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The Memory of Healthcare Encounters: How Past Experiences Shape Trust, Future Engagement, and Long-Term Relationships With Care Systems

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Abstract

Healthcare encounters do not end when patients leave a consultation, ward, diagnostic setting, or digital interaction. Some encounters remain psychologically available as remembered experiences that influence what patients expect from subsequent care, how they interpret ambiguous clinician behaviour, which sources of information they trust, and whether they approach future healthcare with openness, vigilance, avoidance, or conditional engagement. Existing research has examined patient experience, trust, medical mistrust, communication, discrimination, institutional betrayal, continuity, and healthcare utilization, but these domains are rarely organized as components of a temporally explicit theory of remembered care. This conceptual article proposes that healthcare encounters become consequential for later engagement through selective encoding, reconstructive memory, anticipatory appraisal, target-specific trust updating, and context-dependent behavioural responses. Negative experiences may sometimes exert disproportionate influence, but such asymmetry is neither assumed to be universal nor reduced to a fixed psychological bias. Trust is treated as target-specific and potentially differentiated across individual clinicians, healthcare teams, institutions, and health systems. The proposed account further distinguishes disengagement from information avoidance, online substitution, delayed help-seeking, and selective re-engagement. Corrective experiences are conceptualized as potentially important but insufficient unless they address the relational or institutional meaning attached to an earlier rupture. The resulting healthcare-memory perspective is intended as a bounded, testable theoretical architecture rather than a claim that prior encounters causally determine future behaviour. It generates longitudinal hypotheses concerning persistence, updating, generalization, repair, and the conditions under which remembered healthcare experiences become durable components of relationships with care systems.

Keywords: Autobiographical memory, Patient experience, Healthcare trust, Medical mistrust, Anticipatory appraisal, Healthcare engagement

Introduction

Healthcare relationships unfold across time, yet much research and practice still assess encounters as if their meaning were confined to the moment in which care is delivered. Patients may leave a consultation with a diagnostic decision, treatment plan, reassurance, uncertainty, humiliation, recognition, or some mixture of these. What persists afterward is not a literal recording of the event. Emotional autobiographical memories can remain vivid while being selectively retained, reconstructed, supplemented, or reinterpreted as circumstances change [1]. This matters for healthcare because later encounters are rarely approached without a history. Even when a clinician has never previously met a patient, the patient may already carry expectations formed by earlier professionals, institutions, family

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narratives, discrimination, illness episodes, or interactions with healthcare information.

Trust is one plausible temporal bridge, but it should not be treated as a simple mediator between experience and outcome. A meta-analysis found that trust in healthcare professionals was associated with several subjective outcomes and health behaviours, while associations with objective and observer-rated outcomes were less consistent [2]. Such evidence supports the importance of trust without demonstrating that greater trust necessarily produces better clinical outcomes or that the direction of influence is unidirectional. Measurement adds another problem. Medical mistrust instruments vary in what they actually measure, including their referent, specificity, population assumptions, and conceptual boundaries [3]. Correspondingly, trust in one's own doctor, doctors generally, and the healthcare team can be measured as distinguishable targets rather than as one interchangeable attitude [4].

Patient experience is similarly heterogeneous. Hospital systems collect complaints, surveys, narratives, online feedback, real-time responses, and other forms of patient-experience information, but these sources differ in purpose and in what they reveal about care [5]. A report of poor experience is therefore not automatically evidence of remembered harm, distrust, future disengagement, or clinical deterioration. Conversely, a highly consequential remembered encounter may not be adequately represented by conventional satisfaction instruments.

The present article develops a proposed healthcare-memory theory that connects these otherwise fragmented domains. Its central argument is that some healthcare encounters become remembered representations that contribute to later expectations, interpretation, trust updating, and engagement. The proposed theory is explicitly bounded. Memory is not treated as a perfect record; trust is not equated with satisfaction, adherence, or clinical outcome; behavioural responses are not assumed to reflect psychology alone; and provider-level experience is not presumed automatically to generalize to institutions or health systems. Rather, the article asks how remembered experience may become one temporally organized input into an evolving relationship with care.

Healthcare encounters as remembered experiences

Healthcare encounters possess emotional, relational, and interpretive dimensions that are poorly represented by a model in which the patient merely receives information or treatment. Work incorporating emotional indicators into the patient journey suggests that emotional experience can reveal dimensions of care that conventional operational indicators may miss [6, 7]. Patients and healthcare professionals may also endorse broadly similar values while holding different expectations about what good healthcare should feel like or accomplish. Consequently, the same objective event can acquire different meanings depending on what the patient believed should have happened, what occurred, and how that discrepancy is interpreted.

A remembered healthcare encounter should therefore be distinguished from the encounter itself. The encounter consists of events that occur in a clinical context; remembered experience consists of what remains psychologically available afterward. That remainder can include fragments of dialogue, emotional tone, perceived recognition or dismissal, inferred motives, sensory details, absence of expected communication, and conclusions about whether the patient was safe, believed, respected, or taken seriously. The proposed distinction matters because later behaviour may be influenced not by every objective feature of the previous encounter but by the subset that was encoded and subsequently reconstructed as meaningful.

