

Reconstructing Patient-Centered Healthcare through Psychological Safety, Trust Formation, and Meaningful Human Connection in Clinical Relationships

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Abstract

Patient-centered healthcare is commonly associated with respectful communication, preference elicitation, shared decisions, and responsiveness to individual needs. These practices are necessary but may be insufficient when patients do not feel able to question clinicians, reveal uncertainty, disclose sensitive information, disagree, or communicate vulnerability without anticipating relational cost. This conceptual article reconstructs patient-centeredness around three distinct but interacting relational processes: psychological safety within the clinical encounter, trust formation under conditions of vulnerability, and meaningful human connection. Drawing on contemporary evidence from communication research, trust scholarship, shared decision-making, healthcare inequity, therapeutic alliance, communication accessibility, and implementation studies, the article distinguishes patient relational safety from workforce psychological safety and separates trust, empathy, satisfaction, participation, and clinical outcome. It proposes that relational safety influences whether interpersonal risk becomes possible; clinician responsiveness to vulnerability contributes to trust and meaningful connection; and accumulated trust or rupture can subsequently reshape perceived safety. Voice and participation therefore depend not simply on invitation but on whether speaking is accessible, consequential, and unlikely to provoke dismissal or penalty. The proposed Psychological Safety–Trust–Connection model is presented as a bounded and testable theoretical synthesis rather than an empirically validated causal mechanism. Its implications concern measurement, clinical communication, organizational design, accessibility, equity, digital care, and the study of rupture and repair across longitudinal clinical relationships.

Keywords: Patient-centered care, Psychological safety, Patient-clinician trust, Therapeutic relationship, Patient participation, Relational communication

Introduction

Patient-centered healthcare is often operationalized through communication quality, information exchange, shared decisions, respect for preferences, or satisfaction. Yet these indicators can miss a more fundamental

relational question: whether patients experience the clinical encounter as a setting in which interpersonal risk can be taken. Adults with serious illness have reported greater fear of speaking up, uncertainty, and experiences of unfair or inferior treatment, illustrating how technically available communication opportunities may not be relationally usable [1]. Empathy and compassion likewise become clinically relevant through recognizable interactional practices rather than through benevolent intention alone [2]. Shared decision-making extends this problem further because care must not merely offer options but become workable within the patient's circumstances, priorities, capacities, and life [3].

Access this article online

<https://smerpub.com/>

Received: 22 November 2025; Accepted: 20 February 2026

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How to cite this article: Anderson J, Rossi M, Clark W. Reconstructing Patient-Centered Healthcare through Psychological Safety, Trust Formation, and Meaningful Human Connection in Clinical Relationships. *Int J Soc Psychol Asp Healthc*. 2026;6(1):1-12. <https://doi.org/10.51847/1x53ndicmp>

This reconstruction also requires restraint. The healthcare empathy literature is substantial, but much of it remains concentrated at individual and interpersonal levels, with heterogeneous measurement and comparatively less evidence about organizational conditions [4]. Patient-centeredness therefore should not be replaced by another broad virtue label. The task is to differentiate processes that are frequently collapsed: feeling safe enough to take relational risk, deciding whether another party is trustworthy, experiencing meaningful connection, exercising voice, and obtaining desirable clinical outcomes.

This article proposes that these processes are linked but non-equivalent. Its central argument is that patient-centered care becomes relationally substantive when healthcare environments support interpersonal risk, respond credibly to vulnerability, and permit trust and connection to develop without assuming that either necessarily produces adherence, satisfaction, or better clinical outcomes.

From patient-centeredness to relational safety

Patient-centered communication is often treated as though more communication necessarily generates more trust. Evidence suggests a more conditional relationship. Among patients with cancer, patient participation mediated the association between patient-centered communication and trust, while preferred decision role modified the participation–trust relationship [5]. Communication may therefore be patient-centered in form while remaining poorly matched to how a particular patient wants or is able to participate.

Trust itself should not be used as a proxy for clinical benefit. Meta-analytic evidence shows an overall association between trust in healthcare professionals and health outcomes, but relationships with objective outcomes are less consistent and the evidence does not establish a universal causal effect [6]. Contemporary trust scholarship similarly identifies patient, clinician, dyadic, temporal, and external contributors rather than locating trust exclusively in clinician behavior or patient disposition [7].

