

Psychological Safety as a Pathway to Healthcare Equity: How Communication Climate Influences Disclosure, Trust, and Patient Participation

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Abstract

Healthcare participation is often treated as evidence that patients have been invited to speak, ask questions, disclose concerns, and contribute to decisions. Yet an opportunity to participate is not equivalent to a psychologically safe opportunity to do so. This conceptual article argues that communication climate may influence healthcare equity partly by shaping the interpersonal risk patients associate with disclosure and voice. Psychological safety is distinguished from trust, satisfaction, participation, adherence, and communicative access. The proposed theory treats anticipated clinician response as a critical intermediary between observable communication and patients' decisions to reveal needs, question recommendations, express uncertainty, or withhold concerns. Prior discrimination, power asymmetry, language barriers, identity-related marginalization, and institutional experience may alter the perceived cost of the same participatory act. Evidence also indicates that increasing observable participation does not consistently increase trust, information provision, care-plan fit, or downstream engagement. Psychological safety should therefore be studied as a bounded and potentially reciprocal pathway condition rather than presumed from participation alone. The framework generates testable clinical and organizational propositions while preserving uncertainty about causality, transferability, and intervention effectiveness.

Keywords: Psychological safety, Patient participation, Patient-clinician communication, Trust, Healthcare equity, Shared decision-making

Introduction

Healthcare equity requires more than formally equal opportunities to ask questions or join decisions. Patients may encounter the same invitation to participate while facing markedly different interpersonal costs if they anticipate dismissal, disbelief, stereotyping, embarrassment, retaliation, or damage to a valued clinical relationship. Initial patient-level measurement work supports psychological safety as a potentially distinguishable construct involving relationship comfort

and belonging, although its empirical development remains early [1]. Patient participation itself is multidimensional, spanning activities such as information exchange, deliberation, question-asking, preference expression, and involvement in decisions rather than constituting a single behavioral endpoint [2]. Communication interventions can increase some forms of active participation, but their heterogeneous outcomes caution against assuming that greater observable activity necessarily represents safer or more equitable participation [3].

This article therefore proposes psychological safety as a pathway condition linking communication climate with disclosure, trust, voice, and participation. The central claim is theoretical rather than causal: patients may participate more equitably when interpersonal risk can be incurred without disproportionate expectation of devaluation or adverse response. The model

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distinguishes patient experience from observable behavior, interpersonal processes from institutional conditions, and participation from later outcomes. It also treats communication history, power, language, identity, and organizational context as conditions capable of modifying the pathway.

Psychological safety in the patient context

Psychological safety in healthcare should not be imported unchanged from organizational-team research. For patients, the relevant interpersonal risk often concerns revealing information, admitting uncertainty, questioning authority, correcting a misunderstanding, discussing stigmatized behavior, expressing disagreement, or saying that a proposed plan is impractical. The emerging Patient Psychological Safety Scale provides initial support for a patient-focused construct involving relationship comfort and belonging, with some connection between lower comfort and nondisclosure [1]. However, early validation does not establish that psychological safety is a universal mediator of communication outcomes.

Communicative vulnerability further complicates the construct. Evidence syntheses involving patients with communication difficulties show that language, cultural accommodation, interpreter practices, and the organization of communication can influence whether interaction is accessible at all [4]. A patient cannot meaningfully exercise interpersonal risk-taking if the communicative channel itself is unreliable.

Patient preferences also matter. In cancer care, patient-centered communication, participation, preferred decision role, and trust were related but nonidentical, and the participation-trust association varied with role preference [5]. A patient who prefers limited decisional responsibility is therefore not necessarily unsafe, disengaged, or disempowered. The proposed distinction is that psychological safety concerns whether a patient *could* express relevant needs or disagreement without excessive interpersonal cost; it does not prescribe how much participation every patient should choose.