This framework also requires an equity boundary. Medical mistrust among Black patients with serious illness has been linked in mixed-methods work to experiences that include discrimination and racism in healthcare [8]. Such evidence does not justify inferring mistrust from racial identity. It instead demonstrates why encounter histories and structural conditions should be measured directly. A patient's expectations of care may be shaped by personally experienced discrimination, but they may also reflect broader histories of institutional treatment, social narratives, or prior observations of how people like them were treated. The theory therefore locates remembered encounters within social and institutional contexts rather than reducing them to individual cognitive disposition.

Not every encounter will become equally consequential. Routine, expected, rapidly resolved interactions may leave little durable trace. Others may be repeatedly revisited because they were frightening, relieving, humiliating, validating, confusing, or identity-relevant. The article therefore proposes selective healthcare-memory encoding: the idea that the long-term significance of an encounter depends partly on which

elements acquire sufficient salience and meaning to become available for later interpretation. This is a theoretical synthesis, not an established clinical mechanism.

Encoding emotionally salient care events

The content most likely to endure after care may be surprisingly specific. In qualitative research with breast-cancer patients, memorable messages included not only spoken statements but also nonverbal behaviour and messages patients believed should have been communicated but were absent [9]. Patients described certain remembered communications as sufficiently consequential to influence distrust and subsequent encounter behaviour. This illustrates that clinically consequential memory may be organized around meaning rather than informational volume. A short phrase, a clinician's visible reaction, or a perceived failure to acknowledge fear can become more memorable than a much longer technical explanation.

Positive relational signals are also relevant, although their long-term effects should not be assumed. Perceived clinician humility has been associated with greater patient trust and satisfaction [10]. Patient-centred communication is likewise associated with trust, but its relationship with participation is conditioned by patients' preferences for their role in decision-making [11]. These findings caution against defining "good communication" as a fixed set of behaviours whose psychological meaning is identical for every patient. Invitation to participate can feel empowering to one person and burdensome or misaligned to another. Likewise, clinician uncertainty can be experienced as honesty, incompetence, transparency, or abandonment depending on context and expectation.

The proposed encoding process therefore has at least three analytically separate components. First is event salience: the degree to which something attracts emotional or cognitive attention. Second is interpretive meaning: what the event implies about safety, competence, recognition, legitimacy, control, or relational intent. Third is self- and context-relevance: whether the event connects to an ongoing illness, previous care history, stigmatized identity, anticipated future dependence, or perceived vulnerability. These components should not be represented as empirically established stages. They are proposed organizing distinctions derived from the evidence that healthcare experiences vary in emotional intensity, relational meaning, and subsequent relevance.

Encoding is also likely to be recursive. A patient who already expects dismissal may attend closely to signs of interruption or disbelief, while a patient with a long history of reliable care may interpret the same ambiguous behaviour more generously. Current expectations may therefore affect what becomes memorable, just as remembered experiences may later alter expectations. This reciprocity becomes important when considering why negative and positive experiences need not have equivalent consequences.

Negative and positive experience asymmetry

An intuitive healthcare model might assume that favourable and unfavourable experiences simply accumulate, with trust increasing after positive encounters and decreasing by a comparable amount after negative ones. Available evidence does not support such symmetry as a general rule. In an analysis of trust and compliance in the Italian National Health Service, positive prior experiences predicted greater trust, whereas negative experiences reduced trust more strongly than positive experiences increased it [12]. Importantly, trust was not synonymous with immediate compliance, underscoring that attitudinal and behavioural outcomes should remain distinct.

Evidence from adverse healthcare events reinforces the possibility that harm cannot always be cancelled by relational strength. Following an adverse event, stronger patient–physician alliance was associated with protection of trust, but it did not eliminate the negative consequences attributed to the adverse experience and institutional betrayal [13]. Similarly, young adults reporting greater healthcare-related institutional betrayal in a past adverse healthcare experience also reported lower current provider trust and more negative expectations about future healthcare [14].

These studies justify taking asymmetry seriously but not universalizing it. The magnitude and durability of an adverse encounter may depend on severity, attribution, preventability, prior relationship quality, perceived intent, illness vulnerability, institutional response, and whether future care requires renewed dependence on the same provider or system. Positive encounters may also be unusually influential when they violate an established expectation of disrespect or neglect. A patient anticipating dismissal who instead experiences sustained

recognition may encounter positive expectancy violation of considerable psychological importance.

The present theory therefore proposes conditional valence asymmetry rather than a fixed negativity principle. Negative experiences may sometimes receive greater weight because they signal danger, betrayal, incompetence, loss of control, or violation of expectations. Yet their influence should be expected to vary across patients and care contexts. The relevant scientific question is not whether negative experience is always stronger, but when remembered negative or positive evidence is assigned greater weight in subsequent appraisal.

Memory, expectations, and anticipatory appraisal

Expectations are not merely predictions about technical outcomes. In chronic primary care, patients describe expectations involving continuity, communication, rapport, accessibility, respect, and acknowledgement of their expertise in living with illness [15]. Such expectations can become relational standards that develop across repeated contact. They provide a reference point against which later encounters are interpreted.

