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Communication Accommodation and Patient Trust in Healthcare and Chronic Illness Care

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Abstract

Communication accommodation in healthcare includes adapting explanations, listening, responding to concerns, and supporting patient participation. This quantitative study examined the association between perceived communication accommodation and patient trust among adults receiving chronic illness care. A cross-sectional survey design was used to assess whether patients who reported more responsive and understandable communication also reported greater confidence in their healthcare professionals. Adults aged 18 years or older with a diagnosed chronic condition who had received care from a healthcare professional were eligible. A structured questionnaire measured accommodation across clarity, responsiveness, listening, adaptation, emotional support, and opportunity to participate. Patient trust was assessed through perceived clinician competence, honesty, reliability, and concern for patient welfare. The analysis included descriptive statistics, scale reliability assessment, correlation, adjusted linear regression, and exploratory subgroup comparisons. Of 300 participants in the sample, 264 had complete data for the primary analysis. Mean accommodation was 3.92 (SD = 0.61) and mean trust was 3.88 (SD = 0.64) on five-point scales. Accommodation and trust were positively correlated ($r = .58$, $p < .001$). In the adjusted model, a one-point increase in accommodation was associated with a 0.48-point increase in trust (95% CI [0.37, 0.58], $p < .001$); the model explained 40% of trust-score variance ($R^2 = .40$). Subgroup estimates were positive across language, health literacy, chronic condition, treatment burden, visit frequency, and continuity categories, but interaction tests did not show statistically significant differences. The findings indicate that more favorable patient perceptions of communication accommodation were associated with greater trust. Because the design was cross-sectional, the association does not establish causality or show how trust changes across repeated consultations. These numerical findings are examples only, not results from an actual dataset, and should not be interpreted as empirical evidence until verified through data collection and analysis.

Keywords

Communication Accommodation; Patient Trust; Chronic Illness; Healthcare Communication; Quantitative Research.

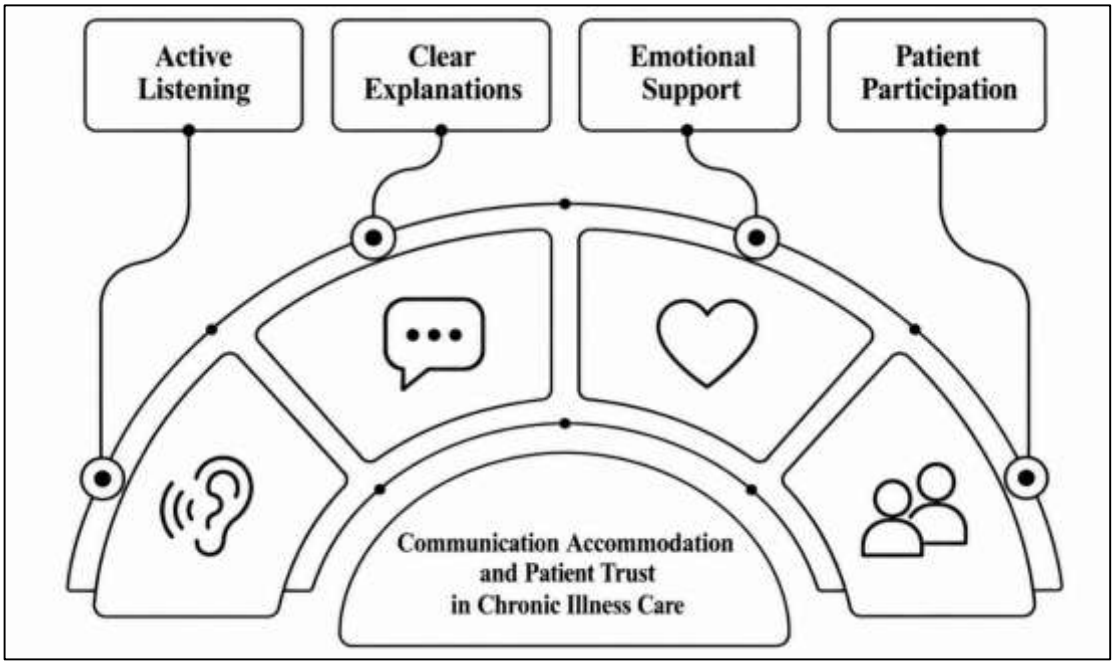
INTRODUCTION

Communication accommodation in healthcare refers to the ways in which patients and healthcare professionals adjust their verbal and nonverbal communication during an interaction (Greene & Samuel-Jakubos, 2021). These adjustments may include changing the pace or complexity of speech, explaining unfamiliar terms, checking understanding, inviting questions, responding to emotional cues, using an interpreter, and adapting conversation to a patient's language, knowledge, culture, or communication preferences. Communication accommodation theory describes how people adjust their communication to manage social distance, convey respect, and support interaction. In healthcare, accommodation can involve convergence, when a professional adapts communication to make it more accessible or responsive to a patient; maintenance, when the professional retains a usual communication style; or divergence, when communication emphasizes difference or distance. Accommodation is not simply the use of simpler words or a warmer tone. It also concerns how the professional organizes the interaction, shares control, acknowledges the patient's perspective, and provides opportunities for participation. Patient trust is the patient's willingness to rely on a healthcare professional, based on expectations of competence, honesty, reliability, respect, and concern for the patient's welfare (Rathert et al., 2017). Trust may relate to an individual clinician, a care team, a healthcare institution, or the medical profession, so its meaning depends partly on the object being assessed. Chronic illness care refers to ongoing care for conditions that require sustained monitoring, treatment decisions, self-management, and repeated interaction with health services. Examples include diabetes, cardiovascular disease, chronic respiratory conditions, arthritis, and other long-term illnesses. These definitions distinguish the study's central concepts: accommodation describes communication behavior as experienced by patients, while trust describes a relational judgment that may be shaped by that experience. Internationally, these concepts matter because chronic illness affects populations across countries and healthcare systems, while communication takes place across differences in language, culture, education, health literacy, resources, and expectations (Drossman & Ruddy, 2020). A quantitative study can examine whether patients who report more accommodating communication also report greater trust, while accounting for relevant patient and care characteristics. In this framework, communication is measured as a set of observable or perceived interaction practices, trust as a patient-reported relational outcome, and chronic illness care as the continuing clinical context in which those practices and judgments develop.

Chronic illness care differs from a single episode of acute treatment because patients and professionals often meet repeatedly over months or years. Each encounter may involve reviewing symptoms, interpreting test results, discussing medication, adjusting treatment, addressing side effects, and setting priorities for daily self-management. Patients contribute knowledge acquired through living with the condition, including changes in symptoms, treatment burdens, family responsibilities, and the feasibility of following recommendations (Kwame & Petrucka, 2021). Professionals contribute clinical knowledge and access to diagnostic and treatment resources. Communication connects these forms of knowledge and helps establish how decisions are made. When a patient can describe concerns and receive explanations that are relevant to those concerns, the encounter can support a shared understanding of the illness and its management. When communication is rushed, highly technical, dismissive, or difficult to follow, patients may have fewer opportunities to clarify uncertainty or disclose difficulties. These interaction patterns are especially consequential in conditions where treatment depends on ongoing patient participation, such as medication use, monitoring, diet, physical activity, symptom reporting, and follow-up attendance. Chronic illness also involves uncertainty: symptoms may fluctuate, treatment effects may take time, and recommended actions can create competing demands in everyday life (Lim et al., 2017). Professionals therefore need to communicate not only clinical information but also acknowledge uncertainty, listen to patient priorities, and check what the patient has understood. Communication accommodation provides a framework for examining how providers respond to differences in patients' needs and circumstances across these recurring encounters. Trust, in turn, may affect whether patients feel able to ask questions, report nonadherence, share sensitive information, or rely on clinical advice. These processes are relevant across healthcare settings, from primary care and specialist clinics to hospitals, community services, and telehealth. They may also vary by illness type, severity, duration, treatment complexity, and

frequency of contact (Ordway et al., 2021). In chronic care, the relationship is therefore not reducible to the information exchanged during one visit. It is shaped through repeated experiences of being heard, receiving understandable explanations, having concerns taken seriously, and seeing whether communication remains responsive as care needs change. This study focuses on communication accommodation and patient trust within that continuing context.

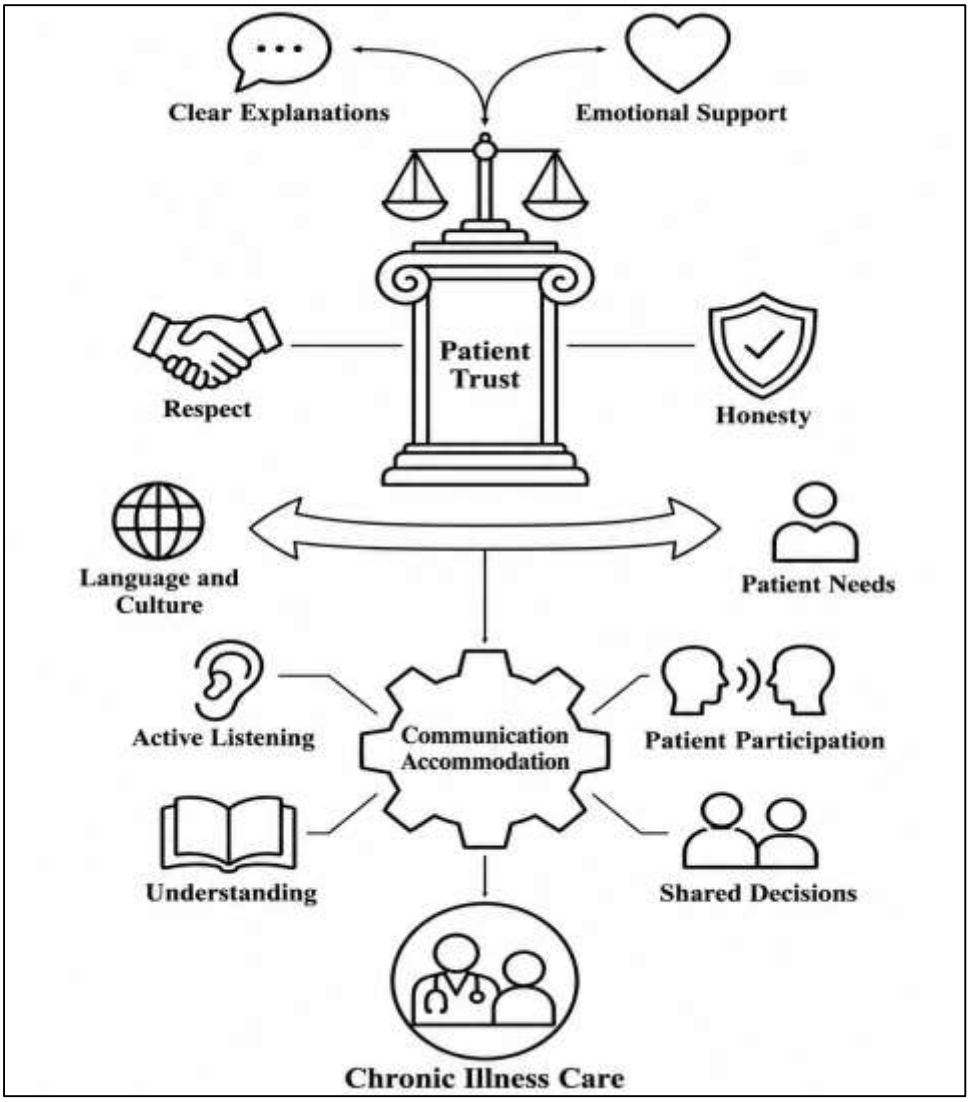
Figure 1: Communication Accommodation and Patient Trust



Communication accommodation theory offers a structured way to examine how interactional choices may influence patients' experiences of care. Approximation concerns how speakers adjust features such as vocabulary, speech rate, tone, or language choice (Aditya & Ahmed, 2022; Asheke & Maksudul, 2022; Asheke & Badrul, 2022). Interpretability concerns efforts to make information understandable, including explaining terminology, organizing information, repeating key points, and checking comprehension. Discourse management concerns how participants share conversational space, including whether patients can introduce concerns, ask questions, and influence the agenda (Kelly et al., 2019). Interpersonal control concerns how authority and decision-making are distributed, including whether professionals invite participation or retain control over the interaction. Emotional expression concerns communication that recognizes, responds to, or supports patients' emotional needs (Khalid & Sadmeen, 2022; Akter & Sumaiya, 2022; Mashiat & Morshedul, 2022). These dimensions are useful because accommodation can be present in one aspect of an encounter and absent in another. A professional may provide a clear explanation but give little space for patient questions; another may invite participation but fail to adapt technical language (Imran & Jannatul, 2022; Maksudul & Islam, 2022; Morshedul & Islam, 2022). Research applying accommodation concepts to healthcare has examined provider communication with patients, pharmacist counselling, musculoskeletal care, speaking-up interactions, and care in culturally or linguistically diverse settings. Studies have also reported that accommodation may be interpreted differently depending on patient age, language proficiency, disability, illness experience, and the professional's assumptions about what the patient can understand (Gavurova et al., 2021). Overaccommodation, such as unnecessarily simplified or patronizing speech, can undermine respect and patient autonomy, while insufficient adjustment can leave information inaccessible. The goal is therefore not maximal adjustment in every situation, but communication that is appropriate to the patient's expressed needs and preferences (Islam & Md, 2023; Feroz & Pervaz, 2022; Feroz & Shabbir, 2022). This distinction is important in quantitative research because broad measures of "good communication" may not capture the particular behaviors that

constitute accommodation. Measures that assess clarity, responsiveness, listening, emotional support, and participation can help distinguish these dimensions and test how they relate to trust (Hajat & Stein, 2018). Empirical work on healthcare accommodation and related communication strategies has used interview, observational, experimental, and survey approaches, although the number of studies directly connecting accommodation theory with patient trust in chronic illness care remains comparatively limited (Mostari & Kynatun, 2023; Mashfiqur & Jamil, 2023; Mashiat & Binte, 2023). Empirical applications have included communication accommodation in musculoskeletal care, medication counselling, and maternity services in Bangladesh.