Communication climate and interpersonal risk

Communication climate is created through repeated signals about what happens when patients expose uncertainty, emotion, disagreement, or practical difficulty. Responses to emotional expression provide one observable example. Recorded clinical encounters show that different clinician responses to emotion are

associated with different patient evaluations of communication [6]. These findings do not prove that response style causes psychological safety, but they demonstrate that clinician behavior can supply information from which patients may infer whether vulnerable expression is welcomed.

Disagreement provides another test of climate. Clinicians describing difficult differences of opinion identify relationship-building, validation, curiosity, and exploration of patient values as strategies for maintaining constructive engagement [7]. Such practices matter theoretically because interpersonal safety is most informative when agreement cannot be assumed. A climate that appears supportive only while the patient accepts the clinician's view is qualitatively different from one that can tolerate dissent.

Collaboration also depends on whether information offered by patients can alter the clinical conversation. Qualitative analysis of diabetes consultations shows that care can be made more workable by eliciting biography, circumstances, and practical constraints and using them to adapt the care plan [8]. The proposed pathway therefore assigns importance not merely to clinician warmth but to response contingency: patients observe whether disclosure changes understanding, deliberation, or planning. A climate becomes psychologically safer when speaking carries a credible possibility of being taken seriously rather than merely being permitted.

Disclosure of needs, symptoms, and concerns

Disclosure is a critical transition because undisclosed information is frequently invisible to clinical observation. Recorded primary-care encounters demonstrate that requests and responses can be identified interactionally [9], yet observed requests cannot reveal all needs that patients considered but decided not to voice. The absence of a question or concern is therefore ambiguous: it may indicate comprehension and agreement, or it may reflect anticipated interpersonal cost.

Structured participation support illustrates this distinction. In a randomized oncology trial involving Black patients, a question prompt list increased active participation, although communication outcomes did not improve uniformly [10]. Subsequent analysis showed that patients and companions exposed to the prompt list generated more information-seeking prompts, while oncologist information provision did not necessarily increase in parallel [11]. Implementation across an

outpatient oncology network further suggests that question-prompt approaches can be embedded in routine care and perceived positively [12].

These studies demonstrate that the behavioral threshold for question-asking can be modified. They do not establish that prompting produces trust or psychological safety. The present theory therefore separates opportunity, expression, and response. A prompt may lower the cost of initiating a question; what happens after the question may determine whether subsequent disclosure feels safer or more hazardous. Repeated encounters can consequently generate feedback: a responsive answer may lower the perceived risk of future disclosure, whereas dismissal, defensiveness, or nonresponse may increase it. This feedback relation is proposed and requires longitudinal testing.

Trust and expectations of response

Trust overlaps with psychological safety but should not substitute for it. Trust can concern confidence in a clinician's competence, motives, reliability, or in the healthcare system more broadly. Psychological safety, as proposed here, is narrower and more situational: whether exposing uncertainty, disagreement, need, or identity-relevant information feels interpersonally tolerable in a particular care relationship or encounter.

Audio-recorded cardiology encounters provide evidence that trust-related communication itself can differ across racialized interactional contexts. Black patients in one study expressed less trust and were rated as less open than White patients, although distrust indicators did not uniformly differ [13]. This distinction is important because trust and distrust are not necessarily opposite ends of a single scale, and guardedness should not automatically be interpreted as an intrinsic patient characteristic.

Prior experience also shapes expectations. Among patients with serious illness, greater reported discriminatory healthcare experiences were associated with medical mistrust [14]. In a national sample of adults with and without cancer, racial discrimination in medical care was likewise associated with lower healthcare-system trust [15]. These studies are observational and do not establish that discrimination causes later nondisclosure. They nevertheless support a history-sensitive account in which patients enter encounters with expectations formed beyond the immediate clinician relationship.

Interventions designed to increase collaboration do not reliably repair this history. A scoping review of shared decision-making interventions found heterogeneous trust effects, with many studies showing no significant improvement in trust [16]. Similarly, outpatient evidence indicates that patient involvement, communication, trust, and satisfaction have related but nonidentical determinants [17]. Increasing participation should therefore not be treated as proof that the underlying response environment has become psychologically safe. The proposed distinction is consequential for equity analysis. Two patients may display similar levels of observable participation while assuming very different risks in doing so. Conversely, reduced participation may arise from preference, illness burden, communicative difficulty, prior discrimination, uncertainty about response, or other constraints. Psychological safety cannot be inferred from behavior alone.