This article therefore proposes relational safety as a patient-facing construct distinct from both satisfaction and trust. Relational safety refers to the perceived and contextually afforded capacity to ask, correct, question, disclose, disagree, express uncertainty, or reveal vulnerability without anticipating humiliation, dismissal, retaliation, abandonment, or other relational penalty.

Trust may develop partly from repeated experiences in which such risks are handled competently and respectfully, but relational safety can be locally present before durable trust exists. Conversely, a patient may trust a clinician's technical competence while still feeling unable to disclose disagreement.

The distinction shifts patient-centeredness from whether a clinician nominally offers participation toward whether the relationship makes participation psychologically and practically possible. It also prevents the proposed framework from assuming that every patient should seek maximal conversational control. Respect for relational safety includes respecting preferences for supported, delegated, or changing levels of involvement.

Psychological safety in clinical encounters

Psychological safety provides a useful conceptual starting point but cannot simply be imported from organizational research. Healthcare evidence on psychological safety has primarily examined clinicians and teams, where the construct concerns interpersonal risk taking, speaking up, learning, and team functioning [8]. Patients occupy a different position. They may depend on the clinician for diagnosis, treatment, certification, medication, referral, or continuing access to care, creating asymmetries that make silence rational even when a clinician believes the encounter is open.

For that reason, patient relational safety must be studied directly rather than inferred from team climate. Evidence among Black patients with chronic musculoskeletal pain illustrates the importance of this distinction: perceived healthcare discrimination was associated with lower patient activation and communication self-efficacy, while working alliance did not consistently buffer these relationships [9]. Interpersonal warmth can therefore coexist with structural or identity-linked experiences that constrain voice.

The proposed construct consequently concerns more than whether a clinician invites questions. It includes whether the invitation is credible, whether communication is accessible, whether disagreement is tolerated, whether prior mistreatment shapes anticipated consequences, and whether speaking can influence the encounter. Relational safety is thus best treated as a situated condition emerging between person, relationship, clinical task, and healthcare context—not as an enduring psychological property of the patient.

Trust formation and relational vulnerability

Trust becomes most consequential when patients must act under uncertainty while depending on another party. Evidence from a large US cohort suggests that experiences of medical-care discrimination are associated with lower trust in physicians and may account for more of the observed variation than demographic category alone [10]. National survey evidence similarly links perceived racial or ethnic discrimination in healthcare with medical mistrust [11]. These findings caution against explaining trust through identity alone: the analytically relevant issue is how people are treated, what they anticipate, and what institutional histories make those expectations plausible. Vulnerability also becomes visible during disagreement. Qualitative work with vaccine-hesitant patients and clinicians showed how discordant values and interpretations could generate mutual frustration, reduced empathy, and threats to trust even when the clinical relationship continued [12]. Relational quality therefore cannot be defined as agreement. A relationship may be safer when disagreement can remain discussable without moral dismissal or relational withdrawal.

Serious illness intensifies these questions because dependence, uncertainty, and emotional exposure may be greater. In advanced cancer, stronger therapeutic alliance has been associated with better patient-reported quality of life, while the study design leaves causal direction unresolved [13]. Alliance may influence experience, patients with better experiences may form stronger alliances, or both may arise from additional clinical and personal conditions.

The article consequently proposes trust formation as repeated relational updating under vulnerability. Competence, respect, consistency, epistemic responsiveness, credible concern, and the handling of disagreement can increase or reduce expectations that future vulnerability will be treated well. Trust is neither an automatic product of patient-centered language nor a prerequisite that a patient must supply before participation begins.

Because the relevant conditions differ in how they affect vulnerability and interpretation, they are more clearly compared as a relational boundary register than as a simple list of “trust factors.” (**Table 1**).