Figure 2: Healthcare Communication and Patient Trust



Patient trust is a multidimensional judgment that reflects whether a patient considers a professional or healthcare system dependable and worthy of reliance. Its components commonly include perceived technical competence, honesty, confidentiality, fidelity to the patient's interests, and interpersonal respect (Shahid, 2023; Islam & Ahmed, 2023; Sadia & Mosheur, 2023). Trust can be directed toward a particular clinician, a clinical team, an institution, or the medical profession as a whole (Nolan-Isles et al., 2021). These targets should not be treated as interchangeable: a patient may trust a familiar clinician while expressing reservations about the organization, or may trust medical expertise generally while feeling unheard in a particular encounter (Sadmeen & Khalid, 2023). Communication is one of the main ways patients encounter professional competence and intentions. Clear explanations can help patients assess whether information is understandable and consistent; attentive listening can signal that their

experiences are being considered; transparent discussion of risks and uncertainty can support perceptions of honesty; and shared decision-making can demonstrate respect for patient preferences. Trust is also influenced by factors beyond communication, including prior experiences, continuity of care, disease severity, treatment outcomes, access barriers, discrimination, and institutional reputation. For that reason, an observed association between communication and trust does not by itself establish that communication caused trust (Hajat & Stein, 2018). In chronic illness care, trust may be particularly relevant because patients repeatedly depend on professionals for interpretation, advice, and coordination while managing substantial aspects of care outside the clinic. Patients who feel respected and understood may be more willing to disclose treatment difficulties or uncertainty. Conversely, a communication experience perceived as dismissive or inaccessible may affect confidence in the clinician and willingness to participate in decisions. Trust measures in empirical studies have included confidence in the physician, trust in the medical profession, and assessments of clinician reliability and honesty (Prince-Paul & Kelley, 2017). A quantitative study should state which target and dimensions are being measured, and should distinguish trust from related constructs such as satisfaction, perceived communication quality, and treatment adherence. This distinction supports more precise analysis of whether specific accommodation behaviors are associated with patient trust, rather than assuming that any favorable care rating represents the same relational outcome. In this study, patient trust is understood as a patient-reported assessment of confidence and reliance in the healthcare professional involved in chronic illness care.

Empirical research across health conditions has repeatedly examined associations among provider communication, patient trust, treatment participation, and adherence. In chronic illness populations, communication ratings have been linked with trust and patient-reported outcomes, although effect sizes and patterns may differ by illness, setting, and measurement approach (Brooks et al., 2019). A study of adults with sickle cell disease found that better ratings of prior provider communication were associated with higher trust in the medical profession. Research among adults with serious illness has assessed communication quality and physician trust alongside patient characteristics, illustrating that these relationships may vary across socioeconomic and demographic groups. In rheumatoid arthritis, lower physician trust and language or health-literacy barriers were associated with less shared decision-making. Diabetes research has examined communication in relation to medication adherence, self-management, and treatment participation; findings indicate that the content and quality of communication can matter alongside clinical and demographic factors. International research on type 2 diabetes diagnosis has reported patient-rated communication patterns across 26 countries, with collaborative and encouraging communication associated with more favorable ratings of the diagnostic conversation (Mason et al., 2019). These findings are consistent with the view that communication may connect to trust through proximal experiences such as understanding, confidence, agreement, and perceived involvement. Yet the evidence base includes different populations and outcome definitions, ranging from trust in one clinician to trust in the profession, and from self-reported adherence to objective medication measures. Quantitative studies have used cross-sectional surveys, cohort data, recorded consultations, experiments, and mixed-method designs, each providing a different level of evidence about the association and its direction. Research on patient-centered communication and adherence has also shown that effects may operate through multiple intermediate processes rather than through a single direct pathway. The established body of research includes studies of communication and trust, communication and adherence, patient-centered interaction, shared decision-making, and illness-specific communication in diabetes, rheumatoid arthritis, sickle cell disease, and serious illness (Famiyeh, 2017).

The relationship between accommodation and trust must be considered in light of international variation in language, culture, healthcare organization, and access to care. Patients may differ in their preferred language, familiarity with clinical terminology, expectations about professional authority, willingness to question clinicians, and experience of discrimination. Providers may work under differing time pressures, staffing levels, interpreter availability, and consultation practices (Harrison et al., 2019). These conditions can affect both the communication behaviors patients encounter and how they interpret them. For example, a direct recommendation may be experienced as reassuring in one context and overly controlling in another; a quieter communication style may reflect respect in one

setting but appear disengaged in another. Studies in Bangladesh have used communication accommodation theory to examine how providers perceive and respond to patient needs in maternity care, identifying the role of facility constraints and interactional strategies. Cross-national research on diabetes communication has shown the feasibility of examining patient-reported communication across multiple countries, while research on language proficiency and health literacy has highlighted the relevance of linguistic access to shared decision-making. Digital consultations introduce additional conditions, including text-based interaction, limited nonverbal cues, and differences in access to technology (Harrison et al., 2019). For quantitative research, these contextual differences raise measurement questions: whether accommodation and trust scales retain comparable meaning across groups, whether translation preserves item meaning, and whether observed differences reflect communication behavior or different response patterns. Studies should define the care setting and patient population, identify the professional or institution toward which trust is assessed, and specify how accommodation is operationalized. Relevant covariates may include age, gender, education, health literacy, language proficiency, illness type and duration, treatment burden, visit frequency, continuity of care, and care setting (Austad et al., 2017). Researchers may also need to consider clustering when patients are nested within clinicians or facilities, and to distinguish statistical association from causal interpretation in cross-sectional designs. International and condition-specific evidence provides a basis for studying these factors, but direct quantitative evidence that measures accommodation and trust together among people receiving chronic illness care remains less developed than adjacent research on communication quality, trust, adherence, and shared decision-making.

This quantitative study examines the relationship between communication accommodation and patient trust in healthcare communication among people receiving chronic illness care. Communication accommodation is considered through patient perceptions of whether healthcare professionals make information understandable, respond to questions, listen to concerns, adapt communication to the patient's needs, and support participation in discussion. Patient trust is considered as confidence in the healthcare professional's competence, honesty, reliability, and concern for the patient's interests (Yu et al., 2017). The focus on chronic illness recognizes that these perceptions develop within repeated interactions involving monitoring, treatment decisions, and self-management. The central research problem is whether patients who report more accommodating communication also report higher trust, and whether the strength of this relationship varies across relevant patient and care characteristics. A quantitative approach permits the constructs to be measured systematically and their association to be estimated using statistical analysis. The study can describe levels of perceived accommodation and trust, assess the association between the two variables, and examine whether demographic, linguistic, clinical, or service-related factors are related to the observed relationship. The conceptual basis draws on communication accommodation theory and patient-centered communication research while treating trust as a distinct relational outcome (Etherington et al., 2019). This distinction allows the analysis to focus on communication behaviors rather than combining them with satisfaction, adherence, or general perceptions of care. The study's population, setting, instruments, and statistical procedures should specify how patients are recruited, which chronic conditions are represented, how communication accommodation and trust are measured, and how potential confounding variables are handled. The resulting analysis addresses a focused empirical question at the intersection of communication theory and chronic illness care: how patient-perceived adjustment in healthcare communication relates to patient trust (Colver et al., 2018).

The objective of this quantitative study is to examine the relationship between communication accommodation and patient trust among individuals receiving care for chronic illnesses. Specifically, the study aims to assess how patients' perceptions of healthcare professionals' communication practices—including the clarity of explanations, adaptation of language to patients' needs, responsiveness to questions, attentive listening, recognition of patient concerns, emotional support, and encouragement of participation—are associated with patients' confidence in their healthcare professionals. Patient trust will be considered in relation to perceived professional competence, honesty, reliability, respect, and concern for the patient's welfare. The study will also describe the reported levels of communication accommodation and patient trust within the selected chronic illness care population and determine whether these measures vary according to relevant patient and care

characteristics. Such characteristics may include age, gender, education, health literacy, preferred language, type and duration of chronic illness, treatment burden, frequency of healthcare visits, and continuity of care. A further objective is to estimate whether communication accommodation remains associated with patient trust after accounting for these factors. By examining the concepts as distinct but potentially related variables, the study will avoid treating general satisfaction or treatment adherence as substitutes for trust and will focus on patients' perceptions of how communication is adapted during ongoing care. The quantitative design will support systematic measurement, comparison, and statistical assessment of the proposed relationship within the specified study setting. Findings will clarify the extent to which patients who perceive more responsive and understandable communication also report greater trust in their healthcare professionals. The study will thereby provide an empirical assessment of communication accommodation as a relational factor in chronic illness care and establish a basis for interpreting how communication experiences and trust are associated across the participants included in the analysis.

LITERATURE REVIEW

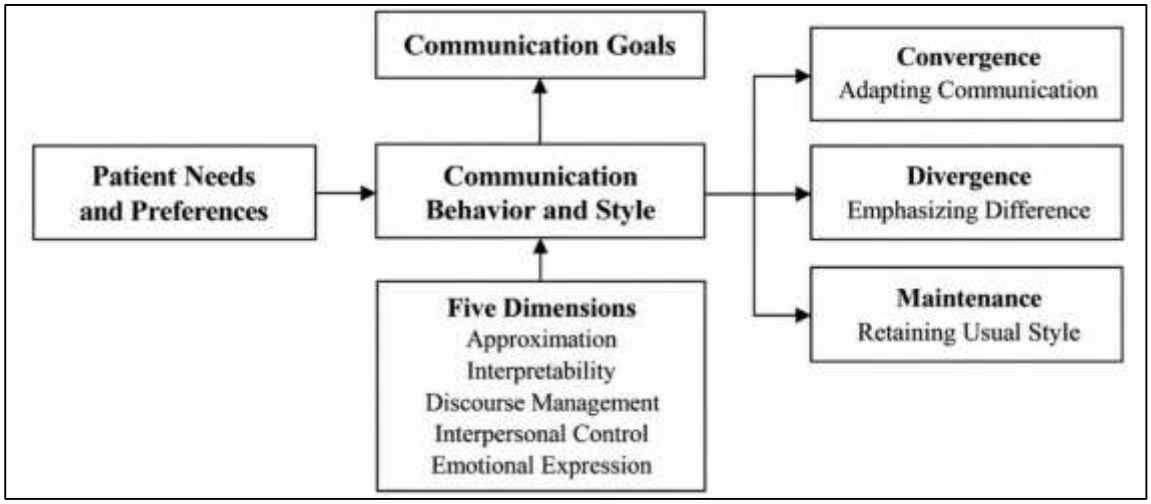
This section reviews the concepts, theories, and empirical evidence relevant to the quantitative examination of communication accommodation and patient trust in chronic illness care. It first defines the study's central constructs and distinguishes accommodation from related communication concepts, such as patient-centered communication, communication quality, satisfaction, and shared decision-making. It then considers how trust is conceptualized and measured in healthcare, and how communication behaviors may be associated with patients' trust in professionals. The review also addresses the distinctive demands of chronic illness care, including repeated consultations, self-management, treatment decisions, and continuity of relationships. Attention is given to measurement, study designs, relevant patient and care characteristics, cross-cultural considerations, and limitations in existing evidence. The final sections identify the empirical gap and present the quantitative framework guiding the study.