The distinctions are easier to evaluate when response expectations, contextual modifiers, competing explanations, and pathway consequences are placed alongside one another rather than collapsed into a single trust score (**Table 1**).

Table 1. Response expectations that can alter the meaning of apparently similar patient participation

Encounter evidence pattern	Response process relevant to interpersonal risk	Context that changes interpretation	Competing explanation or uncertainty	Boundary case that prevents overinterpretation	Consequence for the proposed psychological-safety pathway
Patient expresses emotion or uncertainty	Recognition, exploration, validation, or passive response supplies information about whether vulnerability is tolerated	Emotional intensity, clinical urgency, relationship history	Positive communication ratings do not establish sustained safety	A technically appropriate brief response may appear less relational in time-pressured care	Response style may update expectations about the cost of future disclosure
Patient disagrees with a recommendation	Curiosity, validation, and values exploration can	Treatment stakes, reversibility, decisional	Agreement after discussion may reflect persuasion	A patient may freely delegate a decision without	Safety concerns whether disagreement can be

	preserve dialogue despite disagreement	preference, clinician authority	rather than felt safety	experiencing coercion	expressed, not whether disagreement persists
Patient reveals practical barriers or life circumstances	Clinician incorporates disclosed context into reasoning or planning	Chronic illness burden, treatment flexibility, material resources	Plan modification may be impossible even when disclosure is respected	Clinical constraints can limit accommodation without implying interpersonal dismissal	Credible responsiveness can make disclosure instrumentally meaningful
Patient enters care after discriminatory experiences	Current responses are interpreted against prior experiences of devaluation or exclusion	Serious illness, racialized experience, continuity of care	Present guardedness cannot be causally assigned to one prior encounter	A supportive current clinician may not immediately reverse system-level mistrust	Prior healthcare history may raise the threshold for taking interpersonal risk
Patient reports low healthcare-system trust	Expectations extend beyond the individual clinician to institutional reliability and fairness	Institutional reputation, accumulated experience, structural inequity	System mistrust and clinician-specific trust may diverge	High trust in one clinician can coexist with low trust in the wider system	Psychological safety may depend on nested clinician and system expectations
Patient participates actively during shared decision-making	Participation creates observable voice but may or may not change trust	Baseline trust, patient preference, decision context	Participation may be produced by intervention structure without changing expectations of response	High involvement can coexist with unresolved mistrust	Observable participation is evidence of behavior, not sufficient evidence of psychological safety
Patient reports a satisfactory encounter	Positive global evaluation may incorporate convenience, outcomes, courtesy, or expectations	Prior expectations, health status, service setting	Satisfaction can obscure distinct problems in voice or trust	A satisfied patient may still withhold sensitive information	Satisfaction should remain separate from disclosure safety and relational trust

A multilevel representation is also needed because expectations of response are formed inside the encounter but are not confined to it (**Figure 1**).