Consultation research in chronic pain further shows that whether expectations are met or exceeded is associated with patients' post-consultation evaluations, including trust [16]. The implication is not that expectations mechanically determine satisfaction. Rather, an encounter is partly evaluated through a comparison between anticipated and experienced care. When this comparison occurs repeatedly, expectations can become a temporal bridge between memory and new appraisal.

Negative healthcare experiences may also alter what patients do before or outside subsequent encounters. Among adults with health concerns, negative experiences were associated with uncertainty-related anxiety and intentions to seek health information in online spaces; for participants with chronic conditions, mistrust was also involved in the statistical pathway [17]. Such evidence complicates the assumption that mistrust produces simple withdrawal. A patient may disengage from one source of care while becoming more active elsewhere, seeking second opinions, online communities, independent information, or alternative providers.

The proposed theory therefore conceptualizes anticipatory appraisal as the pre-encounter interpretation of what future care is likely to offer and what risks participation may entail. Remembered healthcare experiences are one input into this appraisal, alongside current symptoms, illness seriousness, prior trust, social information, access constraints, clinician reputation, digital information, family experience, and structural conditions. Anticipatory appraisal may concern expected respect, diagnostic credibility, pain recognition, clinician competence, waiting burden, discrimination, autonomy, treatment pressure, or whether disclosing information feels safe.

Crucially, memory and expectation must remain distinct. A remembered event refers to a reconstructed representation of prior care. An expectation concerns what is anticipated from future care. Anticipatory appraisal refers to the current interpretation of approaching that future encounter. These constructs may influence one another, but collapsing them would make longitudinal testing impossible.

The analytical distinctions needed to test this part of the theory are summarized in **Table 1**. The table is necessary because similar patient statements can reflect different psychological objects and therefore imply different measurement and clinical consequences.

Table 1. Distinguishing remembered care from expectations and anticipatory interpretations when evaluating future healthcare engagement

Patient-relevant analytical state	What is being represented	Principal interpretive process	Context that can alter its meaning	Competing explanation or uncertainty	Consequence for measurement and inference
Recalled prior encounter	A reconstructed representation of earlier care	Retrieval and present reinterpretation of an earlier event	Time elapsed, illness progression, later encounters, current emotional state	Current distress may alter recall without proving that the original encounter was experienced identically	Measure remembered experience separately from contemporaneous encounter ratings

Persistent emotionally salient episode	A prior episode that remains readily accessible and meaningful	Selective retention around threat, relief, validation, betrayal, or unresolved uncertainty	Severity, perceived preventability, dependence on future care, relational history	Vividness does not establish objective accuracy or causal importance	Assess salience, meaning, and attribution rather than treating vivid memory as a factual event log
Accumulated relational expectation	A standard about how care is normally or appropriately delivered	Generalization across repeated interactions	Continuity, previous reliability, clinician role, chronicity	Expectations may derive from social norms or non-healthcare experience as well as personal care history	Distinguish learned relational expectations from single-event recall
Encounter-specific expectation	A prediction about an imminent consultation or treatment episode	Comparison between anticipated and subsequently experienced care	Reason for visit, uncertainty, urgency, prior information, decision preference	High or low expectations may reflect illness severity or knowledge rather than prior trust	Measure expectations before the encounter if expectancy confirmation is being tested
Threat-oriented anticipatory appraisal	Current interpretation that upcoming care may involve harm, dismissal, loss of control, discrimination, or futility	Prospective appraisal of risk based on available cues	Stigma, prior discrimination, institutional reputation, symptoms, accessibility, social information	Anxiety and structural barriers can produce similar avoidance without being memory-driven	Do not infer mistrust or remembered harm from avoidance alone
Opportunity-oriented anticipatory appraisal	Current interpretation that future care may provide recognition, competence, relief, collaboration, or repair	Prospective appraisal of potential benefit and safety	Prior corrective encounters, continuity, trusted referral, transparent communication	Optimism may arise independently of prior healthcare memory	Separate positive expectation from established trust
Proposed memory-conditioned appraisal	A future-care interpretation partly shaped by retrieved prior healthcare experience	Interaction between remembered meaning and current contextual cues	Similarity between past and present setting, provider, institution, illness, or perceived power structure	Direct longitudinal evidence for the complete pathway remains limited	Test temporally with separate repeated measures rather than assuming mediation

Note: The final row presents a proposed synthesis rather than an empirically validated pathway. The matrix deliberately separates remembered experience, expectation, appraisal, and behavioural inference; none should be treated as interchangeable with trust or clinical outcome.

The same distinction motivates **Figure 1**, which represents anticipatory appraisal as a field of interacting prior-memory, current-context, and prospective-evaluation processes rather than as a simple sequence from “bad experience” to “low trust.”