Table 1. Conditions That Alter How Relational Vulnerability Becomes Trust, Guardedness, or Continued Uncertainty

Vulnerability state	Trust appraisal	Context	Behavioral response	Failure condition	Continuity effect
Relational condition — Preference-sensitive participation					
How vulnerability is exposed	The patient must indicate how much decisional responsibility is wanted	What may support trust formation	Invitations that adapt to the preferred role	Context that changes interpretation	Illness burden, decision type, prior experience
Boundary or competing explanation	Less participation may reflect preference rather than fear	Consequence for the proposed account	Proposed: relational safety permits authentic preference expression rather than requiring maximal participation		
Relational condition — Experienced unfair or discriminatory treatment					
How vulnerability is exposed	Identity, need, or credibility becomes vulnerable to judgment	What may support trust formation	Respectful recognition plus consistent procedural fairness	Context that changes interpretation	Prior healthcare history and institutional context
Boundary or competing explanation	Demographic category alone cannot establish mistrust	Consequence for the proposed account	Proposed: accumulated treatment history alters the threshold for taking relational risk		
Relational condition — Value-laden disagreement					

How vulnerability is exposed	The patient risks being judged for a contested belief or decision	What may support trust formation	Curiosity, clarification, continued care despite disagreement	Context that changes interpretation	Polarization, urgency, perceived expertise
Boundary or competing explanation	Agreement itself is not evidence of trust	Consequence for the proposed account	Proposed: safe disagreement is a distinct test of relational robustness		
Relational condition — Serious illness and dependency					
How vulnerability is exposed	The patient relies more heavily on clinician knowledge and continuity	What may support trust formation	Competence paired with responsiveness and predictability	Context that changes interpretation	Prognostic uncertainty, symptoms, treatment dependence
Boundary or competing explanation	Strong alliance does not prove clinical efficacy	Consequence for the proposed account	Proposed: greater dependency can amplify both trust formation and relational injury		
Relational condition — Continuity and repeated encounters					
How vulnerability is exposed	Earlier interactions become evidence for future expectations	What may support trust formation	Consistency between words, actions, and follow-through	Context that changes interpretation	Fragmentation and clinician turnover
Boundary or competing explanation	Continuity can also preserve an already damaged relationship	Consequence for the proposed account	Proposed: trust is updated longitudinally rather than created in one encounter		
Relational condition — Institutional constraint around the dyad					
How vulnerability is exposed	Patients experience the clinician within a wider system	What may support trust formation	Transparent acknowledgement of limits and credible advocacy	Context that changes interpretation	Time pressure, policy, access, resources
Boundary or competing explanation	A caring clinician cannot independently remove structural barriers	Consequence for the proposed account	Proposed: relational trust and institutional trust may diverge		

Note: The final column presents a proposed synthesis rather than an empirically validated classification.

Meaningful human connection as a therapeutic process

Human connection is frequently invoked in healthcare but can become analytically vague if it simply means kindness. A qualitative systematic review of healthcare professionals' accounts of compassion identified recurring emphasis on humanity, presence, understanding, values, and responsive action [14]. Patient-perceived empathy is also measurable, yet meta-analytic evidence shows variation across providers, settings, and consultation conditions [15]. Connection should therefore be treated as something enacted and interpreted within context rather than a stable quantity residing in the clinician.

Importantly, relational outcomes do not move in unison. Large outpatient evidence indicates that communication quality, satisfaction, trust, and participation can diverge; features associated with greater satisfaction need not produce greater participation [16]. Similarly, patient-centered communication has been associated with lower cancer-information avoidance through pathways involving trust and health literacy, but observational mediation does not establish a fixed causal sequence [17].

This article proposes meaningful human connection as a relational process in which recognition, attentive presence, responsive understanding, and credible action

make vulnerability consequential. “Meaningful” does not mean emotionally intense. A brief encounter may communicate recognition, while a long conversation may fail to do so. Nor does connection require unrestricted disclosure. It becomes relevant when the patient experiences that what has been expressed has been noticed, interpreted with care, and incorporated appropriately into what happens next.

Three relational strands are therefore analytically separable but interdependent: recognition of the person

and situation; communicative attunement to emotion, uncertainty, preference, and meaning; and responsive action that demonstrates that understanding had consequences. Rupture can occur within any strand, while repair may require returning to an earlier point rather than proceeding linearly.

The interaction is better represented as braided and recursive than as a communication pipeline (**Figure 1**).