Communication Accommodation in Healthcare: Definitions and Quantitative Dimensions

Communication accommodation refers to the ways speakers adjust verbal and nonverbal communication in response to another person's needs, preferences, or circumstances. In healthcare encounters, these adjustments may include changing vocabulary, speech pace, tone, language choice, or nonverbal behavior; explaining clinical information in accessible terms; inviting patients to raise concerns; and responding to emotional cues (Aditya & Ahmed, 2022; Donetto et al., 2017). Accommodation theory commonly distinguishes convergence, maintenance, and divergence. Convergence occurs when a professional adapts aspects of communication to make the interaction more accessible or to signal attention and affiliation. For example, a clinician might replace unfamiliar terminology with everyday language, slow the pace of an explanation when a patient requests it, or pause to check understanding. Maintenance occurs when a speaker keeps a usual communication style rather than adjusting it substantially. This may be appropriate when the style already fits the patient's needs, but it may leave barriers unaddressed when it does not. Divergence occurs when communication emphasizes difference or distance, whether through deliberate contrast, failure to respond to a patient's communication needs, or interaction that reinforces unequal roles (Asheke & Md Maksudul, 2022; James et al., 2017).

These patterns are not automatically helpful or harmful in every encounter: their meaning depends on the patient, the task, and the clinical context. Healthcare research has applied accommodation theory to general consultations, medication counselling, musculoskeletal care, and communication across language and cultural differences. Across these settings, studies have described adjustment as a set of interactional choices rather than a single behavior. This distinction is relevant to chronic illness care, where consultations may repeatedly address treatment, symptoms, and self-management, and where patients may have different communication preferences over time (Asheke & Mohammad Badrul, 2022; Biringer et al., 2017). Accommodation can therefore be examined as a multidimensional construct that captures how professionals respond to patients during care.

Figure 3: Communication Accommodation in Healthcare Encounters



Five communication dimensions are commonly used to describe accommodation in healthcare. Approximation concerns adjustment of language, speech rate, tone, or terminology to suit the interaction. Interpretability concerns how clearly information is explained, including the use of plain language, repetition where useful, organized explanations, and checks for understanding (Kazi Mohammad Khalid & Sumaiya Sadmeen, 2022; Pijls et al., 2017). Discourse management concerns how the conversation is organized: whether patients can ask questions, introduce concerns, influence the topic, and receive enough time to respond. Interpersonal control concerns how influence and conversational authority are shared, including whether the professional invites patient input or directs the exchange without participation. Emotional expression concerns recognition of and response to patients' emotional needs, such as providing reassurance or acknowledging worry. The dimensions can overlap in practice. For instance, inviting questions may support discourse management while also sharing control, and explaining information in response to a patient's concern may involve both interpretability and emotional expression (Mansura Akter & Sumaiya, 2022; Woodgate et al., 2017). Still, treating these dimensions separately can help researchers identify which aspects of communication are associated with patients' evaluations. Studies of pharmacist–patient counselling have used these categories to analyze recorded consultations and reported examples of both adjustment and non-adjustment, including whether professionals used understandable language and made space for patients in agenda-setting. Research on health communication in language-concordant and language-discordant encounters has likewise used the dimensions to classify communication behavior. Such work demonstrates how theoretical concepts can be translated into categories for observation or measurement (Mashiat & Md. Morshedul, 2022; Shin et al., 2021). For a quantitative study, each dimension should be defined in terms of observable or reportable behaviors, with items that are distinct enough to support reliable scoring. The selected dimensions should also fit the study's setting and its intended unit of analysis, such as communication with a usual clinician or during a specific consultation.

Communication accommodation can be studied from more than one perspective. Researchers may examine a provider's observable behavior, a patient's perception of the provider's behavior, or the provider's own report of their communication choices. These perspectives are related, but they are not interchangeable. A clinician may intend to simplify an explanation, while the patient may experience it as unclear, rushed, or patronizing. Conversely, a patient may feel understood even when an outside observer identifies few visible adjustments, because the professional's established style already matches the patient's preferences (Mao et al., 2020; Md Imran & Jannatul, 2022). Research comparing patient and provider perspectives has found that their descriptions of effective communication can emphasize different aspects of the interaction. Studies using recorded consultations and structured coding can document behavior such as turn-taking, clarification, interruption, and emotional response. Questionnaires and encounter ratings can capture how patients experienced those behaviors and

whether communication met their expectations (James et al., 2017; Md Maksudul & Md Tazul Islam, 2022). Interviews can identify behaviors patients consider meaningful, while validated scales can support consistent comparisons across participants. For a study focused on perceived accommodation, patient-reported measures are relevant because they represent the patient's evaluation of whether communication was responsive and understandable. However, measurement should specify the recall period and referent: a patient might rate the most recent encounter, their usual clinician, or communication over a defined period of care. A measure referring vaguely to "healthcare professionals" may prompt different participants to think of different clinicians or visits. Studies of patient perceptions, pharmacist–patient interaction, and consultation satisfaction provide examples of combining patient reports with observations or encounter data. In quantitative work, clearly distinguishing perceived accommodation from satisfaction, trust, and general communication quality also helps preserve construct validity and supports interpretation of the resulting scores (Sirili et al., 2018).

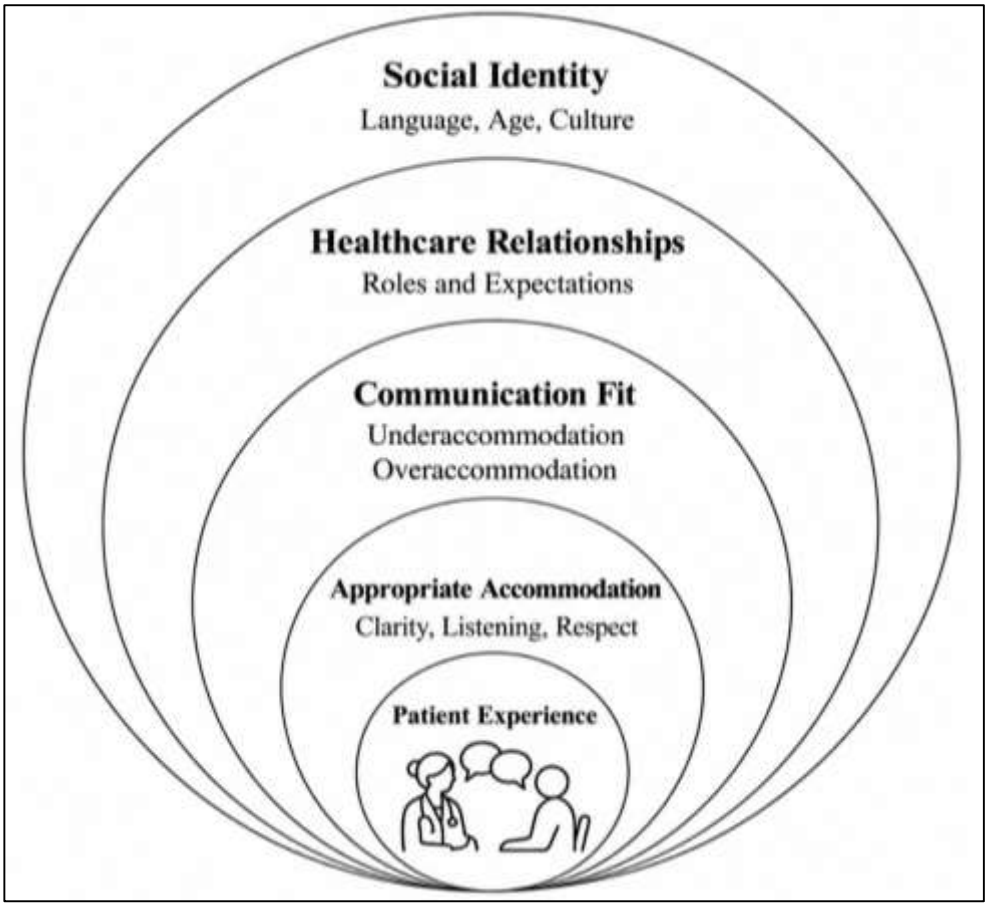
Communication accommodation has been examined through questionnaires, patient encounter ratings, coded recordings, and structured observation. A questionnaire can ask patients how often a clinician explained terms, listened without interruption, adapted information, invited questions, or responded to concerns. Encounter ratings can focus those questions on a particular visit, which may reduce ambiguity about the interaction being assessed. Recorded consultations can be transcribed or coded using a defined framework to identify specific verbal and nonverbal behaviors, while structured observation uses a standardized checklist during or after the encounter. Each approach captures a different aspect of communication (Valaitis et al., 2020). Patient reports reflect experienced accommodation; recordings and observation capture behaviors available to an observer; provider reports capture the professional's account of their own choices. The methods may produce different findings because intention, visible behavior, and patient interpretation do not always align. Selecting the unit of analysis is therefore central. A "most recent encounter" measure captures a specific interaction but may be affected by an unusual visit. A "usual clinician" measure reflects an ongoing relationship but depends on patients having an identifiable regular provider. A period-based measure can summarize repeated interactions but places greater demands on recall. Research has also examined accommodation in discrete encounters such as medication counselling and emergency consultations, while other studies have explored communication across continuing or condition-specific care. For a quantitative study of chronic illness care, the chosen unit should match the research question and survey wording (Md. Morshedul & Aminul Islam, 2022; Sirili et al., 2018). The instrument should identify the professional or encounter being rated, use response options consistently, and be pilot-tested for clarity. Researchers should report scoring procedures and examine internal consistency and construct validity in the study population. If measures are translated, the translation process should preserve the intended meaning of each communication behavior. These decisions make it possible to interpret accommodation scores as reflecting a defined perspective and period, rather than an unspecified impression of healthcare communication (Dawson et al., 2021).

Communication Accommodation Theory and Patient–Provider Interaction

Communication Accommodation Theory explains how people adjust their communication during interaction and how those adjustments can reflect social identity, relationship goals, and perceived differences in status or group membership. In healthcare, these differences may involve language, age, culture, health knowledge, disability, professional authority, or familiarity with medical systems (Berger et al., 2020; Syed Feroz & Md Mahamud Pervaz, 2022). Communication can shift when a clinician adapts terminology, pace, tone, nonverbal cues, or conversational structure in response to a patient. Research applying accommodation theory to healthcare has examined interactions between doctors and patients, health professionals and older adults, pharmacists and patients, and providers and people whose language or cultural background differs from their own. These studies show that accommodation is not limited to matching speech patterns (Andreassen et al., 2018). It can also involve acknowledging a patient's perspective, allowing time to explain concerns, checking whether information is understood, and recognizing the patient's preferred role in decisions. Social identity is relevant because patients may interpret communication through prior experiences with healthcare institutions and professional authority. A clinician's attempt to adjust may be understood as

attentiveness and respect when it reflects a patient's expressed needs. The same behavior may be interpreted differently when it rests on assumptions about a person's age, education, language ability, or capacity to participate. Research on communication in musculoskeletal care has illustrated how clinicians and patients may approach the same illness with different priorities, while studies in pharmacy counselling have documented the importance of attending to patients' medication concerns and conversational needs (Andreassen et al., 2018; Syed Feroz & Shabbir, 2022). Together, this literature positions accommodation as a relational process shaped by both the communication behavior and the identities and expectations brought into the encounter. Accommodation may support comprehension when healthcare professionals make explanations accessible, organize information clearly, clarify unfamiliar terminology, and check whether patients have understood. It may also reduce interactional distance by making space for patients to introduce concerns, ask questions, and describe their experiences in their own terms (Law et al., 2019).

Figure 4: Communication Accommodation Shapes Patient Experience



In healthcare studies, these behaviors have appeared in clinical consultations, medication counselling, maternity care, and interactions involving patients with different language backgrounds. Recorded consultations and patient interviews have highlighted the role of clarification, attentive listening, turn-taking, and responsiveness in making exchanges more effective from the perspectives of both patients and professionals. Research on pharmacist counselling has shown how professionals combine information with reassurance and rationale, while studies of patient perceptions have linked their assessment of communication with their willingness to participate in the conversation. Respect is communicated not only through friendliness but also through whether the professional treats the patient as a credible source of information about their own life and illness. Accommodation can therefore involve adapting communication while preserving the patient's autonomy (Aminul Islam & Md, 2023; Harris & Panozzo, 2019). It may include explaining options without overwhelming the

patient, giving the patient time to respond, and acknowledging uncertainty without dismissing concerns. In encounters involving language differences, communication adjustments may help bridge gaps in comprehension, although a shared language or simplified explanation alone does not guarantee mutual understanding (Cao et al., 2017). Research in emergency and maternal care has also shown that organizational conditions can shape the opportunities professionals have to accommodate patients. These findings indicate that comprehension, participation, and respect are related but distinct features of the interaction, each of which can be studied as part of patient–provider communication.

