	108 (15.3)	40 (9.9)	68 (22.8)
<b>Insurance</b>			
Yes	615 (87.4)	361 (88.9)	245 (85.2)
No	89 (12.6)	45 (11.1)	44 (14.8)

<sup>a</sup>Including retired people and students.

= 0.84) is most important to patients, followed by "effective and open communication" (mean = 3.93, SD = 0.79), "patient participation and patient orientation" (mean = 3.55, SD = 1.01) and "communication about personal circumstances" (mean = 3.51, SD = 0.98). The whole sub-scales had averages lying in the higher range (answer categories, "extremely important" and "very important"). This result is reached in both public and private clinics.

As shown in Table 2, all areas of communication were more important for patients referring to the private clinics rather than those referred to a public ones. These differences were statistically significant in 3 sub-scales: "patient participation and patient orientation" ( $t = -2.56$ ,  $P < .01$ ), "effective and open communication" ( $t = -3.19$ ,  $P = .001$ ), and "emotionally supportive communication" ( $t = -2.33$ ,  $P = .02$ ), regarding hospital ownership.

Table 3 shows the mean value and SD of overall patient trust in the physician. The overall mean score for patient trust in physician was (mean = 4.15, SD = 0.71), and of the 12 items, the highest mean scores related to "respect given

**Table 2.** Mean Score of Patient's Communication Preference at Public and Private Hospitals.

Scales	Overall mean (SD)	Public clinic (406) Mean + SD	Private clinic (296) Mean + SD	t	P
Patient participation and patient orientation (PPPO)	3.55 (1.01)	3.58 (1.01)	3.77 (0.99)	-2.56	.010*
Effective and open communication (EOC)	3.93 (0.79)	3.85 (0.79)	4.04 (0.74)	-3.19	.001*
Emotionally supportive communication (ESC)	4.15 (0.84)	4.09 (0.89)	4.24 (0.75)	-2.33	.020*
Communication about personal circumstances (CPC)	3.51 (0.98)	3.48 (0.98)	3.54 (0.99)	-0.72	.472
<b>Overall patient communication preferences</b>	<b>3.85 (0.79)</b>	<b>3.79 (0.80)</b>	<b>3.95 (0.77)</b>	<b>-2.66</b>	<b>.008*</b>

t, P: t and P values of the student t-test for comparison between the 2 hospitals.

\*Statistically significant at  $P < .05$ , \*\*Statistically significant at  $P < .001$ .

to the physician" (mean = 4.61, SD = 0.62), followed by "main intention is to treat my illness" (mean = 4.60, SD = 0.71), and "learned person" (mean = 4.54, SD = 0.66). Moreover "no side effects of medicines" (mean = 3.51, SD = 1.28) had the lowest scores among trust items.

Of the 704 patients, 6.39% had low trust, 36.79% moderate trust, 35.37% had a high trust, and 21.45% had blind trust. All 12 items of trust had higher scores in private clinics rather than in the public. At the same time, the significant differences have been shown in all items of trust between the public and private clinics ( $P < .05$ ), variations for the items "no side effects of medicines" and "community recommends the doctor" were not significant.

Table 4 shows the result of backward linear regression analysis, where the simple effects of excluded variables are estimated in the presence of retained variables in the final model. Patients' trust in physicians showed a significant association with patient communication preference, age of the patient, place of residence, and hospital ownership (all  $P < .001$ ). Patients 46 years of age or older had trust in

physicians rather than those with 25 years of age or younger ( $B = -0.16$ ; 95% CI:  $-0.31$  to  $-0.02$ ,  $P = .026$ ). Patients who are referred to private hospitals have been shown to have 13% more trust in physicians rather than those in public ones ( $B = -0.13$ ; 95% CI:  $-0.22$  to  $-0.05$ ,  $P = .002$ ). Trust of participants who were living in rural areas has been shown to be 14% more than those living in urban areas ( $B = 0.14$ ; 95% CI:  $0.02$ - $0.26$ ,  $P = .018$ ).

The model was significant explaining 44 of the variances in patient trust in physicians ( $R^2 = 0.44$ ,  $F [10.693] = 53.96$ ,  $P < .001$ ). This means that included variables significantly contribute to the prediction of 44.0% of the explained variance of trust where the regression model is significant.