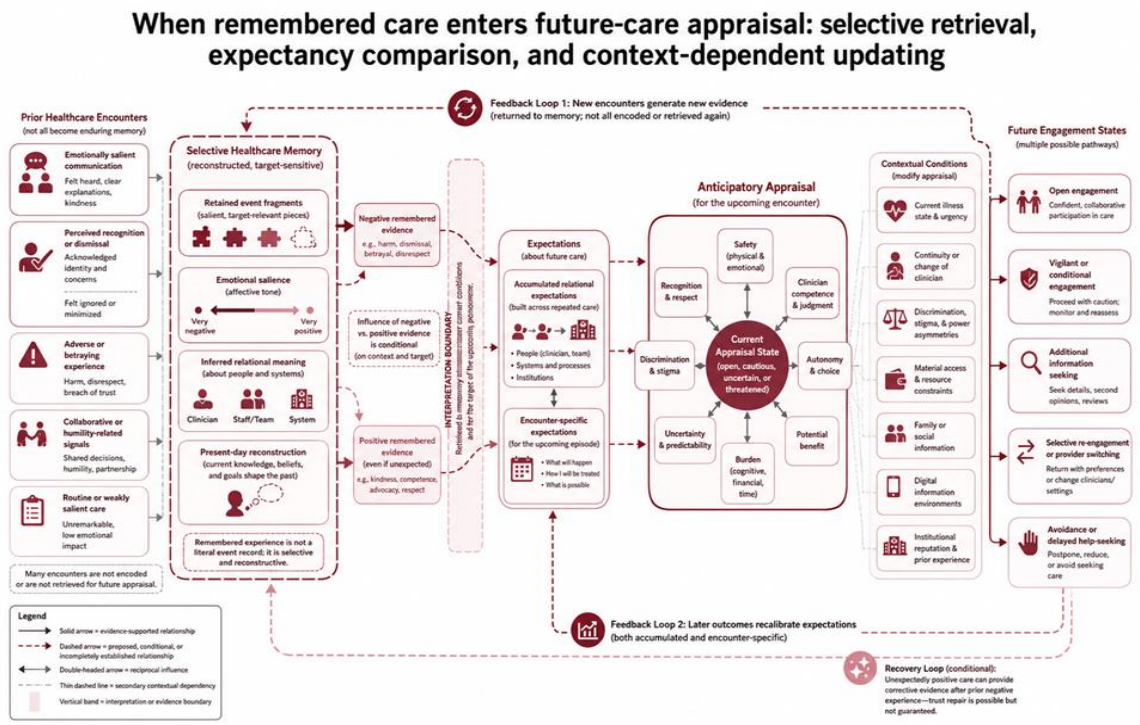

Figure 1. When remembered care enters future-care appraisal: selective retrieval, expectancy comparison, and context-dependent updating

Trust updating across encounters

Trust should be conceptualized as something that can change across encounters, but "updating" should not be interpreted as a mathematically established learning rule. Current trust reflects prior relationships, observed clinician behaviour, social and institutional experience, and broader expectations. Evidence from older US adults illustrates why encounter history must not be replaced by demographic inference: experiences of medical-care discrimination were strongly associated with lower general trust in doctors, and accounting for discrimination substantially altered apparent demographic differences in trust [18]. What appears superficially to be a stable group difference may therefore partly reflect accumulated differences in treatment.

New encounters can also provide evidence that reinforces or challenges prior expectations. In primary care, the ways clinicians seek and communicate information during consultations have been associated with patient trust [19]. Clinicians sometimes fear that admitting uncertainty or looking up information will undermine authority, yet patients may interpret visible information seeking through other lenses, including thoroughness, transparency, or collaboration. The meaning of the behaviour depends on the existing relationship and expectations attached to professional competence.

Trust updating can extend beyond interpersonal warmth or communication style to epistemic treatment: whose knowledge counts and whose account of illness is treated as credible. Research examining discrepancies between patient and professional knowledge in reproductive healthcare suggests that privileging population-level professional knowledge while dismissing lived experience can generate harm and mistrust that is directed not only toward a particular clinician but toward the broader medical community [20]. Such findings are especially relevant when a patient experiences the encounter not as an isolated interpersonal failure but as evidence of a repeated professional norm.

The proposed theory therefore defines a trust update as a change in the patient's expectation about the reliability, intentions, competence, fairness, or responsiveness of a specific healthcare target following interpreted evidence. The target must always be specified. An encounter may decrease trust in one clinician while leaving confidence in the wider institution intact; alternatively, it may be interpreted as evidence of a systematic problem. Prior trust can also affect interpretation of ambiguous events,

producing reciprocity between trust and experience appraisal.

This makes trust updating conditional rather than additive. Similar events can produce different changes depending on prior trust, perceived intent, severity, institutional response, and similarity between past and present care. The healthcare-memory model developed later therefore treats trust not as a single reservoir that simply rises and falls, but as an evolving set of target-specific expectations.

Avoidance, re-engagement, and help-seeking

Low trust does not map onto one behaviour. In cancer communication, patient-centred communication has been linked to information avoidance through pathways involving trust and health literacy [21]. The finding supports a relationship among communication, trust-related appraisal, and engagement with information, but it does not establish a universal causal sequence. Information avoidance may reflect emotional overload, prognosis-related fear, literacy barriers, or preferences unrelated to mistrust.

Other responses involve healthcare utilization itself. Among transgender and gender-independent individuals, direct and vicarious healthcare discrimination and erasure have been associated with mistrust and utilization-related behaviour [22]. This is theoretically important because patients need not personally experience every event that shapes expectations. Accounts from peers or communities may become part of the informational environment through which future care is judged. Such socially transmitted experience is not autobiographical memory and therefore must remain conceptually separate, but it can influence anticipatory appraisal.