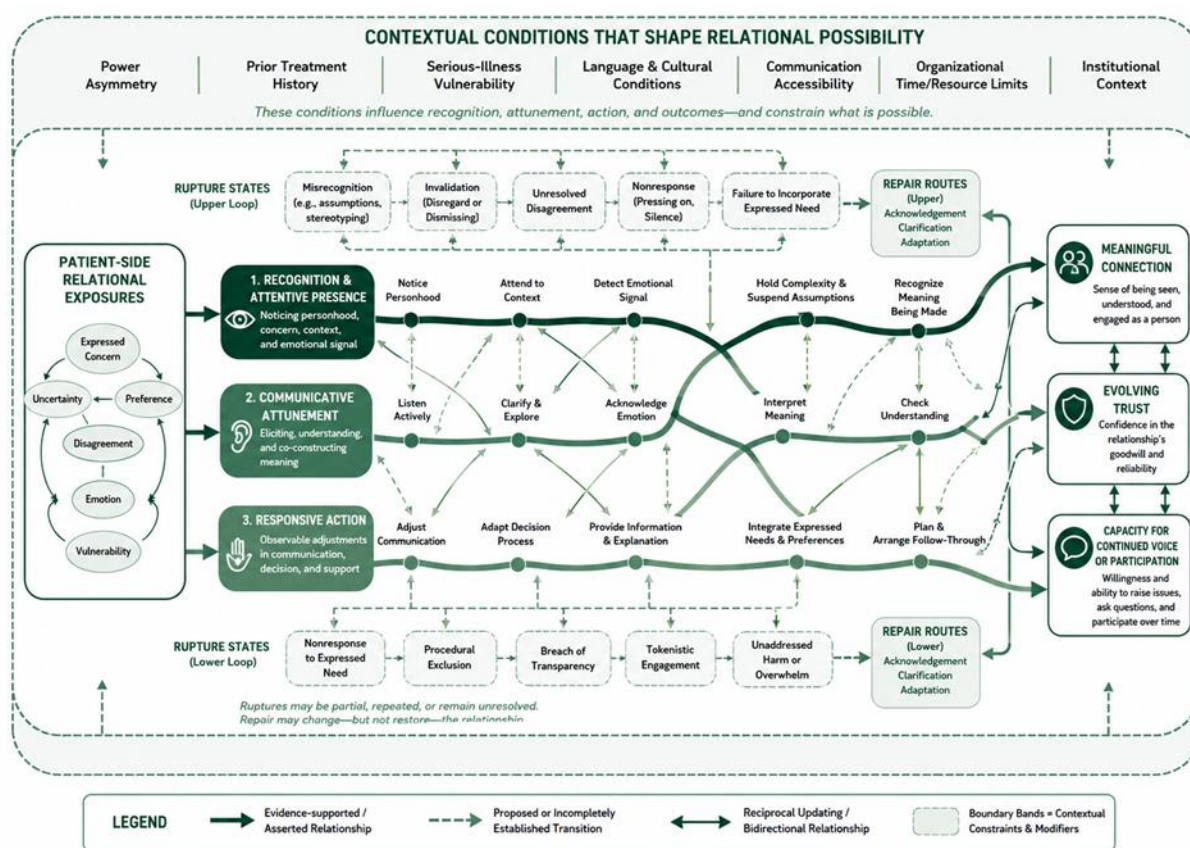


Figure 1. When Human Connection Becomes Clinically Meaningful: Braided Recognition, Responsiveness, and Repair Under Relational Constraint

Voice, disclosure, and patient participation

Voice is not equivalent to speaking frequency, decision ownership, or adherence. Shared decision-making is better understood as a method of care in which clinician and patient make sense of available options in relation to what is practically, intellectually, and emotionally workable [18]. From this perspective, participation requires more than an invitation: the patient must have a usable route for contributing information or preference,

and that contribution must have some possibility of shaping the encounter.

Implementation evidence reinforces this distinction. A stepped-wedge trial of routine shared decision-making in cancer care did not significantly improve its primary patient-reported outcome despite implementation of a multicomponent program [19]. National US data also show that impairment status and disability identity are not interchangeable and are associated with different patterns of trust, respect, fairness, and speaking-up

experience [20]. Accessibility therefore belongs inside, rather than outside, the theory of participation.