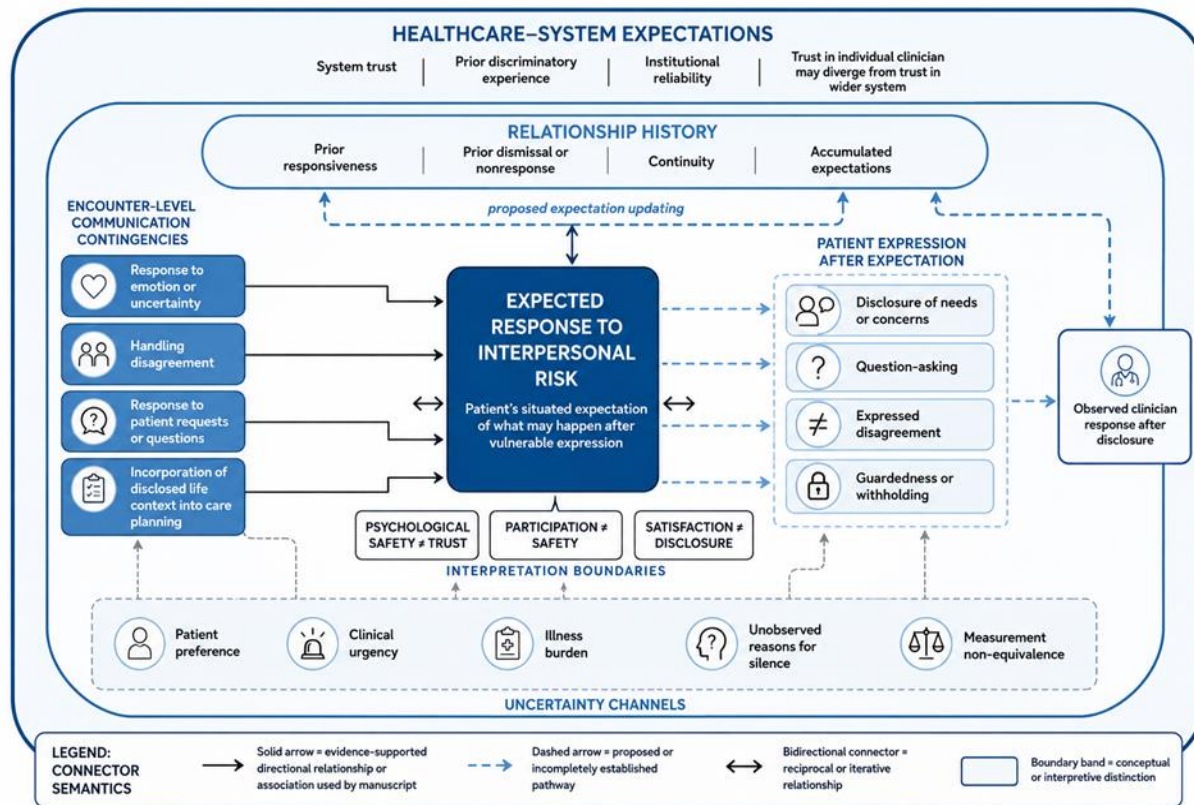


Figure 1. Response Expectations Across Nested Clinical Contexts: Boundaries on Patient Interpersonal Risk

Voice, question-asking, and participation

Voice is the observable portion of a larger participation process. Question-asking and preference expression require both an opportunity to speak and sufficient ability to use that opportunity. Research with older adults illustrates that health literacy, anxiety, education, observed participation, shared decision-making, and decisional conflict are related in differentiated ways rather than forming one uniform participation construct [18]. Thus, a communication environment may formally invite participation while leaving substantial differences in who can comfortably act on the invitation.

Patient-reported evidence across settings similarly identifies recurring barriers and facilitators to shared decision-making but also shows that their expression varies across groups and clinical contexts [19]. Participation should therefore be analyzed as context-enabled behavior, not simply as patient motivation.

Even high measured involvement does not guarantee a desirable downstream result. In atrial-fibrillation decision encounters, greater observed involvement was not equivalent to greater care-plan sensibility or adherence [20]. This matters for the proposed theory

because psychological safety should not be justified by assuming a linear sequence from voice to better decisions or clinical behavior.

Instead, voice is conceptualized as one testable transition. A psychologically safer environment should make relevant questions, uncertainty, disagreement, and preferences less costly to express, but individual patients may still choose delegation, silence, or limited participation. Equity therefore concerns whether meaningful options for expression are genuinely available rather than whether every patient behaves identically.

Power differences and unequal safety

Interpersonal risk is inherently shaped by power because patients and clinicians do not enter healthcare encounters with equal authority, knowledge, institutional legitimacy, or control over resources. The same question or correction may therefore carry different perceived consequences depending on whether a patient expects credibility, dismissal, stereotyping, or escalation.