Similarly, among Black women living with HIV, experienced stigma in healthcare has been associated with anticipated and internalized stigma and trust-related pathways relevant to ongoing care [23]. The evidence again argues against interpreting later engagement purely as an individual motivational choice. Anticipated stigma and mistrust may emerge within environments where prior treatment has provided credible reasons for vigilance.

The proposed model therefore separates at least several possible behavioural states. Avoidance refers to delaying or declining an encounter that might otherwise be sought. Conditional engagement describes participation accompanied by vigilance, limited disclosure, requests for verification, or restricted trust. Substitution involves turning toward another clinician, institution, information source, or online environment. Re-engagement describes renewed participation after distance or rupture. These states can look similar in utilization data while reflecting different psychological and structural processes.

Resource constraints complicate interpretation further. A missed appointment may reflect distrust, transport failure, inability to obtain leave from work, financial barriers, caregiving responsibilities, disability access problems, symptom improvement, or administrative friction. The theory therefore rejects behaviour as a direct proxy for remembered experience. Longitudinal research should measure both the patient's appraisal and the material opportunity to act.

Generalization from provider to institution

Perhaps the most consequential theoretical transition is from a remembered encounter with a person to a judgement about a larger healthcare entity. Such generalization should never be assumed. Evidence distinguishes trust targets, and institutional interpretation becomes more plausible when patients perceive that an experience reflects policies, norms, recurring practices, or organizational responses rather than one professional's behaviour.

Institutional betrayal research in inpatient psychiatry demonstrates the importance of this distinction. Experiences interpreted as institutional betrayal have been associated with lower trust and reduced willingness to engage with subsequent care after discharge [24-26]. Broader multilevel evidence also shows that trust is embedded within socioeconomic and national contexts and varies with perceived fairness, access, and structural conditions. These findings jointly support the proposition that relationships with care systems cannot be understood solely by aggregating individual clinician encounters.

The mechanism of transfer, however, remains theoretically unresolved. This article proposes an attribution–generalization boundary between encounter memory and institution-level trust. When a harmful experience is attributed primarily to one clinician, updating may remain local. When the experience is interpreted as reflecting organizational policy, professional culture, repeated administrative failure, discrimination, or a broader pattern encountered across settings, trust updating may extend to a team, institution, profession, or healthcare system.

Generalization can also occur without complete distrust. A patient may trust an individual physician while distrusting hospital billing practices, believe in a treatment while expecting administrative disrespect, or remain willing to seek urgent care while avoiding preventive services. Target-specific trust states can therefore coexist and even conflict.

Structural context establishes priors before any new encounter occurs. Income, access, corruption, healthcare-system characteristics, perceived fairness, and national context can influence baseline trust independently of a particular remembered event. Conversely, repeated institutional encounters can reinforce structural interpretations. The proposed theory therefore positions institutional trust at the intersection of memory, attribution, repeated experience, social information, and structural context rather than at the endpoint of a simple provider-to-system pathway.

This boundary is central to the article's later healthcare-memory feedback model. It prevents a common analytical error: inferring that dissatisfaction with a single encounter necessarily represents generalized medical mistrust. It also prevents the reverse error of treating institutional distrust as an idiosyncratic patient attitude when repeated organizational or discriminatory experiences may supply its evidentiary basis.

Corrective experiences and trust repair

If remembered healthcare experiences contribute to future appraisal, an important clinical question follows: can later encounters revise an established expectation of harm, dismissal, or unreliability? Evidence supports caution. A strong patient–physician alliance may protect trust following an adverse event without eliminating the adverse event's effect [13]. Likewise, relational qualities such as humility and patient-centred communication are associated with trust [10, 11], while transparent information seeking by clinicians can be interpreted positively rather than automatically weakening confidence [19]. These findings identify potentially corrective signals, but they do not establish a universal process of durable trust repair.

The proposed theory distinguishes a positive encounter from a corrective experience. A positive encounter is evaluated favourably in its own right. A corrective experience provides evidence that directly contradicts an expectation produced or reinforced by an earlier rupture. This distinction means that pleasant communication may have little reparative effect if the remembered problem concerned diagnostic disbelief, coercion, discrimination, confidentiality, administrative abandonment, or institutional refusal to acknowledge harm.

Repair should therefore exhibit diagnostic fit. The corrective evidence must address the meaning assigned to the rupture. When the remembered problem is not being believed, careful listening and explicit recognition of uncertainty may be more relevant than generic reassurance. When the rupture is interpreted as institutional betrayal, interpersonal kindness without organizational accountability may fail to alter institution-level expectations. Evidence from psychiatric care reinforces the importance of the institutional target because experiences attributed to institutions can remain associated with later trust and willingness to engage [24].

Time and repetition also matter. One favourable encounter may create uncertainty about a negative expectation without replacing it. Repeated discrepant experiences may be required before the patient regards the earlier event as exceptional rather than representative. Conversely, another harmful encounter that resembles the original rupture may reinforce the existing interpretation. Repair is therefore better conceptualized as an updating opportunity than as restoration to a previous trust level.

Table 2 converts this reasoning into propositions that can be tested prospectively. Its purpose is to distinguish different rupture states by the evidence that would count as genuinely corrective and by the observations that would falsify an assumed repair process.