A multisystem cluster randomized trial of communication interventions similarly found no overall intervention effect, with differences across healthcare systems and outcomes [21]. Communication design cannot therefore assume that training, prompting, or additional conversational structure automatically produces voice.

This article consequently proposes voice as an enacted relational capability requiring at least four conditions: an

opportunity to contribute; psychological and relational permission to do so; practical communication access; and credible uptake of what is expressed. Disclosure is one form of voice but should not be treated as an obligation. Patients may reasonably choose not to disclose when anticipated costs exceed expected benefit.

Because similar invitations can produce different participation depending on context, the mechanism–context distinctions are summarized below (**Table 2**).

Table 2. When an Invitation to Participate Becomes Usable Voice, Partial Voice, or Silence

Evidence pattern or boundary case	Relational mechanism governing voice	Context shaping whether participation is usable	What an observer might misclassify	Uncertainty or competing explanation	Implication for the proposed account
Invitation without preferred-role alignment	Permission to choose both whether and how to participate	Decision burden, illness severity, patient preference	Low participation as disengagement	Delegated decision-making may be intentional	Proposed: voice includes authentic preference for less direct decisional control
Reduced communication self-efficacy after mistreatment	Anticipated interpersonal cost constrains speaking	Prior discrimination and credibility concerns	Silence as lack of knowledge or motivation	Other social and clinical factors may contribute	Proposed: voice depends partly on expected relational consequences
Disability or communication-access need	Participation requires an accessible expressive channel	Functional impairment, communication method, environmental accommodation	Standard invitation as equal opportunity	Disability identity and impairment are heterogeneous	Proposed: formal invitation without access is incomplete relational opportunity
Organization-wide SDM implementation	Programs must alter encounter practice, not merely introduce tools	Workflow, reach, clinician uptake, adaptation	Program presence as successful participation	Measures may not capture all valued effects	Proposed: institutional adoption is not equivalent to enacted voice
Communication intervention with null overall effect	Relational change depends on implementation and context	Health system, clinician, patient, selected outcome	Training exposure as relational effectiveness	Secondary effects or system variation may matter	Proposed: relational mechanisms require context-specific testing
Information withholding or selective disclosure	Patients judge safety, relevance, and expected response	Stigma, uncertainty, literacy, prior response	Non-disclosure as noncompliance	Privacy or preference may be legitimate	Proposed: disclosure should be enabled, not demanded

Note: Entries marked “Proposed” represent theoretical synthesis developed here rather than validated categories.

Relational threats, ruptures, and trust erosion

Relational safety can fail even when communication appears procedurally adequate. Language illustrates why. A systematic review of patient-provider language

concordance found heterogeneous associations with health outcomes and substantial concentration in particular populations and settings [22]. Linguistic matching may improve communication in some

circumstances, but it cannot by itself guarantee understanding, respect, accessibility, or trust.

Relational threats also have behavioral consequences. Among adults with diabetes or hypertension, perceived discrimination in healthcare was associated with delayed care, with patient-centered communication implicated as one possible pathway [23]. Among sexual and gender minority adults, healthcare discrimination and identity-related discordance were associated with care avoidance [24]. These findings should not be interpreted as meaning that group membership determines mistrust or avoidance. They instead demonstrate that treatment history, anticipated judgment, representation, and structural conditions can alter whether seeking care or speaking openly feels safe.

Communication vulnerability is likewise broader than language. A scoping review of knowledge syntheses identified communication challenges and adaptations involving language, culture, disability and other forms of communicative vulnerability, while also showing substantial heterogeneity in evidence quality and reporting [25]. Equal relational opportunity may therefore require differentiated forms of support.

The proposed theory distinguishes threat, rupture, and erosion. A relational threat is an event or condition that raises the anticipated cost of vulnerability. A rupture occurs when an encounter materially changes expectations of safety, respect, competence, benevolence, or responsiveness. Trust erosion describes cumulative updating across encounters, especially when threats recur or repair fails. These processes need not be consciously articulated by either party, and they should not be inferred solely from demographic identity, dissatisfaction, or one difficult conversation.