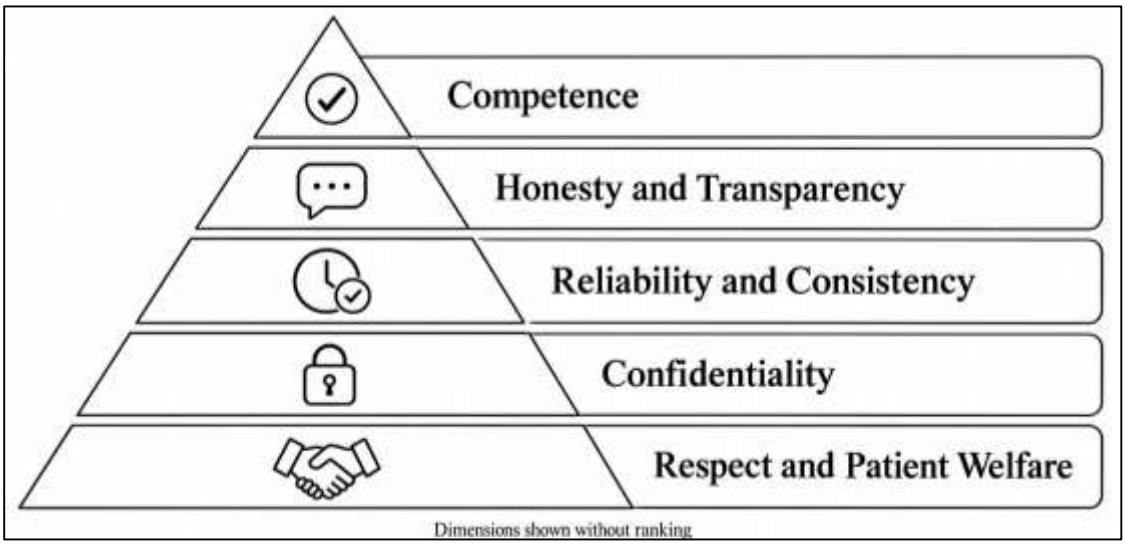
Underaccommodation occurs when communication does not respond adequately to a patient's needs or stated preferences. In healthcare, this may involve unexplained medical terminology, rapid or overly dense explanations, failure to check understanding, interruption, limited opportunity to ask questions, or lack of attention to emotional concerns. Studies of recorded clinical and pharmacy interactions have documented examples in which professionals did not include patients in agenda-setting or used terms patients might not understand (Bajgain et al., 2020; Maishar Mostari & Kynatun, 2023). Patient accounts of unsatisfactory encounters have similarly described feeling unheard or having difficulty contributing relevant information. Such patterns can make it harder for patients to clarify treatment instructions, communicate uncertainty, or participate in decisions. Overaccommodation presents a different concern. It occurs when a professional adjusts communication in an excessive, inappropriate, or assumption-driven way. Examples include speaking in a patronizing manner, simplifying information unnecessarily, using exaggeratedly slow speech, or assuming that a patient's age, disability, language background, or education determines their level of understanding. Research on older adults and linguistically diverse patients has emphasized that communication adjustments can be experienced as respectful when they fit the patient's needs, but as condescending when they rely on stereotypes (Boon-itt, 2019; Mashfiqur & Md Jamil, 2023). The distinction between appropriate accommodation and overaccommodation depends partly on the patient's interpretation and the professional's responsiveness to feedback. A useful interaction allows patients to indicate whether they need clarification, more detail, a different language, or a different pace (Lee & Kim, 2017; Mashiat & Taru Binte, 2023). The literature therefore treats accommodation as a matter of fit rather than the quantity of adjustment. Both insufficient and excessive adjustment may interfere with communication when they restrict patients' ability to understand, express preferences, or retain control over their participation.

Patient Trust: Constructs, Dimensions, and Measurement

Patient trust refers to a patient's confidence in a healthcare professional or healthcare organization and willingness to rely on that person or organization in matters related to care. Healthcare trust studies have examined trust in individual physicians, primary care providers, specialists, care teams, hospitals, health systems, and the medical profession. These targets represent distinct relationships and should not be combined without a clear rationale (Coats et al., 2018). Trust in an individual clinician can develop through repeated consultations and may reflect the patient's experience of that clinician's knowledge, honesty, and responsiveness. Trust in a care team may also depend on coordination, information-sharing, and consistency among professionals. Trust in an institution or health system concerns wider expectations about service quality, privacy, fairness, and organizational reliability. Trust in the medical profession refers to broader beliefs about clinicians as a group and may be influenced by personal experience, community views, and public confidence in healthcare. Quantitative studies of patients with chronic and serious illnesses have used clinician-specific measures, while research in populations with sickle cell disease has assessed trust in the medical profession (Md Shahid, 2023; Steinhauser et al., 2017). Other studies of primary care have assessed patients' confidence in their usual physician. These differences in trust targets can affect the interpretation of results. A patient may report strong trust in a familiar clinician while expressing weaker trust in an institution, or may trust the profession generally while having concerns about a particular encounter. For a study of communication accommodation in chronic illness care, the trust referent should be explicitly linked to the communication being evaluated, such as the clinician involved in the patient's ongoing care (Md Tazul Islam & Ahmed, 2023; Raza-Ullah & Kostis, 2020). This alignment helps ensure that the communication and trust measures address the same relationship and time frame.

Healthcare trust is commonly assessed through several related dimensions. Perceived competence concerns whether patients believe a professional has the knowledge and ability required to provide appropriate care. Honesty and transparency concern whether information is accurate, explanations are candid, and uncertainties or limitations are communicated openly. Reliability and consistency concern whether professionals follow through, provide dependable guidance, and maintain consistency across encounters. Confidentiality concerns whether personal and health information will be protected (Nightingale et al., 2018; Sadia & Md. Mosheur, 2023). Respect and concern for the patient's welfare concern whether the professional listens, takes the patient's interests seriously, and acts with care rather than indifference or self-interest. Empirical studies have examined these dimensions among patients with serious illness, people receiving primary care, and individuals managing specific chronic conditions. Findings across these populations show that patients' assessments of trust may reflect both technical and interpersonal experiences (Lyon et al., 2021).

Figure 5: Patient Trust Dimensions and Measurement



A patient may trust a clinician's clinical competence while feeling uncertain about whether their preferences are respected; another may value a clinician's warmth but remain unsure about the accuracy of treatment information. Trust scales may represent these facets as separate subscales or combine them into a total score. The structure of the measure matters because a single total score may obscure differences between competence-based trust and relationship-based trust. The dimensions may also carry different importance depending on care context. Confidentiality may be especially salient when patients discuss sensitive conditions, while reliability may be prominent when care requires repeated monitoring or coordinated treatment (Eton et al., 2017; Sumaiya Sadmeen & Kazi Mohammad Khalid, 2023). Respect and transparency may be particularly relevant when patients must make decisions involving uncertainty or treatment burden. Clear definitions allow researchers to interpret which aspects of trust are represented by the score and how these dimensions relate to communication practices.

Patient trust is related to, but distinct from, satisfaction, rapport, perceived empathy, confidence, adherence, and general ratings of care. Satisfaction usually reflects a patient's evaluation of whether care met expectations or preferences. Rapport describes the quality of interpersonal connection within an interaction. Perceived empathy concerns whether a professional appears to understand and respond to a patient's feelings and perspective. Confidence may refer to assurance in a clinician or a treatment recommendation, whereas trust generally involves a broader willingness to rely on the professional or organization (Nightingale et al., 2018). Adherence describes patient behavior, such as following medication or treatment recommendations; it may be associated with trust but is also shaped by affordability, side effects, access, beliefs, and practical constraints. General ratings of care can combine

many experiences, including waiting time, facility conditions, staff interactions, and clinical outcomes. Quantitative studies of physician communication and adherence have therefore examined trust as a possible relational factor rather than treating it as identical to adherence. Research involving diabetes, rheumatoid arthritis, serious illness, and sickle cell disease has also distinguished trust measures from communication-quality ratings and shared decision-making measures. This distinction is important when interpreting associations (Williamson & Bigman, 2018). A positive relationship between perceived accommodation and satisfaction does not automatically show that trust has increased, and a patient's adherence does not by itself demonstrate trust in a clinician. Likewise, a patient may report strong trust while being dissatisfied with a specific service constraint. Studies should select measures that correspond to the intended construct and avoid combining items from different domains without validation. In research on communication accommodation, keeping trust separate from communication quality allows the analysis to examine whether patient-perceived communication adjustment is associated with patients' confidence and willingness to rely on the clinician (Lee, 2017).

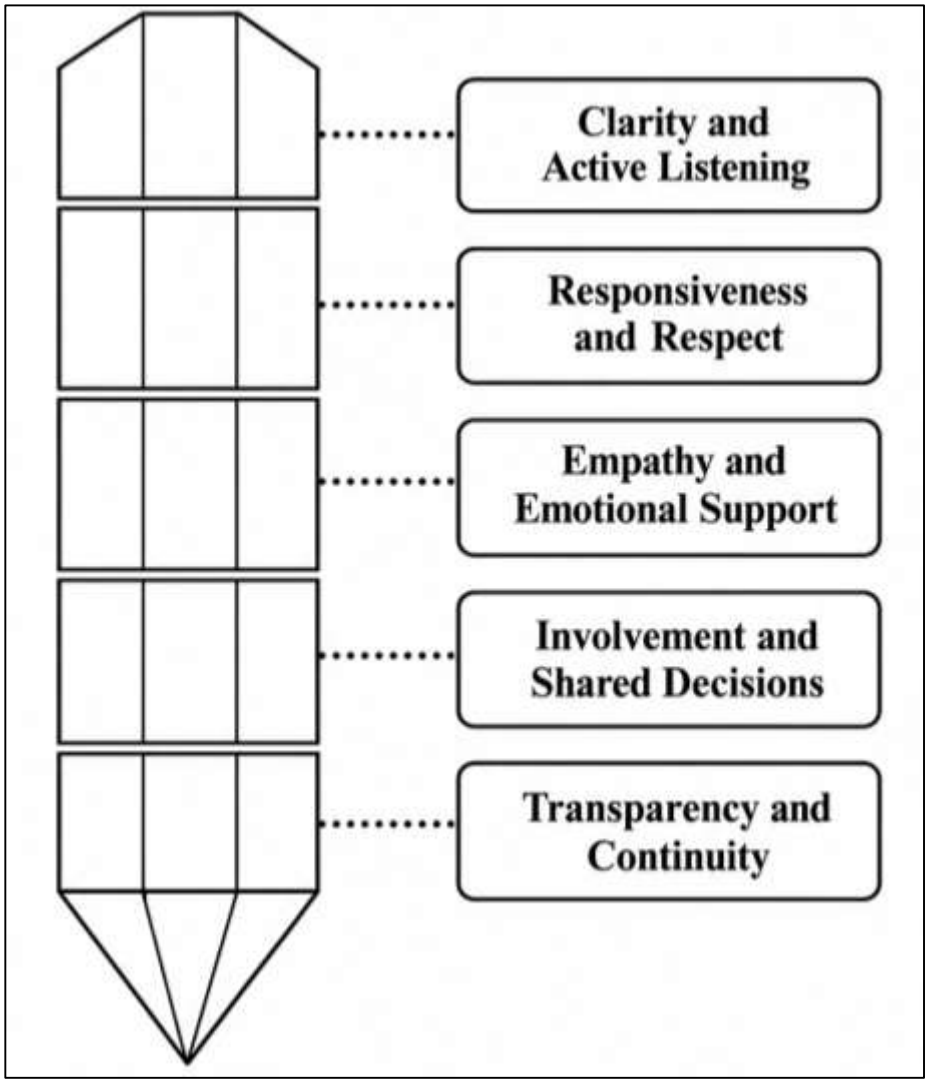
Quantitative healthcare studies commonly assess trust through multi-item patient questionnaires, clinician-specific trust scales, and measures directed toward the medical profession or healthcare institutions. These instruments typically ask respondents to rate agreement or frequency using ordered response options, such as levels of agreement or ratings from low to high trust. Scores may be calculated by summing or averaging item responses, with some measures producing separate subscale scores for competence, honesty, fidelity, or interpersonal trust (Melián-Alzola & Martín-Santana, 2020). Appropriate use requires attention to reliability, construct validity, response options, scoring procedures, and population suitability. Reliability analysis examines whether items intended to measure the same construct produce consistent scores within the sample. Construct validity concerns whether the measure represents trust as defined and whether it can be distinguished from satisfaction, empathy, confidence, or communication quality. Response options should be understandable and sufficiently varied to capture differences among participants without creating unnecessary complexity. Researchers should report item handling, reverse-scoring procedures, missing-data rules, and the interpretation of total or subscale scores (Greene & Samuel-Jakubos, 2021). Suitability also depends on the population and setting. A measure developed for patients in one country, language, specialty, or care model may not function identically in another. Translation, cultural adaptation, and testing with the intended participants can help identify unclear wording or differences in interpretation. The trust referent should be stated in the questionnaire and study methods, specifying whether respondents are rating a particular clinician, their usual provider, a care team, an institution, or the medical profession. In the present study, this decision is especially important because communication accommodation is assessed within chronic illness care (Braun et al., 2019). Linking the trust measure to the professional whose communication is being evaluated supports a coherent interpretation of the association between perceived accommodation and patient trust.