Qualitative evidence from Black adults with serious illness describes racism and epistemic injustice alongside

mistrust and disrupted patient-clinician communication and decision-making [21]. These accounts support treating credibility as a substantive component of communication climate. Being allowed to speak is not equivalent to expecting one's account to be treated as knowledge.

Power also operates through organizational and digital practices outside spoken interaction. Analysis of hospital admission notes identified racial patterning in clinicians' linguistic expressions of doubt [22]. Documentation is therefore not merely a passive record of an encounter; it can become part of the institutional environment through which patient credibility is represented and transmitted. Identity-related healthcare experiences further show why unequal safety cannot be reduced to clinician manner. Among transgender and gender-independent adults, direct and vicarious healthcare discrimination and erasure were related to healthcare mistrust and utilization behavior [23]. Sexual and gender minority adults have also reported care avoidance associated with discrimination and patient-clinician identity discordance [24]. These observational findings do not justify inferring mistrust or psychological safety from identity itself. They instead establish that histories of healthcare treatment can differ systematically and may alter the conditions under which interpersonal risk is evaluated.

The theory consequently rejects the assumption that identical invitations generate identical participatory opportunities. A clinician can ask every patient the same open-ended question while patients face unequal expected costs of correcting, challenging, or revealing information. Psychological safety becomes equity-relevant when those costs are socially or institutionally patterned.

Language, identity, and marginalization

Language access illustrates the difference between interpersonal welcome and actual communicative capability. A systematic review and evidence map of patient-provider language concordance found both positive and null associations across outcomes, with substantial concentration in particular populations and settings [25]. Language concordance should therefore not be treated as a universally sufficient mechanism for better communication or outcomes.

More recent synthesis indicates that professional interpreters and genuinely shared language generally provide stronger support for communication than weaker strategies for overcoming language barriers, although

effectiveness varies with the complexity of the interaction [26]. The practical requirement is not simply that some verbal exchange occurs, but that patients have a sufficiently reliable channel through which uncertainty, preferences, symptoms, and disagreement can be communicated.

Partial concordance demonstrates the boundary especially clearly. Primary-care research suggests that limited shared language can facilitate rapport while simultaneously creating risks of misunderstanding, supporting continued use of qualified interpreter resources when needed [27]. Relational ease and informational accuracy therefore should not be collapsed. The proposed theory treats communicative access as a prerequisite for meaningful psychological safety rather than as psychological safety itself. A patient cannot safely disclose what cannot be expressed accurately, but accurate translation alone does not guarantee that disclosure will be respected or free from identity-based devaluation. Language, identity, credibility, and power thus interact without becoming interchangeable constructs.

Marginalization also requires caution in interpretation. An individual's demographic category cannot be treated as evidence of trust, willingness to participate, or psychological state. The relevant theoretical question is whether healthcare histories and current communication conditions distribute interpersonal risk unequally. Psychological safety becomes an equity pathway only insofar as these contextual differences alter patients' practical freedom to reveal clinically relevant information, ask questions, challenge assumptions, and participate according to their own preferences.

From psychological safety to equitable participation

Equitable participation should not be defined as identical amounts of speaking, questioning, or decision involvement. It concerns whether patients have a practically usable opportunity to disclose relevant information and participate according to their preferences without disproportionate interpersonal or structural cost. In adults with diabetes or hypertension, perceived healthcare discrimination was associated with delayed care, with patient-centered communication occupying a partial statistical pathway that varied across demographic groups [28]. During the COVID-19 pandemic, medical mistrust similarly occupied an intermediate statistical position between racialized context and willingness to

participate in vaccine trials or vaccination decisions [29]. Neither analysis establishes causal mediation. These findings nevertheless support treating participation as history- and context-sensitive. Discrimination can shape expectations before an encounter begins; communication can then reinforce, weaken, or leave

those expectations unchanged. The resulting pathway may diverge even when clinicians offer formally identical opportunities.

Table 2 therefore begins with exceptions and failure modes rather than assuming that more observable participation necessarily indicates greater equity.