Repair is therefore not simply an apology technique. Depending on the source of rupture, it may require acknowledgement of harm, clarification of misunderstanding, accommodation of communication needs, restoration of choice, visible follow-through, continuity, or changes beyond the dyad. Some ruptures may remain unresolved because organizational policies, resource scarcity, discrimination, accessibility barriers, or prior histories continue to generate the same threat.

This framing completes the first half of the argument: patient-centered care becomes relationally credible only when patients can take interpersonal risk, have

vulnerability handled without penalty, experience responsive human recognition, and possess usable forms of voice. The next stage integrates these processes into the article's proposed Psychological Safety–Trust–Connection model and specifies the conditions under which its relationships should be expected to weaken, reverse, or fail.

The psychological safety–trust–connection model

The preceding evidence suggests that psychological safety, trust, and human connection should neither be collapsed nor arranged as a one-way sequence. Digital consultations reinforce this distinction: patient-centered online communication has been associated with benevolence- and ability-related trust, yet recommendation is not a clinical outcome [26]. Emerging medical-AI scholarship further distinguishes interpersonal trust from appropriate reliance on technology [27]. The relational architecture must therefore remain specifically human while acknowledging that digital systems can alter the cues through which responsiveness is judged.

This article proposes the Psychological Safety–Trust–Connection (PSTC) model as a reciprocal relational architecture. Relational safety conditions whether vulnerability, disagreement, uncertainty, or preference can be expressed. How that vulnerability is received contributes to evolving judgments of trustworthiness and meaningful connection. Trust and connection can then alter the perceived safety of subsequent encounters, increasing or decreasing willingness to take further relational risk. Voice is therefore both a possible expression and a diagnostic consequence of this system, while rupture updates expectations in the opposite direction.

The model is deliberately non-deterministic. Safety does not guarantee disclosure; disclosure does not guarantee trust; trust does not guarantee agreement; connection does not guarantee adherence or clinical improvement. Repeated encounters, organizational constraints, accessibility, culture, illness, and power can modify every relationship.

Because these influences are reciprocal and cross-level rather than sequential, their architecture is represented as a lattice with explicit uncertainty corridors (**Figure 2**).