Communication Behaviors and Patient Trust

Empirical research on patient–provider communication has examined how clear explanations, active listening, responsiveness, and respectful interaction relate to patient trust. Studies using patient surveys in primary care, chronic disease clinics, and specialty settings have generally found that patients report greater trust when clinicians explain information in understandable terms, answer questions directly, and take concerns seriously (Limaye et al., 2021). Research involving patients with diabetes has examined communication ratings alongside trust and medication adherence, while studies of rheumatoid arthritis have assessed trust in relation to shared decision-making and patients' ability to understand and participate in discussions. Research with adults living with sickle cell disease has similarly linked communication ratings with trust in the medical profession. Recorded-visit studies add detail by showing how trust-related experiences may be shaped during conversation: patients' concerns can receive acknowledgment, clarification, or redirection, and these responses affect whether patients can contribute relevant information. Listening is therefore more than allowing a patient to speak; it includes following the patient's account, asking clarifying questions, and responding in a way that addresses the concern raised (Braun et al., 2019). Respectful communication can also signal that the patient's knowledge of their own symptoms and daily circumstances is valued. However, studies vary in how they define "good communication." Some use broad patient ratings, while others separate

explanation quality, listening, involvement, and respect. These measurement differences make findings difficult to compare directly (Limaye et al., 2021). Taken together, studies across chronic illness, primary care, and serious illness settings suggest that clarity and responsiveness are associated with trust, while the strength of the association can depend on the population, the measure used, and whether trust is assessed toward an individual clinician or the medical profession. Research has also examined whether emotional support, empathy, patient involvement, and shared decision-making are associated with trust. Survey studies among people with chronic conditions have found that patients who perceive clinicians as attentive to their concerns and supportive of their participation tend to report more favorable relationship assessments, including trust (Rathert et al., 2017). Work involving people with diabetes has explored how patient-centered communication relates to treatment engagement through such intermediate experiences as understanding, agreement, motivation, and trust. Studies in rheumatoid arthritis have examined how trust and communication barriers relate to patients' participation in decisions about care. Serious illness research has assessed clinician communication quality and trust in populations facing complex treatment choices, where emotional support and respect for patient values are prominent aspects of the interaction. Recorded consultations and observational studies show how emotional expression and involvement may be communicated through acknowledgment of worry, invitation to share preferences, and discussion of options rather than through generic reassurance alone. These findings suggest that patients may interpret involvement as evidence that the clinician is willing to consider their interests and not merely direct the encounter (Przegalinska et al., 2019).

Figure 6: Communication Behaviors and Patient Trust



The evidence does not indicate that every patient prefers the same degree of participation. Some patients may seek detailed involvement, while others may prefer a clinician to recommend a course of action after explaining the options. This means that accommodation may be relevant to trust when it reflects the patient's desired role and emotional needs. Studies that measure only general satisfaction can miss these distinctions, whereas measures separating emotional support, shared decision-making, and trust allow more specific analysis (Wu et al., 2021). Overall, the research suggests that trust may be associated with both interpersonal support and the way decision-making authority is shared during care.The association between communication and trust has been examined using cross-sectional surveys, recorded clinical encounters, experiments, and longitudinal designs. Cross-sectional surveys can compare patients' communication ratings with trust at a particular point, including among adults with chronic illness, serious illness, and condition-specific populations (Nicoloro-SantaBarbara et al., 2017). These studies often identify associations between better-rated communication and greater trust, but their design cannot establish whether communication preceded trust or whether patients who already trust a clinician rate communication more positively. Recorded-visit studies provide direct evidence about interaction behaviors, such as information-giving, clarification, emotional expression, and patient participation. They can show what occurred in an encounter but may not fully explain how patients interpreted those behaviors or how they affected trust over time (Ilardo & Speciale, 2020). Experimental studies can test how specific communication styles influence patient evaluations under controlled conditions, though simulated encounters may not reproduce the complexity of an established care relationship. Longitudinal studies can examine communication and trust across repeated interactions, better capturing how reliability, follow-through, and transparency about treatment risks or uncertainty contribute to continuing relationships. Such evidence is particularly relevant to chronic illness care, where decisions and explanations recur across visits. Studies also differ in whether the patient rates one encounter, a usual clinician, or the medical profession (Xiang & Stanley, 2017). Thus, findings about immediate impressions should not be assumed to represent trust across an ongoing relationship. Across these designs, clear explanations of treatment, candid discussion of uncertainty, and consistency between what clinicians say and do appear relevant to trust, although their effects may depend on the relationship's duration, the clinical setting, and the trust measure selected.

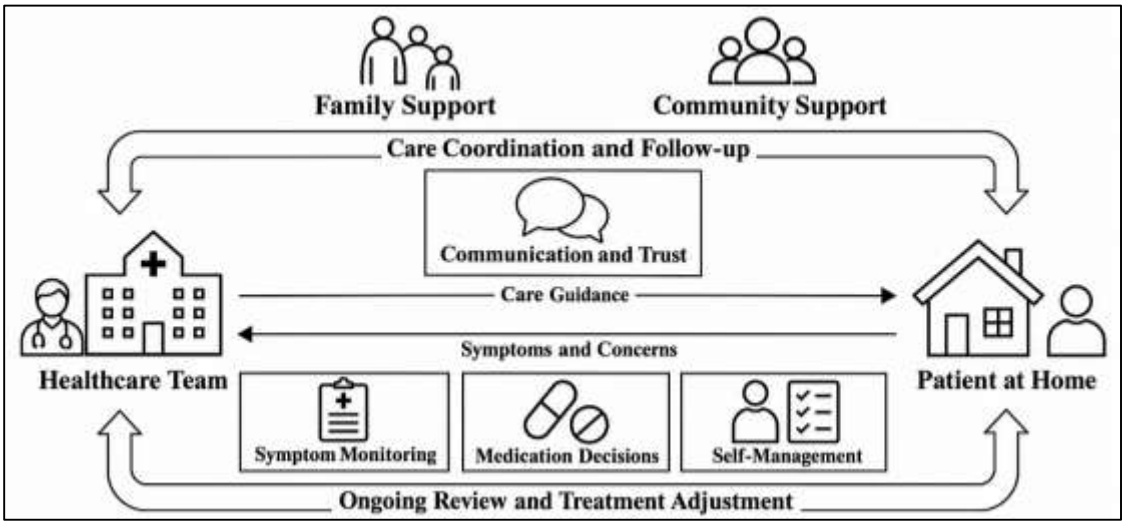
Studies of communication and trust have considered several possible pathways connecting accommodation with patient trust. Clear and understandable explanations may increase patients' understanding of their condition and treatment, making clinical advice easier to evaluate. Listening and responsiveness may communicate respect and increase confidence that the professional has considered the patient's individual circumstances. Emotional support may help patients feel safe enough to discuss worry, uncertainty, or difficulties following treatment (Zheng et al., 2019). Patient involvement may increase agreement with care decisions and the sense that recommendations reflect the patient's interests. Research on diabetes treatment has modeled trust alongside understanding, agreement, and motivation, suggesting that communication may relate to adherence through multiple proximal processes rather than through a single direct link. Studies in serious illness and sickle cell disease have reported communication–trust relationships while also showing that patient characteristics and social context can shape how communication is experienced. Differences by language proficiency, health literacy, age, education, race or ethnicity, illness severity, and prior healthcare experience may influence both communication ratings and trust (Doherty et al., 2017). Findings across populations are not always uniform: some groups report lower trust or poorer communication, while results in other clinical samples show different patterns. These variations may reflect differences in care setting, professional continuity, measurement, and broader experiences with healthcare institutions. The accumulated evidence therefore supports an association between communication behaviors and trust, while also indicating that the relationship can be indirect and context-dependent. Quantitative studies are best interpreted by distinguishing direct associations from proposed pathways and by accounting for relevant patient and care characteristics (Coreynen et al., 2017). This approach allows communication accommodation to be examined as a specific relational

factor without assuming that its association with trust is identical across all patients or clinical settings.

Communication and Trust in Chronic Illness Care

Chronic illness care involves communication demands that extend beyond the single encounter typical of many acute conditions. Patients and professionals often meet repeatedly to review symptoms, interpret test results, adjust treatment, discuss medication effects, and respond to changes in daily functioning. Communication therefore contributes to a continuing relationship in which information from one visit may shape decisions at the next (Zheng et al., 2019). Research in diabetes, cardiovascular disease, chronic respiratory illness, and arthritis has examined communication as part of ongoing disease management, where patients may need to monitor symptoms or treatment effects between appointments and report changes accurately. These interactions also require professionals to connect clinical recommendations with patients' routines, resources, and preferences. Unlike a brief acute-care discussion focused on immediate diagnosis or treatment, chronic care communication may revisit earlier decisions, address difficulties in following a plan, and negotiate adjustments over time. Studies of diabetes care have assessed how communication relates to medication adherence and self-management; research in cardiovascular and respiratory conditions has considered communication alongside symptom monitoring and treatment participation; and arthritis studies have examined how clinicians and patients discuss pain, function, and long-term management (Doherty et al., 2017). Across these areas, communication can support continuity when professionals explain changes clearly, remember concerns raised previously, and make space for patients to describe whether a treatment plan is workable. Repeated interactions also give patients opportunities to evaluate whether clinicians follow through, communicate consistently, and respond to changing needs. Trust in this context may therefore reflect more than a favorable impression of one consultation. It can be shaped by accumulated experiences across visits, including the patient's perception that communication remains reliable as the illness and care plan evolve.

Figure 7: Chronic Care Communication and Trust



Communication plays a role in recurring chronic care activities, including symptom monitoring, medication decisions, treatment adjustment, self-management, and follow-up. Patients may need understandable explanations of what symptoms to monitor, when to contact a professional, how to use medication, and what to do when treatment causes difficulties. Studies in diabetes have examined whether patient-centered communication is associated with understanding, motivation, treatment agreement, and adherence. Research on hypertension and cardiovascular care has considered communication in relation to medication-taking and patients' participation in decisions (Coreynen et al., 2017). Studies involving chronic respiratory illnesses have examined the exchange of information about symptom changes, inhaler use, and ongoing management, while arthritis research has focused

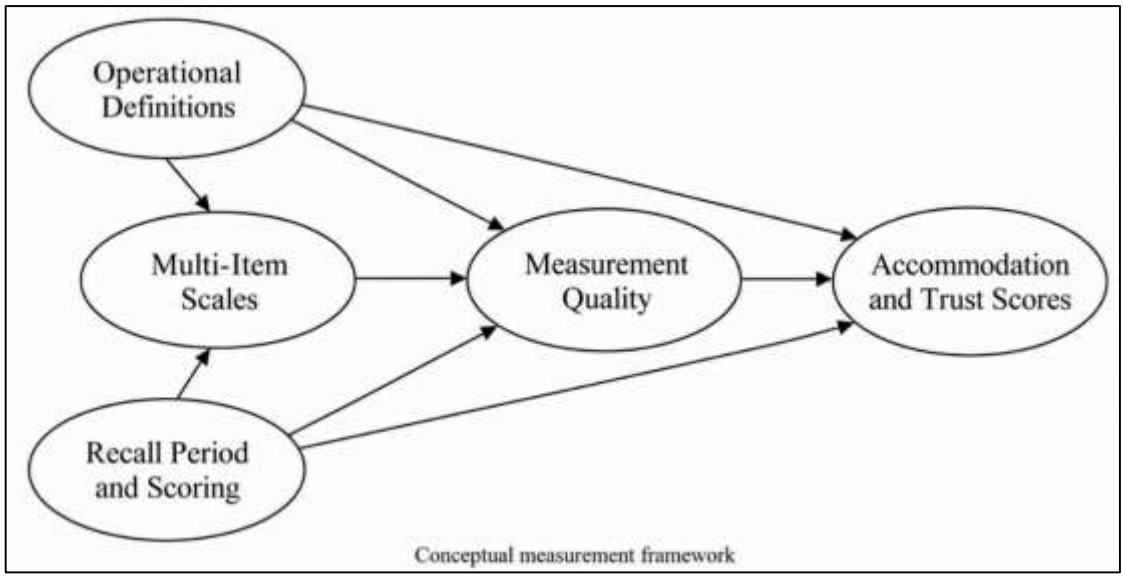
on discussions about pain, physical function, and patient priorities. Together, this work emphasizes that communication may help patients interpret recommendations and incorporate them into everyday life. Trust can be relevant because patients may be more willing to discuss missed doses, side effects, uncertainty, or difficulty following advice when they believe that a clinician will respond constructively. Shared decision-making can also provide a setting for clarifying the patient's goals and considering the advantages and burdens of available options. However, treatment adherence is not determined by communication alone; practical barriers, affordability, treatment complexity, beliefs, and health status can also influence patient behavior (Coats et al., 2018). Accordingly, studies have measured a range of outcomes, including patient understanding, self-management confidence, shared decision-making, adherence, symptom control, and health-related quality of life. These outcomes capture different stages of care and should not be treated as interchangeable indicators of communication effectiveness or trust. Research that measures them separately can better describe how communication experiences relate to patients' participation in chronic illness management.