Table 2. Testable conditions under which later healthcare encounters may revise rather than merely coexist with remembered trust ruptures

Remembered rupture state	Corrective evidence that would be meaningfully discrepant	Proposed updating process	Observation that would challenge a repair interpretation	Boundary or exception	Testable implication

Prior dismissal or disbelief	Explicit recognition of the patient's account, transparent reasoning, and responsiveness to unresolved concerns	Reassessment of whether future disclosure is likely to be taken seriously	Patient rates the encounter positively but remains unwilling to disclose important information	Persistent diagnostic uncertainty, repeated invalidation elsewhere, or unresolved power asymmetry	Repeated recognition should predict greater disclosure only when perceived credibility improves
Prior loss of control or coercion	Meaningful choice, understandable options, and participation matched to patient preference	Revision of expectations about autonomy during care	Participation is offered but experienced as abandonment or unwanted responsibility	Emergency care, limited feasible options, or preference for clinician-led decisions	Repair should depend on preference-concordant participation rather than participation quantity alone
Prior adverse event with relational rupture	Acknowledgement, explanation, relational continuity, and credible response to the harm	Differentiation of the adverse event from expectations about future relational reliability	Trust improves transiently but expected recurrence remains unchanged	Severe harm, disputed responsibility, or absence of accountability	Relational improvement should not be interpreted as full repair unless future expectations also change
Institution-attributed betrayal	Organizational acknowledgement, procedural change, accountability, or consistently different treatment across representatives	Reattribution from "systemic pattern" toward "bounded event"	One clinician is trusted while institution-level distrust remains stable	Continuing structural barriers, repeated administrative failure, or discriminatory policy	Institution-level repair should require evidence at the same organizational level as the attributed rupture
Repeated history of unreliable care	Multiple temporally separated encounters that contradict the established expectation	Gradual reduction in the perceived representativeness of earlier negative experiences	A single positive episode produces no durable change across later encounters	Fragmented continuity or continued exposure to conflicting providers and settings	Durable updating should depend more on consistency across time than on one unusually positive encounter
Proposed unresolved-memory state	Evidence addressing the original meaning of the rupture together with opportunity for reinterpretation	Reconstruction of what the prior event signifies for present and future care	Behaviour changes because access improves while remembered distrust remains unchanged	Structural constraint may dominate psychological updating	Longitudinal measures should separate memory reinterpretation, target-specific trust, and behavioural opportunity

Note: The final row and all stated updating processes are proposed theoretical distinctions. The table does not assign a repair score, threshold, probability, or expected effect size. A favourable experience should not be classified as trust repair unless evidence shows change in the expectation or trust target implicated by the earlier rupture.

A Healthcare-Memory Feedback Model

The evidence considered across preceding sections suggests a temporal architecture in which healthcare relationships develop through repeated interactions among remembered experience, expectations, current context, trust and behaviour. No selected study tests this complete architecture. The healthcare-memory feedback model developed here is therefore explicitly proposed rather than empirically validated.

The model begins with an encounter, but the encounter itself is not the enduring psychological unit. Some features become selectively available afterward as remembered experience. General research on emotional autobiographical memory supports the premise that emotionally meaningful memories can remain persistent while still being reconstructive [1]. Healthcare-specific evidence adds plausible contents of such memories, including memorable communication [9], adverse experience [13], institutional betrayal [14], discrimination [18], and epistemic dismissal [20].

At a later decision point, remembered experience interacts with accumulated expectations and current circumstances. Its influence need not be direct. A previous event may be retrieved strongly when the new situation resembles the original context but remain weakly relevant in a different setting. Current illness severity can also override distrust when care is unavoidable, while low urgency may permit avoidance, substitution, or prolonged information seeking. Consequently, observed utilization cannot reveal the underlying memory state by itself.

The next element is target-specific trust updating. Trust in an individual clinician, clinicians generally, a healthcare team, an institution, or the wider system should remain distinguishable [4]. The model therefore includes an attribution boundary at which patients interpret whether new evidence applies narrowly or broadly. Generalization becomes more plausible when experiences are understood as manifestations of organizational policy, professional culture, repeated discrimination, or system-level unfairness rather than isolated behaviour.

Behaviour then modifies the environment from which subsequent evidence can be obtained. Avoidance reduces opportunities for corrective encounters. Conditional engagement may preserve contact while restricting disclosure or cooperation. Provider switching can create access to discrepant evidence while simultaneously interrupting continuity. Online information seeking may alter expectations before the next clinical interaction. These pathways create feedback because engagement choices influence which future encounters become possible.

Structural conditions surround rather than sit downstream from this cycle. Socioeconomic and national differences in healthcare trust indicate that relationships with care are embedded within wider environments [25]. Perceived fairness and access conditions likewise coexist with psychological and system-level variation in trust [26]. The model therefore rejects an individual-memory explanation for patterns that may arise from transport, cost, discrimination, accessibility, service availability, coercion, organizational policy, or other constraints.

Figure 2 integrates these distinctions in a temporal state field. It is intended to show how memory can persist, be reopened, remain target-specific, generalize under particular attributions, or become subject to corrective updating across repeated care without implying deterministic transitions.