Table 2. When participation fails to demonstrate equitable psychological safety

Participation signal	Psychological-safety condition	Equity failure mode	Interpretive requirement
Patient or care-context state — Patient speaks frequently			
Apparent participation signal	High verbal participation	Hidden failure mode or exception	Questions may be answered without concerns being taken seriously
What remains uncertain	Whether speaking feels safe or merely necessary	Consequence for equity interpretation	Voice alone cannot establish safety
Patient or care-context state — Patient remains quiet			
Apparent participation signal	Low observable participation	Hidden failure mode or exception	Silence may reflect preference, fatigue, fear, language barriers, or perceived futility
What remains uncertain	Reason for nondisclosure is usually unobserved	Consequence for equity interpretation	Silence should not be classified automatically as disengagement
Patient or care-context state — Patient agrees with the plan			
Apparent participation signal	Apparent concordance	Hidden failure mode or exception	Agreement may coexist with unexpressed doubt or constrained choice
What remains uncertain	Whether disagreement felt possible	Consequence for equity interpretation	Agreement is not evidence of unconstrained participation
Patient or care-context state — Patient receives an invitation to ask questions			
Apparent participation signal	Formal opportunity	Hidden failure mode or exception	Literacy, language, prior discrimination, power, or anticipated response can alter the usable opportunity
What remains uncertain	Whether invitation reduced interpersonal risk	Consequence for equity interpretation	Equal invitation can produce unequal practical access
Patient or care-context state — Patient uses shared decision-making tools			
Apparent participation signal	Structured involvement	Hidden failure mode or exception	Participation can increase without corresponding gains in trust, information provision, or plan fit
What remains uncertain	Which pathway component changed	Consequence for equity interpretation	Intervention exposure should not be treated as pathway validation
Patient or care-context state — Patient avoids or delays care			
Apparent participation signal	No encounter-level participation	Hidden failure mode or exception	Prior discrimination or identity-related threat may shift the pathway upstream of the visit
What remains uncertain	Relative roles of mistrust, access, resources, and other barriers	Consequence for equity interpretation	Equity analysis must include non-entry into care

An equity pathway model

The article therefore proposes a bounded Equity Pathway Model. Communication climate influences the immediate response environment; patients interpret that environment through prior relational and institutional experience; anticipated interpersonal consequences

shape whether needs, uncertainty, disagreement, and preferences are expressed; clinician response then supplies new information that can update later expectations.

This sequence is not proposed as a fixed causal chain. Trust may precede and influence communication,

participation can itself change clinician behavior, and structural conditions may constrain action regardless of psychological safety. Discrimination-related mistrust across serious-illness and population studies illustrates why response expectations can be history-sensitive [14, 15].

The model's equity claim is correspondingly limited: communication becomes equity-relevant when socially patterned differences in credibility, language access, institutional treatment, or prior experience alter the practical cost of participation.

Figure 2 represents these parallel processes while preserving their points of divergence.