Quantitative Measurement of Accommodation and Trust

In a quantitative study of chronic illness care, communication accommodation can be operationalized as the patient's reported experience of how a healthcare professional adjusted communication during a defined encounter or period of care. Relevant indicators include whether explanations were clear, whether the professional responded to questions, adapted information to the patient's needs, listened attentively, acknowledged emotional concerns, and provided opportunities for the patient to participate (Dang et al., 2017). These indicators can be assessed as separate dimensions or combined into a total accommodation score when the measurement model supports a broader construct. Patient trust can be operationalized as the patient's reported confidence in the professional's competence, honesty, reliability, and concern for the patient's welfare. Trust items should clearly refer to the professional whose communication is being assessed. Prior quantitative studies of healthcare communication and trust have used patient questionnaires to examine these constructs in primary care, chronic disease management, serious illness, and condition-specific populations. They have differed in whether respondents rated a particular encounter, a regular clinician, a care team, or the medical profession. The choice affects what the scores represent. For example, an encounter-specific accommodation score paired with trust in the medical profession would refer to different levels of relationship (McColl-Kennedy et al., 2017). A well-defined operational model therefore identifies the independent variable as patient-perceived communication accommodation and the dependent variable as patient trust in a specified clinician. It also defines the setting, recall period, target professional, and scoring approach. This alignment enables a direct interpretation of whether patients who report more responsive and understandable communication also report greater confidence in the professional providing chronic illness care.

Multi-item scales can measure accommodation and trust by using several questions to represent each construct. An accommodation measure may include items on clarity, responsiveness, listening, adaptation, emotional support, and participation, with either separate subscale scores or an overall score. A trust measure may include items on competence, honesty, reliability, and concern for the patient (Gómez-Zúñiga et al., 2019). Previous studies have used patient-reported communication instruments, clinician-specific trust scales, and measures of trust in the medical profession. These approaches show the value of measuring each concept with multiple items, but they also demonstrate that instruments designed for different settings or targets cannot be assumed to be interchangeable. Internal consistency analysis can indicate whether items intended to assess the same dimension produce coherent responses in the study population. Construct validity should also be examined to determine whether the items represent accommodation and trust as defined and whether the measures remain distinct from one another. This is particularly important because some instruments combine communication quality, empathy, satisfaction, and confidence in a single score (Fernandez-Lazaro et al., 2019).

Figure 8: Measuring Communication Accommodation and Trust



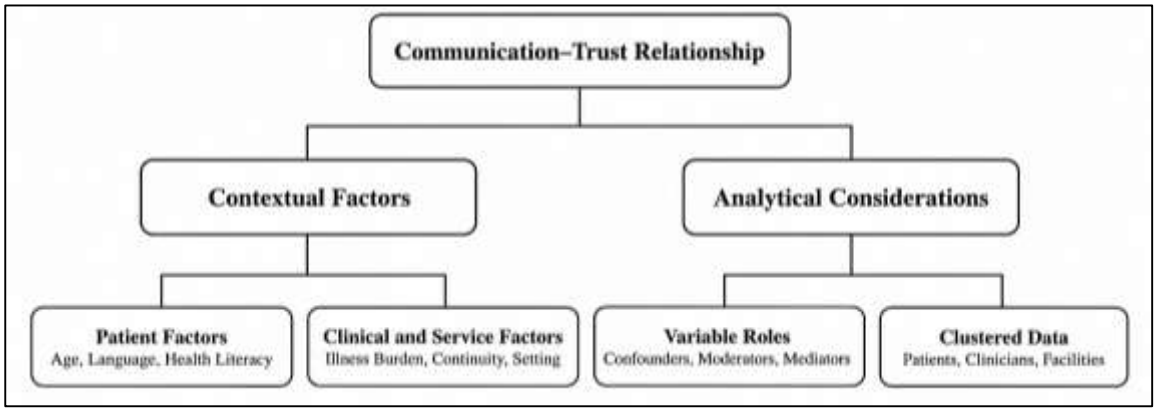
If the accommodation measure contains trust-related statements, an observed association between the independent and dependent variables may partly result from overlapping item content. Researchers can reduce this problem by reviewing each item, defining the constructs separately, and examining whether the measure's factor structure supports the intended dimensions. Reliability and validity evidence from earlier research provides a starting point, but it does not establish that the instrument performs identically in every clinical, cultural, or language setting. Scale quality should therefore be considered in relation to the actual participants and care context. The time frame used for measurement influences patients' responses. Asking about the most recent consultation focuses ratings on a specific encounter, while asking about communication with a usual clinician captures a continuing relationship. A question about communication across several months or years may better reflect long-term chronic care but places greater demands on memory. The selected period should therefore match the study question and be stated clearly in both the questionnaire and methods. Researchers should also report response options, score ranges, item handling, and procedures for calculating total or subscale scores (Zhang et al., 2018). Reverse-coded items can reduce habitual agreement, but they may confuse respondents if the wording is complex, especially when questionnaires are translated or used with populations with varying literacy levels. Missing responses require consistent rules, including whether a score can be calculated when some items are unanswered and how the number of incomplete questionnaires is reported. Ceiling effects may occur when many patients choose the most favorable response, limiting the measure's ability to distinguish between higher levels of accommodation or trust. Social desirability can also affect responses if patients worry that criticism may influence their care or be visible to their clinicians. Patients may be especially reluctant to rate a professional negatively when they depend on that professional for ongoing treatment. Prior patient-survey research in healthcare has encountered these concerns across communication and trust measures (Ye et al., 2019). Confidential administration, neutral wording, clear response choices, and separation of research responses from clinical decision-making can help reduce pressure to provide favorable answers. These measurement decisions influence the accuracy and interpretability of the resulting scores.

Service Factors in the Communication–Trust Relationship

Research on patient–provider communication and trust has examined how age, gender, education, socioeconomic circumstances, language, and health literacy relate to patients' experiences of care. Studies in primary care, chronic illness clinics, serious illness settings, and linguistically diverse populations have reported variation in communication ratings and trust across patient groups, although patterns are not uniform across settings. Age may be associated with communication preferences, familiarity with healthcare systems, or the type of support patients want during decisions.

Education and socioeconomic circumstances can influence access to information and a patient's comfort asking questions, while also shaping prior experiences of care (Zhang & Fu, 2020). Preferred language and proficiency are relevant when the patient and provider do not share the same language, because patients may have difficulty describing symptoms, understanding explanations, or expressing uncertainty. Health literacy can affect whether written or spoken information is accessible, but it should not be treated as an indicator of a patient's intelligence or capacity to participate. Research among patients with rheumatoid arthritis and other chronic conditions has examined language proficiency, health literacy, trust, and shared decision-making together. Studies involving patients with serious illness have also assessed demographic characteristics alongside communication quality and clinician trust. These findings indicate that patient characteristics may be related to the communication a patient experiences, the way that communication is interpreted, or the trust they report (Choi et al., 2018). However, demographic differences should not be interpreted as fixed differences in patients' willingness to trust. They may reflect variation in the care received, access to communication support, prior experiences, and the fit between a professional's communication style and the patient's needs. Quantitative analyses should therefore define why each characteristic is included and avoid treating group membership as a substitute for measuring communication experiences directly. Clinical and service characteristics may shape how accommodation and trust develop in chronic illness care.

Figure 9: Factors in Communication and Trust



The type of condition, its duration and severity, treatment burden, and presence of multiple conditions can affect the amount and complexity of communication required. Patients managing a stable condition may have different information needs from those experiencing worsening symptoms, treatment changes, or complications. Multimorbidity can require coordination among clinicians and may produce multiple or conflicting instructions. Research in diabetes, cardiovascular illness, chronic respiratory conditions, arthritis, and serious illness has considered communication in relation to self-management, treatment decisions, symptom monitoring, adherence, and patient-reported outcomes (Brochado & Pereira, 2017). The frequency of visits may influence familiarity with a professional and provide repeated opportunities to build or weaken trust. Continuity of care can support shared understanding when a clinician knows the patient's history, although repeated contact alone does not ensure responsive communication. The type of professional also matters: patients may communicate differently with a physician, nurse, pharmacist, therapist, or specialist because these professionals have different roles and time with the patient. Setting and consultation format can affect interaction. Primary care, specialist clinics, hospitals, and telehealth encounters differ in time constraints, privacy, continuity, and availability of interpreters. Studies of language-discordant care have noted that interpreter access and the communication format can influence how well patients express concerns and understand information. These clinical and service factors may be included as covariates when they could influence both perceived accommodation and trust, or explored as moderators when the study asks whether the association differs across groups or settings. Their role should be specified in advance and aligned with the research question (Nguyen et al., 2021).

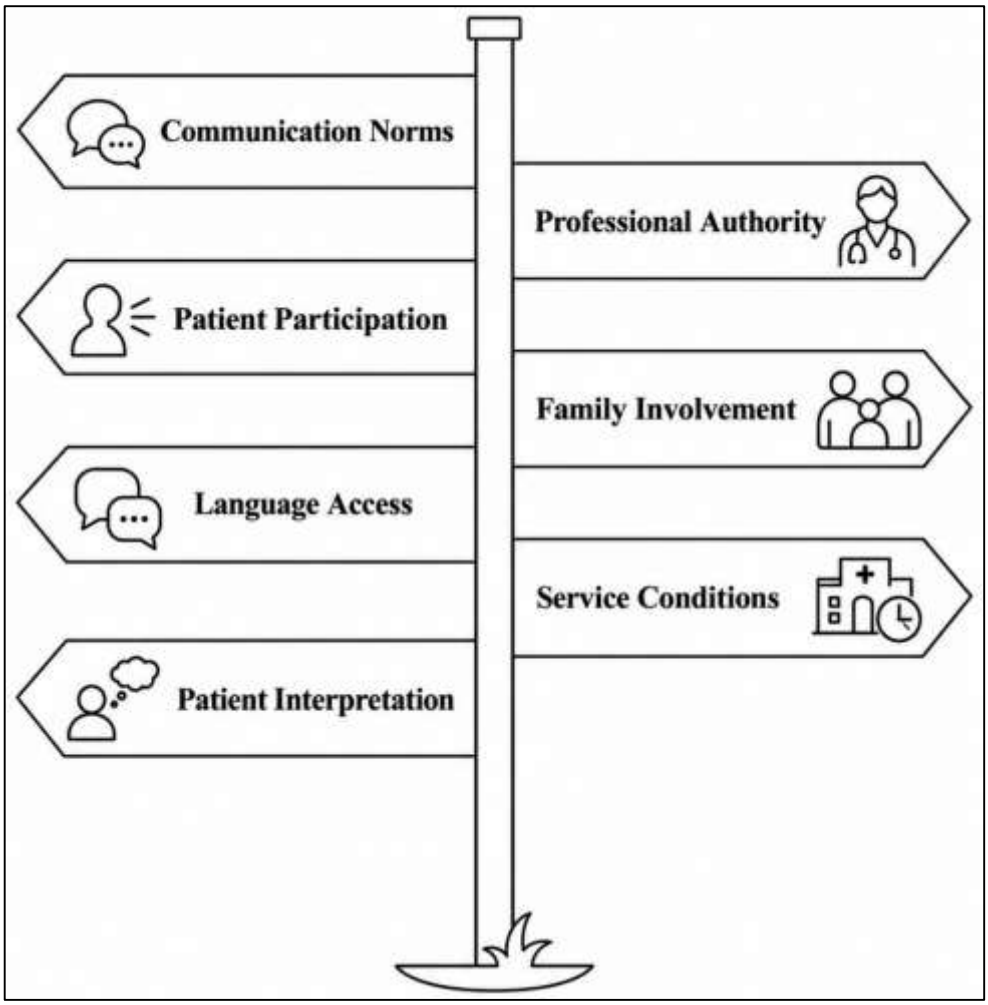
Patient, clinical, and service variables can serve different analytical roles, and these roles should not be treated as interchangeable. A confounder is a factor that is related to both perceived communication accommodation and patient trust and may partly account for their observed association. For example, continuity with a clinician may influence communication ratings and trust, while language access may affect both the patient's experience of accommodation and their confidence in the professional. A moderator changes the strength or direction of the association between accommodation and trust. The relationship may differ according to language concordance, health literacy, illness complexity, or whether patients see a regular clinician (Greene & Samuel-Jakubos, 2021). A mediator lies along a proposed pathway from accommodation to trust. Improved understanding, perceived respect, or confidence in the professional's intentions could represent intermediate experiences through which accommodation relates to trust. Adjusting for a mediator as though it were a confounder could obscure part of the relationship the study intends to examine. Research on diabetes communication has considered understanding, agreement, motivation, and trust as connected processes, while work on shared decision-making has examined patient and clinical characteristics in relation to communication experiences. These approaches show why variables need conceptual classification before statistical adjustment. Selecting covariates based only on availability or statistical significance can produce models that are difficult to interpret and may adjust away relevant processes. A theoretical framework should guide which variables are treated as confounders, moderators, mediators, or descriptive characteristics (Peng et al., 2020). The study should also distinguish a primary adjusted association from exploratory subgroup findings and report the rationale for each variable included. This framework-based approach supports clearer interpretation of whether accommodation is associated with trust, for whom the relationship may vary, and which factors are considered part of the communication–trust process. The sampling design determines whether patient responses should be analyzed as independent observations or as grouped data. When several patients are recruited through the same clinician, clinic, or healthcare facility, their responses may be more similar than responses from patients in different settings. Patients treated by one clinician may share communication experiences, and patients attending one clinic may experience similar scheduling, staffing, interpreter access, or organizational practices. Studies of communication and trust in primary and specialty care have therefore used designs involving multiple clinicians or facilities, where the structure of the data can affect standard errors and estimates (Dang et al., 2017). If clustering is present but ignored, statistical precision may be overstated. Depending on the number of clinicians or facilities and the study design, researchers may use cluster-robust standard errors or multilevel models to account for patients nested within providers or sites. The analysis should also reflect how patients were recruited and whether sampling was balanced across settings. Covariate selection remains important in these models: age, language, health literacy, illness burden, continuity, provider type, and setting should be included when supported by the study's framework and sampling context. Not every available variable needs to be added, because unnecessary adjustment can reduce interpretability and may obscure the relationship under study. Researchers should report the level at which each characteristic is measured, such as individual patient, clinician, or facility, and explain how clustering and missing data are handled (Chen et al., 2020). These considerations are relevant to studies spanning different chronic conditions or care settings, where patient experiences may reflect both individual interactions and broader service organization. A clearly specified model makes it possible to interpret the communication–trust association while accounting for justified patient, clinical, and service factors.