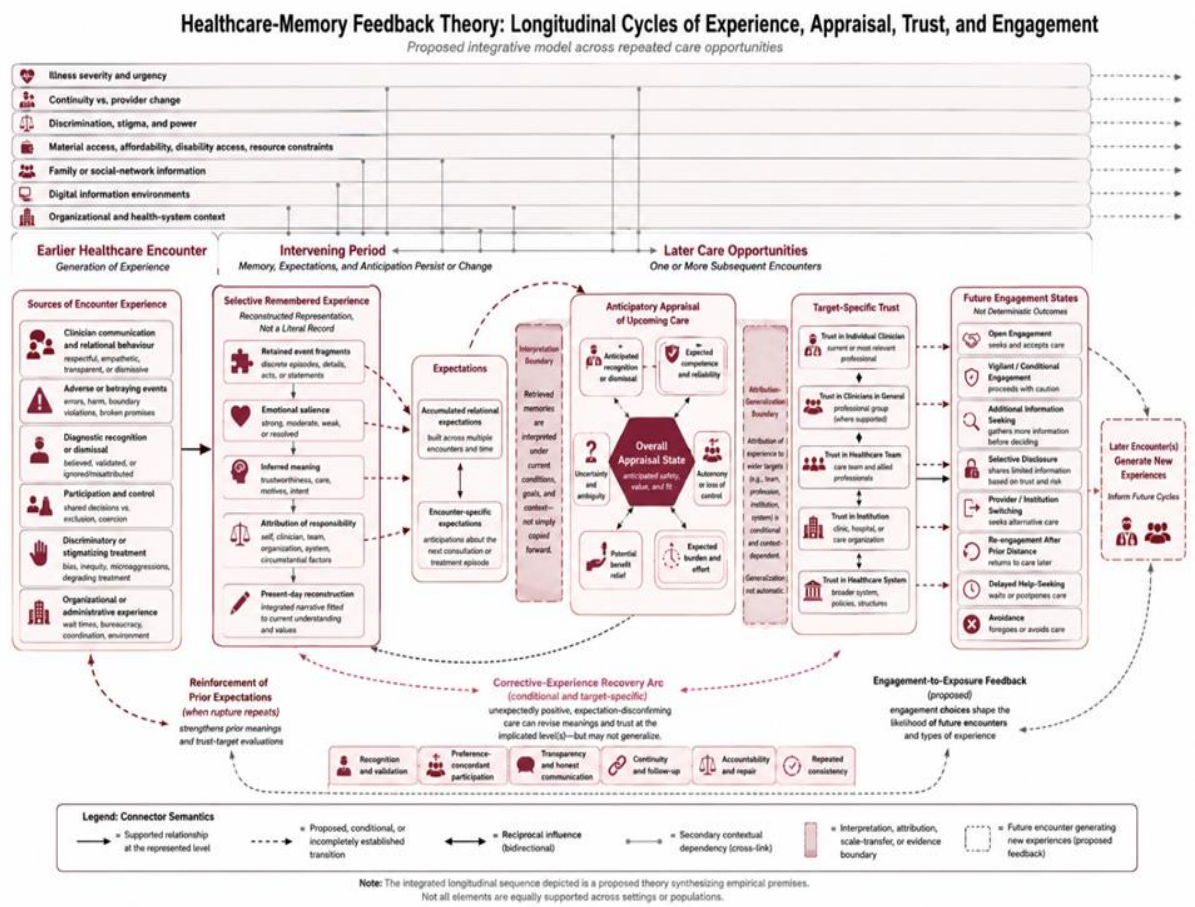

Figure 2. How encounter memories accumulate, generalize, and reopen across repeated healthcare relationships

Longitudinal and clinical predictions

The proposed model becomes scientifically useful only if its components can be separated and tested. Longitudinal studies should therefore measure the relevant states at different time points rather than infer an entire sequence from one survey. Patient-experienced continuity can be measured with dedicated instruments, although psychometric evaluation also demonstrates why measurement properties, local dependence, subgroup functioning, and context require scrutiny [27]. Target-specific trust should likewise remain separated across clinicians, teams, institutions, and broader healthcare referents [4].

Several bounded predictions follow. First, emotionally salient remembered experiences should predict later expectations more strongly when the subsequent encounter is perceived as similar to the original context. Second, the relationship between recalled negative experience and subsequent behaviour should weaken after adjustment for material access constraints if structural barriers rather than mistrust primarily explain observed disengagement. Third, institution-level trust should change more strongly when patients attribute an experience to organizational policy or recurring practice than when they attribute it to one clinician. The association between prior institutional betrayal and later expectations provides a rationale for testing this prospectively but does not establish the proposed temporal mechanism [14].

Fourth, corrective experiences should change the expectation implicated by the original rupture before they are classified as trust repair. A patient can report a satisfactory consultation while retaining the same expectation of institutional unreliability. Fifth, repeated corrective evidence should have different longitudinal consequences from one isolated positive encounter when distrust reflects repeated prior experience. Sixth, avoidance should reduce opportunities for corrective updating, but this effect should depend on whether alternative providers or information environments remain accessible.