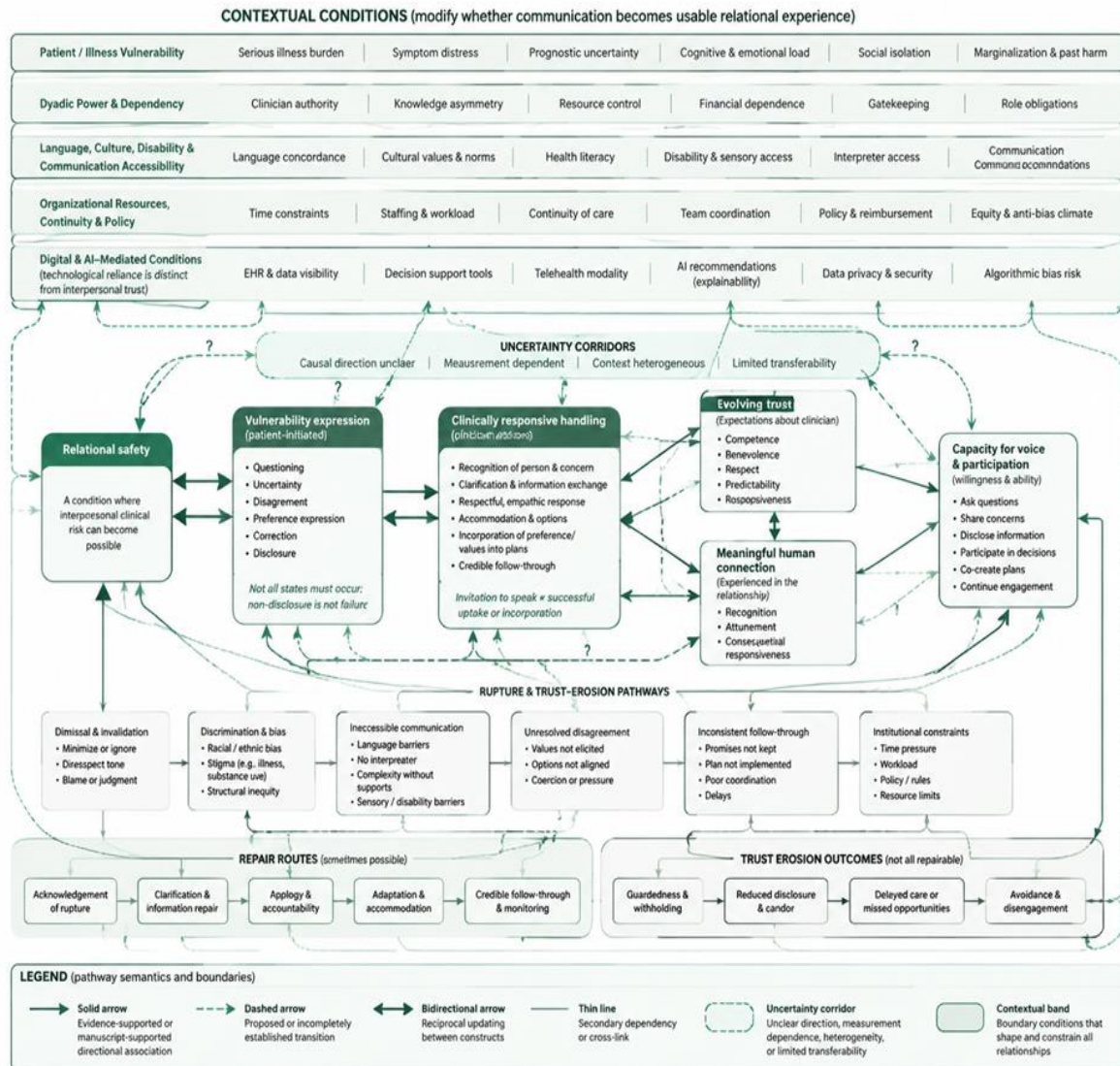


Figure 2. Relational Safety, Vulnerability, and Trust as a Reciprocal Clinical Influence System

Boundary conditions and testable propositions

The PSTC model is useful only if its expected failures are explicit. Experimental vignette evidence indicates that highly patient-centered communication can attenuate some associations between prior medical mistrust and subsequent physician mistrust or treatment endorsement, although simulation limits external validity [28]. Persistent pain and long-term opioid care demonstrate a different boundary: stigma, conflicting goals, fragmented care, prescribing constraints, and resource limitations can make rupture cumulative and partly system-generated [29]. Cross-sectional oncology evidence also shows that patient-centered communication need not have a significant direct association with quality of life even where trust appears in an indirect pathway [30].

The model therefore advances bounded propositions rather than universal effects. **Proposition 1:** greater relational safety should predict greater willingness to take clinically relevant interpersonal risk when communication is accessible and the patient wishes to participate. **Proposition 2:** respectful responsiveness to vulnerability should predict subsequent trust more strongly than invitation alone. **Proposition 3:** accumulated rupture should weaken later voice even when current communication appears patient-centered. **Proposition 4:** accessibility, discrimination, organizational constraint, serious illness, culture, and digital mediation should moderate these relationships. **Proposition 5:** repair should depend on whether the source of rupture is addressed at the level where it arose.

The most important exceptions and failure modes are therefore shown before any assumption of generalization (Table 3).

Table 3. Conditions Under Which the Proposed Relational Architecture Should Weaken, Reverse, or Fail