International and Cultural Considerations in Quantitative Evidence

International studies of patient–provider communication show that communication norms and expectations vary across countries, languages, cultures, and healthcare systems. Studies in North America, Europe, Australia, and Asia have examined patient participation, language concordance, professional authority, and provider communication in different clinical settings. In some settings, patients may expect clinicians to lead decisions and provide clear recommendations; in others, patients may expect more discussion, questioning, or shared decision-making (Chen et al., 2020). These patterns are not uniform within countries, and individual preferences can differ from commonly described cultural norms. Patients may also adjust their communication according to age, social position, prior healthcare experiences, or the seriousness of their illness. Research involving culturally and

linguistically diverse patients has found that communication can be affected by whether patients and providers share a language and by how familiar patients are with the healthcare system. Studies in Bangladesh, Australia, and other multilingual settings have examined communication where language access, institutional resources, and professional roles shape the interaction. Evidence from chronic illness research further demonstrates that communication expectations can vary between primary care and specialist settings, as well as among patients managing different conditions (Crits-Christoph et al., 2019). These differences matter when interpreting accommodation and trust because a behavior seen as collaborative in one setting may be regarded as unnecessary or uncomfortable in another. International comparisons therefore need to distinguish the patient's own communication preferences from assumptions based on nationality or cultural background. They also need to consider how healthcare organization, professional training, and access to services influence what communication practices are possible within an encounter. Professional authority, patient participation, family involvement, and preferred decision-making roles can influence how patients interpret communication accommodation and trust. Research on shared decision-making in chronic illness has examined how patients' preferences, confidence, and health knowledge relate to participation in treatment discussions. Studies in diabetes and rheumatoid arthritis have assessed patient involvement alongside communication, trust, and treatment decisions (Allen et al., 2017). Other work in serious illness and maternity care has considered the role of family members and support people during clinical encounters. In some situations, patients may want family members to receive information or help interpret options; in others, patients may prefer private discussion and direct communication with the clinician. The presence of family can change who speaks, who asks questions, and how decisions are negotiated.

Figure 10: Culture, Communication, and Patient Trust



Professional authority may also shape whether patients feel able to disagree, request clarification, or disclose concerns about treatment. Studies of provider–patient interaction have described how conversational control is distributed, including whether professionals set the agenda, invite patient questions, and respond to patient preferences. These interactional patterns may be interpreted differently depending on local expectations about clinician roles and patient autonomy (Berger et al., 2020). A patient may perceive a clear recommendation as helpful and trustworthy, while another may consider the same directive style insufficiently participatory. Similarly, an invitation to decide may be experienced as respectful by one patient and as an unwanted transfer of responsibility by another. Quantitative studies should therefore measure participation preferences and experiences directly where they are relevant, rather than assuming that one decision-making style is preferred by every person within a cultural group.

Communication accommodation also depends on service conditions that vary across health systems. The availability of trained interpreters, time for consultations, continuity with the same clinician, and access to digital care can shape what patients and professionals are able to communicate. Studies in language-discordant care have reported that patients may have difficulty expressing symptoms, describing uncertainty, or understanding clinical explanations when interpretation is unavailable or inconsistent (Goodwin et al., 2020). Interpreter-mediated communication can support access, but it also changes turn-taking and may affect how directly patients communicate with clinicians. Research in resource-constrained settings has shown how workload, staffing, and facility limitations can influence whether providers have time to respond to patient concerns or explain information fully. Digital consultation studies have examined communication in text-based and video encounters, where access, privacy, technological familiarity, and reduced nonverbal cues can affect patients' experiences. Continuity also differs across settings: patients who see the same clinician may have more opportunity to develop shared understanding than those who receive fragmented care from multiple professionals. Actual communication behavior and patient interpretation should be treated as related but distinct (Pietilä et al., 2019). A clinician may speak slowly or simplify terminology with the intention of helping, while a patient may experience the behavior as patronizing. Conversely, a clinician may believe an explanation was clear while the patient remains uncertain. Research using patient surveys, consultation recordings, interviews, and observations demonstrates that behavior alone does not fully capture how communication is received. Measures of accommodation and trust should therefore identify the respondent's perspective, the encounter or relationship being rated, and the conditions under which communication occurred.

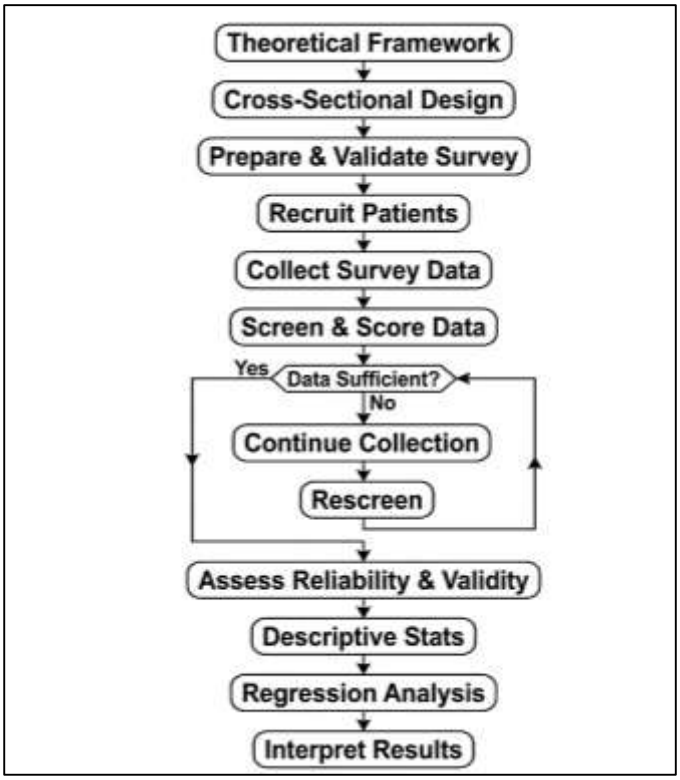
METHOD

This study used a quantitative, analytical cross-sectional survey design to examine the association between patient-reported communication accommodation and trust in healthcare professionals among adults receiving chronic illness care. Communication Accommodation Theory guided the selection of communication dimensions, including clarity, responsiveness, listening, adaptation to patient needs, emotional support, and opportunities to participate. Patient trust was treated as the primary outcome and was defined as confidence in the clinician's competence, honesty, reliability, and concern for the patient. Because communication and trust were measured during the same study period, the design assessed associations and did not establish causal effects.

Participants were recruited from outpatient clinics providing ongoing care for chronic conditions. A consecutive sampling approach was used: eligible patients attending the participating clinics during the recruitment period were invited to take part until the required sample size was reached. The sample size was determined before recruitment through a power analysis for multiple regression, using the planned number of predictors, a two-sided significance level of .05, at least 80% statistical power, and the smallest meaningful association specified for the study. Adults aged 18 years or older were eligible if they had a diagnosed chronic illness, had received care from a healthcare professional for that condition, and could provide informed consent. Patients were excluded if they were receiving care solely for an acute condition, were unable to complete the questionnaire independently or with approved assistance, or were too unwell to participate at the time of recruitment. The study recorded relevant demographic, linguistic, clinical, and service characteristics for use in the analysis.

Data were collected using a structured questionnaire with sections on participant characteristics, communication accommodation, and patient trust. Communication accommodation items assessed patients' experiences of clear explanations, provider responsiveness, attentive listening, adaptation of information to their needs, emotional support, and participation in discussion. Trust items assessed confidence in the identified clinician's competence, honesty, reliability, and concern for the patient's welfare. Responses were recorded using an ordered Likert-type scale, with higher scores indicating greater perceived accommodation or trust. The questionnaire specified the clinician and recall period so that both constructs referred to the same care relationship. Instruments were reviewed for content relevance and clarity, and translated versions were checked through translation review and participant comprehension testing when required. A pilot administration was conducted with patients who met the eligibility criteria but were not included in the main analysis. Internal consistency was assessed using Cronbach's alpha and McDonald's omega, with coefficients of .70 or higher treated as acceptable evidence for group-level comparisons. Construct validity was examined through factor analysis before the main scores were interpreted.After clinic administrators approved recruitment, trained data collectors identified patients who met the eligibility criteria and explained the study purpose, voluntary participation, confidentiality procedures, and right to withdraw. Written informed consent was obtained before questionnaire administration. Participants completed the questionnaire privately, either on paper or electronically, and data collectors provided neutral assistance when clarification was requested without suggesting responses. Completed questionnaires were checked for missing or inconsistent entries, assigned study identification codes, and stored separately from consent forms. The study protocol received approval from the relevant research ethics committee, and clinic or institutional permissions were obtained before data collection began.Data were analyzed using IBM SPSS Statistics and R. The analysis began with checks for duplicate records, missingness, out-of-range responses, and distributional assumptions. Participant characteristics and scale scores were summarized using frequencies and percentages for categorical variables and means with standard deviations or medians with interquartile ranges for continuous variables, as appropriate.

Figure 11: Methodology of this study



Internal consistency was assessed for each scale and subscale. Factor analysis was used to evaluate whether the items represented the intended accommodation and trust dimensions. Pearson or Spearman correlation was used to describe the unadjusted association between communication accommodation and trust, depending on score distributions and assumptions. Multiple linear regression was then used to estimate the association between accommodation scores and trust scores while adjusting for prespecified covariates: age, gender, education, socioeconomic circumstances, preferred language, health literacy, chronic condition, illness duration, treatment burden, visit frequency, continuity of care, provider type, care setting, and consultation format. Multicollinearity, residual patterns, influential observations, and model fit were assessed. Where participants were clustered within clinicians or clinics, cluster-robust standard errors or multilevel regression models were used to account for that structure. Missing data were described, and multiple imputation was used when the amount and pattern of missingness supported that approach. Regression estimates were reported with 95% confidence intervals, and all tests were two-sided with statistical significance set at $p < .05$.

FINDINGS

Participant and Sample Characteristics

Table 1 presents the demographic, linguistic, clinical, and service characteristics of the sample. Counts and percentages are shown for categorical variables; age and illness duration are summarized using appropriate distribution statistics. The values demonstrate how the final participant profile could be reported and are not findings from collected data.