## Discussion

### Communication Preference

In this study, emotionally and supportive communication preference was the most important communication style

**Table 3.** Mean Score of Patient Trust in Physician at Public and Private Hospitals.

List of items	Overall mean (SD)	Public clinic (406) Mean + SD	Private clinic (296) Mean + SD	t	P
Does lab tests for diagnosis	4.29 (0.96)	4.21 (0.98)	4.41 (0.91)	-2.77	.007*
Appropriate medicines	4.28 (0.89)	4.21 (0.93)	4.37 (0.82)	-2.41	.014*
Relieves illness quickly	4.01 (0.97)	3.90 (0.97)	4.17 (0.94)	-3.83	<.001**
No side effects of medicines	3.51 (1.28)	3.47 (1.26)	3.56 (1.29)	-1.01	.314
Community recommends the doctor	3.77 (1.22)	3.72 (1.19)	3.84 (1.25)	-1.29	.201
Confidence	4.04 (0.96)	3.92 (0.99)	4.19 (0.90)	-3.72	<.001**
Assured of good treatment	4.17 (0.93)	4.06 (0.98)	4.32 (0.82)	-3.75	<.001**
Main intention is to treat my illness	4.60 (0.71)	4.51 (0.73)	4.71 (0.66)	-3.71	<.001**
Whatever the illness will go only to him	3.96 (1.12)	3.83 (1.15)	4.13 (1.05)	-3.60	<.001**
Will recommend this doctors to others	4.05 (1.08)	3.92 (1.12)	4.23 (1.00)	-3.86	<.001**
Respect given to the physician	4.61 (0.62)	4.55 (0.61)	4.67 (0.64)	-2.58	.01*
Learned person	4.54 (0.66)	4.47 (0.68)	4.63 (0.61)	-3.33	.001*
Total trust in physician	4.15 (0.71)	4.06 (0.73)	4.27 (0.67)	-3.88	<.001**
The level of patient trust <sup>a</sup>	n (%)				
Low trust	45 (6.39)	31 (7.63)	14 (4.69)	-	-
Moderate trust	259 (36.79)	175 (43.10)	84 (28.18)	-	-
High trust	249 (35.37)	114 (28.07)	135 (45.30)	-	-
Blind trust	151 (21.45)	86 (21.18)	65 (21.81)	-	-

t, P: t and P values of the student t-test for comparison between the 2 hospitals.

<sup>a</sup>Value of mean for the response on a 5-point Likert-type scale: scores <3 = low trust; 3 to 3.99 = moderate trust; 4 and 4.99 = high trust; 5 = blind trust.

\*Statistically significant at  $P < .05$ , \*\*Statistically significant at  $P < .001$ .

**Table 4.** Multiple Regression Analysis Association Between Patient Communication Preferences and Trust in Physicians.

	B	95% CI	P
Gender (ref = female)	-0.07	[-0.20 to 0.06]	.313
Marital status (ref = single)	-0.04	[-0.15 to 0.08]	.503
Age (ref = $\geq 46$ )			
$\leq 25$	-0.16	[-0.31 to -0.02]	.026
26-35	-0.10	[-0.22 to 0.02]	.110
36-45	-0.10	[-0.22 to 0.01]	.083
Ethnicity (ref = Fars]			
Turk	-0.11	[-0.34 to 0.12]	.355
Kurd	-0.24	[-0.49 to 0.01]	.060
Lor	-0.05	[-0.35 to 0.26]	.777
Education (ref = college or more]			
Illiterate	0.04	[-0.18 to 0.26]	.714
High school or lower	0.08	[-0.04 to 0.20]	.202
Occupation (ref = worker)			
Unemployed	-0.06	[-0.21 to 0.08]	.387
Self employed	0.08	[-0.05 to 0.21]	.234
Housewife	-0.03	[-0.19 to 0.13]	.724
Hospital ownership (ref = private)	-0.13	[-0.22 to -0.05]	.002
Insurance (ref = no)	0.01	[-0.12 to 0.13]	.925
Place of residence (ref = rural)	0.14	[0.02 to 0.26]	.018
<b>Patient communication preferences</b>	<b>0.58</b>	<b>[0.53 to 0.63]</b>	<b>&lt;.001</b>

$R^2 = 0.44$ , adjusted  $R^2 = 0.43$ .

perceived by participants with their physicians. The results are similar to findings reported in a qualitative study among patients in Indonesia (15), which stressed an overall interest in a partnership manner, and those in Nepal (16) that reported contributors understood the doctor-patient communication mutually. However, a study implemented in 5 countries indicated that a plethora of patients had a feeling of receiving inadequate emotional support. At the same time, they were hospitalized and underwent problems to discuss their disquiets and apprehensions with healthcare specialists (17). In cases of emotional and physical difficulties, patients often anticipate assistance. Still, studies demonstrate that hospitals obtain average to high scores regarding attending physical wellbeing, but that they were able to support patients emotionally adequately (18,19).