Failure condition	Relational mechanism disrupted	Observed consequence	Revision or validation test
Exception or failure state — Patient prefers delegated decision-making			
Expected disruption	Voice may remain low despite safety	Competing interpretation	Low participation may be authentic preference
Boundary requiring explicit test	Preferred role	Falsifiable implication	Safety should predict freedom to state the preferred role, not maximal participation
Exception or failure state — Prior discrimination or repeated dismissal			
Expected disruption	Current invitations may lack credibility	Competing interpretation	Guardedness may reflect earlier care rather than current clinician behavior
Boundary requiring explicit test	Treatment history and institutional context	Falsifiable implication	Invitation alone should poorly predict disclosure when anticipated relational cost remains high
Exception or failure state — Communication is inaccessible			
Expected disruption	Participation opportunity is nominal	Competing interpretation	Silence may be incorrectly interpreted as passivity
Boundary requiring explicit test	Language, disability, communication modality	Falsifiable implication	Accessibility support should alter the relationship between invitation and usable voice
Exception or failure state — Organizational constraint persists			
Expected disruption	Dyadic repair may be insufficient	Competing interpretation	Clinician warmth may coexist with system-generated threat
Boundary requiring explicit test	Time, continuity, policy, resources	Falsifiable implication	Trust repair should remain incomplete when the originating structural condition persists
Exception or failure state — Digital or AI mediation changes relational cues			
Expected disruption	Human trust and system reliance may diverge	Competing interpretation	High technology acceptance may be mistaken for interpersonal trust
Boundary requiring explicit test	Modality and governance	Falsifiable implication	Measures of reliance and interpersonal trust should show distinguishable patterns
Exception or failure state — Connection is high but outcome remains unchanged			
Expected disruption	Relational benefit may not translate clinically	Competing interpretation	Health status may be driven by disease or treatment factors
Boundary requiring explicit test	Outcome type and follow-up	Falsifiable implication	Relational improvement should not require parallel clinical-outcome improvement

Note: The table specifies proposed, testable implications and boundary conditions; it does not report validated thresholds or effect estimates.

Implications for clinical practice and healthcare design

Relational safety should not become another communication checklist. A recent meta-analysis found that interventions strengthening patient-clinician relationships were associated with improved outcomes overall, but high heterogeneity and low certainty preclude assuming a universally effective relational

intervention [31]. Clinical design should therefore focus on conditions: credible opportunities to question and disagree, communication accessibility, continuity where possible, response to prior harm, and mechanisms for escalation when relational problems arise from institutional rather than interpersonal sources.

Measurement should likewise separate safety, trust, connection, participation, satisfaction, and clinical outcome. Healthcare organizations could test whether patients felt able to raise difficult concerns, whether those concerns altered the encounter appropriately, and whether repair occurred after relational failure. Digital systems should be evaluated for whether they preserve routes for human clarification and challenge rather than merely increasing informational efficiency.

Results and Discussion

The reconstruction developed here moves patient-centeredness from the availability of communicative behaviors toward the conditions under which those behaviors become usable. Evidence linking patient-centered communication with trust, participation, and information behavior is consistent with relational interdependence but also shows that these outcomes can diverge [5, 16, 17]. Accordingly, the PSTC model does not treat any one construct as a surrogate for the others. Equity evidence further shows why relational explanation cannot stop at clinician manner. Discrimination is associated with communication agency and trust, while experience of treatment is analytically more informative than inferring psychological states from demographic identity [9-11]. Accessibility produces a related challenge: impairment, language, and communication vulnerability can determine whether an apparent invitation to participate is practically usable [20, 22, 25].

The model therefore makes two claims at different evidential levels. Evidence supports the importance of communication, trust, alliance, accessibility, discrimination, and contextual variation. The reciprocal organization of these domains into relational safety, trust formation, meaningful connection, rupture, repair, and subsequent voice is the article's **proposed synthesis**. Its value depends on prospective testing rather than conceptual plausibility alone.

Longitudinal studies should measure relational states across repeated encounters and distinguish antecedent trust from encounter-specific safety. Comparative research should test whether relational safety predicts disclosure or questioning beyond satisfaction and general trust. Implementation studies should determine whether improving relational conditions changes outcomes valued by patients without forcing greater participation. Research should also examine when organizational

reform is necessary because dyadic communication cannot repair structurally reproduced threats.

Conclusion

Patient-centered healthcare is incomplete when patients are offered information and choices but cannot safely question, disagree, disclose, or reveal vulnerability. Reconstructing care through psychological safety, trust formation, and meaningful human connection emphasizes the relational conditions that make participation usable. The proposed PSTC model treats safety, trust, connection, voice, rupture, and repair as distinct, reciprocal, and context-dependent processes. Its contribution is not a claim of universal causal validity but a bounded framework for asking more precise questions about when clinical relationships permit vulnerability, respond to it credibly, and remain capable of repair.

Acknowledgments: None

Conflict of Interest: None

Financial Support: None

Ethics Statement: None

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