These propositions require repeated measurement of remembered experience, expectation, target-specific trust, encounter appraisal, behaviour, access conditions, and organizational context. Designs should also distinguish prospective measurement from retrospective reconstruction and test whether model parameters differ across illness stages, cultural settings, marginalized populations, healthcare systems, and levels of continuity. Failure of these predictions would require revision rather than reinterpretation of every discordant observation as confirmation.

Results and Discussion

The proposed healthcare-memory perspective addresses a temporal gap between patient-experience research and research on trust, mistrust, communication, discrimination, continuity, and engagement. Its central contribution is not the claim that healthcare experiences matter; that premise is already well supported. The contribution is a proposed architecture specifying how remembered experience might remain psychologically available, enter anticipatory appraisal, update different trust targets, shape several forms of engagement, generalize conditionally beyond an individual provider, and become open to reinforcement or repair.

Several boundaries are essential. Trust should not be treated as a universal route to objectively improved health. Existing synthesis shows stronger and more consistent relationships with subjective outcomes and behaviours than with objective or observer-rated outcomes [2]. Measurement also constrains inference because medical-mistrust instruments differ in referent and construct content [3]. A study measuring distrust of healthcare institutions cannot therefore be substituted uncritically for one measuring confidence in a personal physician.

The model also rejects demographic essentialism. Experiences of discrimination provide a more defensible explanatory object than assumptions about mistrust based on group membership. In older adults, accounting for prior medical discrimination substantially altered apparent demographic associations with trust [18]. Similar reasoning applies to other populations in which stigma, exclusion, or erasure can shape healthcare expectations. The relevant theoretical inputs are experienced and socially transmitted conditions, not presumed psychological traits.

Structural conditions may sometimes dominate the proposed memory pathway. Cross-national research indicates that healthcare trust is associated with socioeconomic and system-level conditions [25]. Perceived fairness, access inequality, psychological distress, and national context can also coexist in reciprocal and difficult-to-separate relationships [26]. A theory centred entirely on individual memory would therefore misclassify failures of affordability, transportation, accessibility, service availability, or institutional fairness as patient-level reluctance.

Corrective experience represents another evidence gap. Relational studies identify plausible ingredients for maintaining or rebuilding confidence, but there is insufficient evidence to claim that a defined sequence reliably produces durable repair after different forms of rupture. Prospective studies should examine whether change occurs first in remembered meaning, anticipated treatment, target-specific trust, or observed behaviour and whether these changes persist when care settings or providers change.

The model also creates measurement requirements. Longitudinal work should avoid using current trust as a retrospective surrogate for prior experience or using utilization as a surrogate for trust. Continuity itself requires psychometrically defensible measurement [27]. Memory research introduces additional complexity because later reports can change as people reconstruct earlier events. Prospective encounter measures combined with later recall can help distinguish changes in remembered representation from features documented closer to the original event.

Clinical application should therefore remain modest. The framework does not authorize clinicians to diagnose avoidance as mistrust or to reinterpret patient disagreement as a memory distortion. Its practical value is to encourage temporal questions: whether current expectations were shaped by prior care, what target those expectations concern, whether a new encounter resembles the remembered context, what structural constraints limit behaviour, and what evidence would actually contradict an established expectation. These questions may reveal why technically adequate care is not always experienced as sufficient evidence of safety or reliability.

At the organizational level, the theory suggests that institutions cannot delegate every trust problem to individual communication. When remembered harm is attributed to policy, repeated administrative practice,

discrimination, or institutional response to adverse events, interpersonal warmth may be psychologically relevant but analytically mismatched to the attributed source. Future intervention research should therefore test whether repair is more likely when corrective action occurs at the same level at which responsibility is assigned.

The model ultimately treats healthcare relationships as historical without treating them as predetermined. Past care may influence future care, but memory is reconstructive, expectations are revisable, trust is target-specific, structural conditions modify opportunity, and patients can respond through several forms of engagement. These qualifications are not peripheral limitations; they are part of the theory itself.

Conclusion

Healthcare encounters can outlast their immediate clinical consequences because some become remembered experiences against which later care is interpreted. The proposed healthcare-memory theory distinguishes the original encounter from its remembered representation, remembered experience from future expectation, expectation from anticipatory appraisal, trust from behaviour, and provider-level trust from institutional or system-level judgement. It also treats negative–positive asymmetry, generalization, avoidance, re-engagement, and repair as conditional processes rather than universal rules.

The theory proposes that repeated relationships with healthcare evolve through feedback: encounters supply new evidence, selected experiences become psychologically available, expectations influence later interpretation, trust is updated toward particular targets, and behavioural choices alter subsequent exposure to care. Structural inequality, discrimination, access, illness state, social information, and institutional conditions can modify every part of this process and cannot be reduced to patient psychology.

The model is deliberately non-empirical and unvalidated as an integrated system. Its value therefore depends on whether its distinctions generate falsifiable longitudinal research. Future work should determine when encounter memories persist, when they generalize, when they lose relevance, which corrective experiences genuinely revise prior expectations, and how those processes interact with material opportunity and healthcare-system conditions. Understanding the memory of healthcare encounters may ultimately clarify why relationships with care systems are not recreated from zero at every visit but develop through histories that can constrain, reinforce, or sometimes reopen what patients believe future care will be.

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