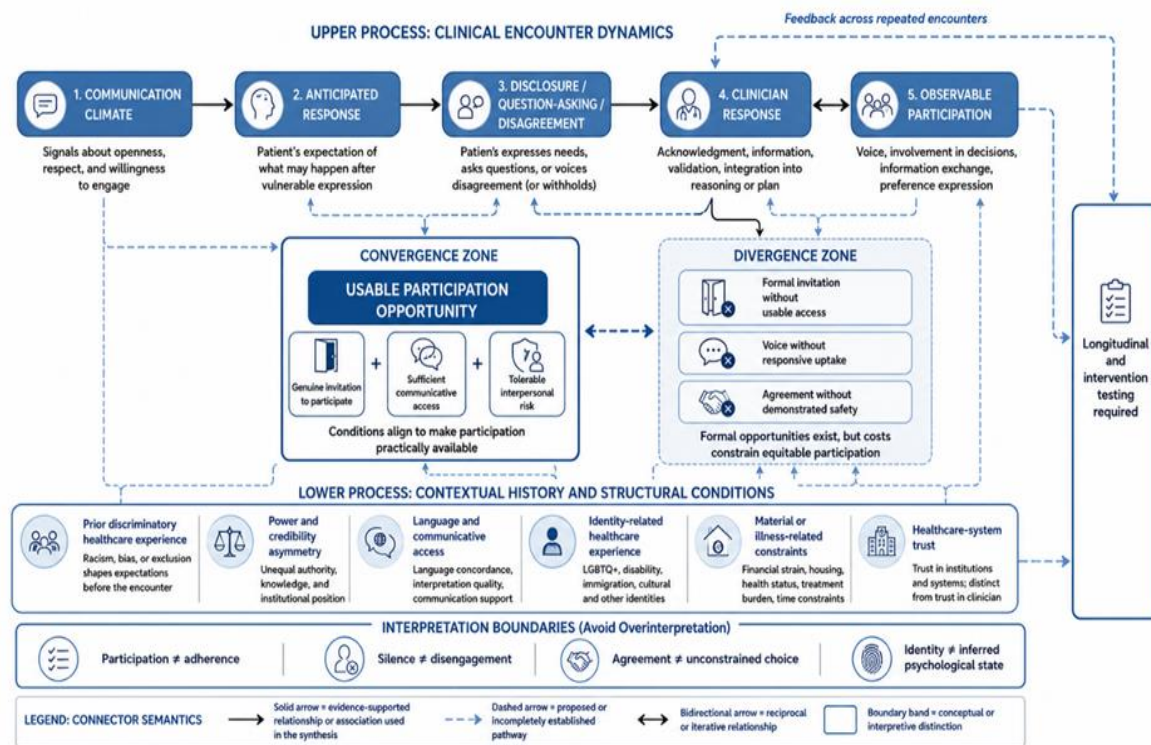


Figure 2. Convergence and Breakdown of Participation Opportunity Across the Equity Pathway

Clinical and organizational design principles

The model implies design requirements rather than proven intervention prescriptions. Clinical communication should make questioning and disagreement ordinary, respond explicitly to vulnerable disclosures, and demonstrate when patient-provided context changes reasoning. Question-prompt interventions show that normalizing information seeking can alter patient behavior without guaranteeing equivalent clinician response [10, 11].

Organizations should also protect communicative access, provide qualified language support when needed, and examine documentation and workflow practices that can reproduce credibility asymmetries. Language concordance and interpreter evidence jointly supports treating access as context-dependent rather than binary [25, 26]. Measurement should separately assess

psychological safety, trust, observed participation, satisfaction, and downstream outcomes.

Results and Discussion

The proposed theory connects literatures that currently differ in empirical maturity. Patient psychological safety has direct but early measurement evidence, whereas communication, discrimination, trust, language access, and participation have broader observational and intervention literatures. This imbalance prevents the complete pathway from being described as established. The strongest constraint on simplistic interpretation is outcome divergence. Participation can increase without parallel increases in clinician information provision, trust, care-plan fit, or adherence. Conversely, low participation can reflect preference or contextual

constraint rather than unsafe communication. Psychological safety is therefore most useful as a hypothesis about the conditions under which interpersonal risk becomes usable participation, not as a hidden explanation assigned retrospectively to every patient behavior.

Future testing should establish temporal order, discriminate patient-level safety from trust and communication satisfaction, examine repeated encounters, and test whether effects differ across language, illness, identity, resource, and organizational contexts. Validation should also include patients who delay or avoid care, because pathway failure may occur before participation becomes observable.

Conclusion

Psychological safety offers a potentially useful way to explain why equal invitations to participate may not create equal opportunities to do so. The proposed pathway places anticipated response between communication climate and interpersonal risk-taking while embedding that process within trust history, language access, power, identity-related experience, and institutional context. It does not equate silence with disengagement, participation with safety, or agreement with unconstrained choice. Its value lies in generating bounded, testable distinctions for studying when patient voice becomes practically available and when formally participatory care can still reproduce inequity.

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