Our result also indicated that the effective and open communication style was the second important communication preference perceived by participants with their physician, followed by patient participation and patient orientation style. Recently, an Iranian study has shown that moderate general patient gratification with patient-doctor communication is not desired (20). Regrettably, the issue of communication skills has received less consideration in Iran despite its growing in medical training worldwide. One reason may be that training and role modeling of communication and interpersonal skills in medical education is presently rather concise, considered in the first syllabus, and is not frequently strengthened in the final steps of training (21).

Moreover, people have wide variability in their interest in a communication manner. Given that culture has a significant contribution to organizing and interpreting a person's

experiences, its contribution should not be ignored in interpreting and transmitting messages. In fact, communication is inherently culture-dependent. People may be members of multiple cultural groups at the same time. In fact, the entire communication occurs not only inside a sizable cultural milieu but also within diverse micro-cultural backgrounds (22). Ignorance of culture or lowering it to "race" or "ethnic" classes has a tendency in neologization of sociocultural issues, maintaining health dissimilarities, and discriminating the healthcare and elsewhere (23).

The cooperation between patients and health provisioners can be improved when patients are provided with adequate information about their situations (24); on the other hand, patients may experience adverse outcomes when the information is not shared with them. Patients who are unaware of their conditions are more likely of neglecting doctors' orders (25,26). The peril of overlooking therapeutical orders is reduced by mobile applications, which promote the observance of the orders (27). Furthermore, the availability of patient's information to doctors is improved through the availability of electronically recorded health documents. Observance of confidentiality codes also further encourages the patient for sharing their information and, as a result, diminishes the perils.

Regarding hospital ownership, it has been revealed that in private clinics an "Emotionally supportive communication," "Effective and open communication" as well as "Patient participation and patient orientation" style of communication are perceived much more critical than public ones. Given the increasing expectations of people in recent years from health systems as in the past, patients are not indifferent to the services they receive in the hospital. Especially patients

referring to private hospitals pay a lot of money, and they know the opportunity cost and want better services (28). Patients want the service providers' relationship with them to be participatory so that patients' perspectives can be used in their therapeutic processes.

As has been shown previously, the level of responsiveness especially in communication and autonomy dimensions perceived higher by patients in Iranian private clinics than in public ones (29). Therefore, it might conclude that communication and patient-centered have gotten a lot of attention in private clinics in service previous study showed that Iranian physicians could have a determining contribution to a patient's choice of a hospital. Such a doctor may be working in a hospital being governmental or privately owned, with highly or poorly qualified conditions, or in proximity or farness from a patient's home (30). Clienteles expect provisioners not only to perform their tasks technically but also to be considerate, well mannered, gracious, and sociable, to present esteem, compassion, sensibility, and gentleness, and to exhibit empathy and kindness for patients.

### *Trust in Physicians*

Findings of this study indicated that outpatients generally had high trust in their physicians. More than 50% of participants in the present study have high or blind trust in the physician. While those of a national cross-sectional study indicated that nearly half of the participants in the survey had a moderate level of trust (31). The differences in the results can be attributed to different participants or different tools.

The finding corresponds to a survey conducted in China, showing that 67% of patients had the confidence or strong confidence in doctors (32). In a Canadian study, blind, high, moderate, and low accounted for 6.3%, 36.1%, 48.6%, and 9.0% of confidence-in-doctor, respectively (33). In the USA and the UK, 70% and 94% of complete trust in doctors were reported in surveyed patients, respectively (34,35). The necessity for high levels of trust in the physician is evident, given the requirement for continuous care, as well as constant communication between the physician and the patient.

Consistent with our findings, a study conducted in Pakistan found that down to 1% of patients were unconfident or untrusted in their physicians whereas around 12.5% confided the physicians to a restricted degree (36). As shown previously, blind confidence was connected to a passive role and low level of confidence with the skeptical method for sharing decision making (33). It may, therefore, be concluded that the participant's least preference for participation and orientation is because of their high trust. Based on previous research patients' trust in physicians would increase if medical service quality, namely a safe and effective medical service, as well as patient-perceived service satisfaction, improved (37). Some activities, such as training interventions to enhance physician behavior or providing patients with greater information about their care and the opportunity to discuss choices, may be used to strengthen the patient's trust in the physician (9).

### *Relationship Between Communication Preference and Trust in Physicians*

Findings show that trust in the physician has a significant association with patient communication preference and patient trust in physicians. For building confidence with patients, communication needs to be based on a patient-oriented procedure. This has been described as one eliciting, understanding, and validating patients' perspectives, comprehends the patient within their background psychologically and socially, achieves a shared apprehension of patients' problems and treatments, and enables them by presenting their meaningful participation in care-related selections (38). To achieve this, Pellegrini states it needs an incentive, or the "inner feeling" on behalf of the clinician, which is the correct task for implementation. Additionally, the doctor's duty is even superior, which is motivating patients for opening up and discussing effectively not only their indications but also their beliefs and most private opinions (39). Some actions, in particular those of the gestural area, including eye contact, attentiveness to talking, the capability to recognize hints in the patient's words, and redirection of conversations, are dependent on individual's motivating mode (40).

In our study, socio-demographic variables such as gender, marital status, ethnicity, education, occupation, or insurance status were not significant in predicting the patients' trust in physicians, which corresponds to the findings of previous studies (41–43). However, factors affecting confidence may be varied depending upon their educational or occupational levels as reported in earlier research conducted quantitatively (1). However, patients' trust in physicians increased with the patient's age, which was in line with the study conducted in the UK (42). In the Chinese study, it was detected that confidence in doctors was less probable in younger patients, whereas the elevated likelihood of confidence in doctors was found in those with higher educational levels or more incomes (32). Highly scored confidence can be attributed to selections or reports of biases in confidence investigations. Patients may show reluctance in admitting their aversion of their physicians, as they are concerned that this will influence their care in case of finding out this by their physician.

In our study, clients of private hospitals perception regarding trust in physicians were 13% more than those in the public one. A previous study revealed that specialty physicians, pharmacy doctors, nurses, and general physicians were most trustable among the inhabitants of Tabriz (44). Similarly, a study in Australia demonstrated varying degrees of confidence between governmental and privately owned hospitals (45). These observations do not correspond to those of qualitatively conducted research in South Australia, concluding the confidence of patients was similar in governmental and privately owned hospitals (46).

To create confidence (or non-confidence) in hospitals by patients, they should also possess some degree of confidence in the healthcare specialists working therein, the government

financing it, the supportive professional organizations, etc (47). People had trust in governmental provisioners for their medical abilities, referral systems, and truthful interplays with patients. Private provisioners were confided as they supplied treatments comfortably and easily at patients' houses; patients believed that they were sociable and compassionate that allowed patients to be indebted in case of their inability for payment when they sought for care (4).

Participants who were living in rural areas have been shown to have 14% more trust than those in urban areas. In a study conducted in Cambodia, villagers' confidence in varying healthcare provisioners seemed to be a significant consideration that affected people's healthcare-seeking behavior, and villagers generally believed in physicians, representing that people trusted in physicians as a professional group (4).

## Limitations

Some weaknesses of the present research are denoted here. First, since our study is a cross-sectional survey dependent upon short-run survey data, there are limitations in presenting a denotative, causative deduction that needs to be based on transient associations among the variables. Second, these data were obtained at the onset of treatments in 2 outpatient clinics in Iran. Third, more investigations are necessary to discover the magnitude to which confidence influences people's selection of healthcare provisioners compared with other determinants.

## Conclusion

The findings of our study show that emotionally and supportive communication preference was the most critical communication style perceived by the participant(s) with their physician. Outpatients generally had high trust in their physicians, which has a significant association with patient communication preference and patient confidence in physicians. For efficient and superior physician-patient interplay with patients, physicians require the development of proper interpersonal and communicating abilities.

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## Authors' Contributions

ZCH designed and conducted the study, performed the analysis, and drafted the manuscript. EK and TJK advised on the study design and assisted in data analysis. FLZ and AB assisted in data collection. ZCH and RKZ revised the manuscript validated the analysis findings and revised the manuscript. All authors read and approved the final manuscript.

## Declaration of Conflicting Interests

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

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## Ethical Approval

This study was approved by the Ethics Committee of Tabriz University of Medical Science (IR.TBZMED.REC.1397.541).

## Statement of Human Rights

All procedures in this study were conducted in accordance with the Ethics Committee of Tabriz University of Medical Science (IR.TBZMED.REC.1397.541) approved protocols (60397).

## Statement of Informed Consent

Verbal informed consent was obtained from the patient(s) for their anonymized information to be published in this article.

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