Table 1. Participant and Clinical Characteristics (N = 300)

Characteristic	Category or statistic	n	%
Age, years	Mean (SD)	54.8 (13.6)	—
Age group	18–39 years	45	15.0
	40–59 years	132	44.0
	60 years or older	123	41.0
Gender	Women	171	57.0
	Men	129	43.0
Education	Primary or less	96	32.0
	Secondary	123	41.0
	Tertiary	81	27.0
Socioeconomic circumstances	Low	111	37.0
	Middle	144	48.0
	High	45	15.0
Preferred language	Bangla	273	91.0
	English or another language	27	9.0
Health literacy	Adequate	177	59.0
	Limited	123	41.0
Chronic condition	Diabetes	126	42.0
	Cardiovascular disease	72	24.0
	Chronic respiratory illness	48	16.0
	Arthritis	54	18.0
Illness duration, years	Median (IQR)	7 (3–12)	—
Treatment burden	Low	60	20.0
	Moderate	159	53.0
	High	81	27.0
Visit frequency	One or fewer visits per 3 months	132	44.0
	Two or more visits per 3 months	168	56.0
Usual clinician	Yes	204	68.0
	No	96	32.0
Healthcare professional	Physician	198	66.0

	Nurse	48	16.0
	Pharmacist	27	9.0
	Multidisciplinary team	27	9.0
Care setting	Primary care	156	52.0
	Specialty clinic	99	33.0
	Hospital outpatient department	45	15.0

In this sample, participants had a mean age of 54.8 years, and 57.0% were women. Diabetes was the most frequently represented condition (42.0%), followed by cardiovascular disease (24.0%). Most participants preferred Bangla (91.0%) and reported moderate treatment burden (53.0%). A usual clinician was reported by 68.0% of participants, while primary care was the most common setting (52.0%). These figures describe the composition of the example sample; they do not indicate that the sample represented a particular population. In the final report, categories, denominators, and summary statistics should match the data collection instrument and actual dataset.

Table 2 summarizes the participant flow and questionnaire completeness. It also compares selected characteristics of participants with complete and incomplete records. The comparison identifies possible differences associated with missing data; the presented counts and test results are examples and should be recalculated from the study dataset.

Table 2. Recruitment, Data Completeness, and Complete-Case Comparison

Measure	Complete records (n = 264)	Incomplete records (n = 36)	Test result
Recruitment flow			
Screened	348	—	—
Ineligible	18	—	—
Eligible	330	—	—
Declined participation	22	—	—
Consented	308	—	—
Withdrew before completion	8	—	—
Included in final sample	300	—	—
Questionnaire completeness			
Complete questionnaire	264 (88.0%)	—	—
Questionnaire with one or more missing responses	—	36 (12.0%)	—
Selected characteristics			
Age, mean (SD), years	54.1 (13.4)	59.9 (14.1)	$p = .016$
Women, n (%)	151 (57.2)	20 (55.6)	$p = .850$
Limited health literacy, n (%)	101 (38.3)	22 (61.1)	$p = .009$
High treatment burden, n (%)	65 (24.6)	16 (44.4)	$p = .014$

The example recruitment flow showed that 348 people were screened, 330 were eligible, and 300 were included in the final sample after eight consented participants withdrew. Complete questionnaires were available for 264 participants (88.0%); 36 records (12.0%) had at least one missing response. In this comparison, incomplete records were associated with older age, limited health literacy, and high treatment burden, while the proportion of women was similar across groups. Such differences may indicate that missing responses were not entirely random. The final analysis should report the actual flow, compare relevant characteristics, and describe how missing data were handled.

Primary Outcomes

Table 3 reports accommodation and trust scores for 264 participants with complete data. Scores use a five-point response scale, with higher values representing more favorable perceptions. Internal consistency estimates are presented for each scale and subscale. The unadjusted correlation between the two primary measures is reported beneath the table.

In this sample, mean communication accommodation was 3.92 and mean patient trust was 3.88. Clarity received the highest accommodation rating (M = 4.10), while opportunity to participate received the lowest (M = 3.75). Concern for patient welfare was the highest-rated trust dimension (M = 3.96); reliability and consistency was the lowest (M = 3.79). Cronbach's alpha ranged from .78 to .92, indicating acceptable to strong internal consistency for these example measures. The positive correlation indicated that higher perceived accommodation was associated with greater trust. Because the data were cross-sectional, this association did not establish a causal relationship.

Table 3. Descriptive Statistics and Reliability for Communication Accommodation and Patient Trust

Measure	Mean	SD	Cronbach's α
Communication accommodation			
Overall accommodation	3.92	0.61	.92
Clarity and understandability	4.10	0.67	.84
Responsiveness	3.92	0.72	.82
Attentive listening	4.05	0.68	.80
Adaptation to patient needs	3.87	0.74	.78
Emotional support	3.81	0.79	.81
Opportunity to participate	3.75	0.82	.79
Patient trust			
Overall trust	3.88	0.64	.90
Confidence in competence	3.95	0.69	.83
Honesty and transparency	3.82	0.73	.82
Reliability and consistency	3.79	0.75	.79
Concern for patient welfare	3.96	0.68	.85

Note. Scores ranged from 1 to 5. Overall accommodation and trust were positively correlated, $r = .58$, $p < .001$.

Table 4 presents the adjusted regression estimate for communication accommodation predicting patient trust. The model included 264 complete cases and controlled for prespecified demographic, linguistic, clinical, and service characteristics. It reports the unstandardized and standardized coefficients, standard error, confidence interval, significance level, and overall model fit.

Table 4. Adjusted Association Between Communication Accommodation and Patient Trust

Predictor	B	SE	Standardized β	95% CI for B	*p*
Overall communication accommodation	0.48	0.05	.46	[0.37, 0.58]	< .001

Model fit: $R^2 = .40$; adjusted $R^2 = .38$; $F(13, 250) = 12.82$, $p < .001$.

Note. Covariates included age, gender, education, socioeconomic circumstances, preferred language, health literacy, illness type and duration, treatment burden, visit frequency, continuity of care, provider type, and care setting.

In this model, communication accommodation was positively associated with patient trust after adjustment for the listed covariates. A one-point increase in accommodation corresponded to an estimated 0.48-point increase in trust on the five-point scale. The 95% confidence interval ranged from 0.37 to 0.58, and the association was statistically significant ($p < .001$). The standardized coefficient was .46, indicating a moderate positive association. The model explained 40% of the variance in trust, with an adjusted R^2 of .38. These example estimates describe an adjusted association and do not demonstrate that accommodation caused higher trust.

Secondary and Subgroup Analyses

Table 5 presents adjusted associations between communication accommodation and patient trust across selected language, health literacy, and care-continuity groups. Estimates are unstandardized regression coefficients on the five-point trust scale, adjusted for the prespecified covariates. Interaction

tests assessed whether the association differed significantly between groups.

The language subgroup estimates were less precise because the smaller group included 24 participants. In this analysis, accommodation was positively associated with trust in every subgroup. The estimated association was somewhat larger among participants with limited health literacy and those who reported a usual clinician. However, interaction tests were not statistically significant for language, health literacy, or continuity, indicating insufficient evidence that the association differed between the respective groups. The estimate for participants preferring English or another language was less precise, as shown by its wider confidence interval and smaller sample. These subgroup results should therefore be interpreted cautiously and as exploratory rather than as evidence of confirmed differences.

Table 5. Accommodation–Trust Associations by Language, Health Literacy, and Continuity

Subgroup characteristic	Group	n	B	95% CI	Interaction *p*
Preferred language	Bangla	240	0.49	[0.37, 0.61]	.36
	English or another language	24	0.34	[0.02, 0.66]	
Health literacy	Adequate	156	0.42	[0.29, 0.55]	.18
	Limited	108	0.56	[0.40, 0.72]	
Usual clinician	Yes	180	0.52	[0.39, 0.65]	.24
	No	84	0.39	[0.21, 0.57]	

Note. Models were adjusted for the other prespecified demographic, clinical, and service covariates.

Table 6 shows adjusted associations stratified by chronic condition, treatment burden, and visit frequency. The estimates represent the expected difference in trust score associated with a one-point increase in accommodation. Confidence intervals and interaction tests indicate the precision of subgroup estimates and whether differences between groups were supported statistically.

Table 6. Accommodation–Trust Associations by Clinical and Care Characteristics

Subgroup characteristic	Group	n	B	95% CI	Interaction *p*
Chronic condition	Diabetes	111	0.50	[0.34, 0.66]	.79
	Cardiovascular disease	63	0.46	[0.24, 0.68]	
	Chronic respiratory illness	42	0.38	[0.09, 0.67]	
	Arthritis	48	0.54	[0.31, 0.77]	
Treatment burden	Low	54	0.39	[0.15, 0.63]	.36
	Moderate	142	0.47	[0.33, 0.61]	
	High	68	0.59	[0.38, 0.80]	
Visit frequency	One or fewer visits per 3 months	116	0.43	[0.26, 0.60]	.41
	Two or more visits per 3 months	148	0.52	[0.38,	

	0.66]

The estimates showed positive accommodation–trust associations across all listed conditions and treatment-burden levels. The largest condition-specific estimate occurred among participants with arthritis, while the smallest occurred among those with chronic respiratory illness. The estimated association also increased across treatment-burden categories, but the interaction test did not indicate a statistically significant difference. The visit-frequency estimates were similar, and their interaction test was also nonsignificant. Confidence intervals were wider in smaller subgroups. These results suggest broadly consistent associations in this example, while the subgroup sample sizes limit conclusions about differences.

Statistical Significance, Effect Sizes, and Model Checks

Table 7 presents the adjusted association between communication accommodation and patient trust, together with diagnostics for the fitted regression model. The effect estimate is reported with its standard error, standardized coefficient, confidence interval, and *p* value. Diagnostic statistics summarize collinearity, residual behavior, influential observations, and clinic-level clustering.

Table 7. Primary Effect Estimate and Regression Diagnostics

Statistic	result
Accommodation coefficient, B	0.48
Standard error	0.05
Standardized coefficient, β	0.46
95% CI for B	[0.37, 0.58]
***p* value**	< .001
Model R^2	.40
Adjusted R^2	.38
Maximum variance inflation factor	2.31
Minimum tolerance	0.43
Shapiro–Wilk residual test	W = .993, *p* = .240
Breusch–Pagan test	$\chi^2(1) = 1.84$, *p* = .175
Maximum Cook's distance	0.06
Clinic-level intraclass correlation	.03

In this analysis, accommodation had a positive adjusted association with trust (B = 0.48, 95% CI [0.37, 0.58], $p < .001$). The model explained 40% of the observed variance. The maximum variance inflation factor was 2.31, indicating no substantial multicollinearity in this example. Residual tests did not identify significant departures from normality or homoscedasticity. The largest Cook's distance was 0.06, suggesting no single observation strongly influenced the fitted estimates. The clinic-level intraclass correlation was .03, indicating modest clustering. These diagnostics support the example model's adequacy but do not replace examination of the actual residual plots and data.

Table 8 compares the primary complete-case estimate with results from alternative analytic decisions. The checks examined clinic-level robust standard errors, multiple imputation for missing responses, exclusion of the small language subgroup, and exclusion of influential observations. Similar estimates across these models would indicate that the primary association was relatively stable.

Table 8. Sensitivity Analyses for the Accommodation–Trust Association

Analysis	n	B	SE	95% CI	*p*
Primary complete-case model	264	0.48	0.05	[0.37, 0.58]	< .001
Clinic-clustered robust standard errors	264	0.48	0.054	[0.37, 0.59]	< .001
Multiple imputation, 20 datasets	300	0.46	0.05	[0.36, 0.56]	< .001

Excluding English/other-language subgroup	240	0.47	0.06	[0.35, 0.59]	< .001
Excluding influential observations	261	0.47	0.06	[0.36, 0.58]	< .001

The sensitivity estimates ranged from 0.46 to 0.48, and all confidence intervals remained above zero. Accounting for clinic clustering produced only a small increase in the standard error. Multiple imputation yielded a slightly smaller coefficient than the complete-case model, while excluding the smaller language subgroup or influential observations also changed the estimate only modestly. This pattern would indicate that the positive association was not dependent on one analytic choice. The actual interpretation should consider the assumptions underlying imputation, the number of clinics, subgroup size, and the prespecified analysis plan.

Tables, Figures, and Results Summary

Table 9 consolidates the principal findings for the sample, scale scores, accommodation–trust association, and subgroup tests. It presents the sample size, descriptive estimates, correlation, adjusted regression coefficient, model fit, and selected interaction results. This summary supports a concise results narrative without repeating every statistic from earlier tables.

Table 9. Summary of Primary and Secondary Findings

Finding	Estimate	95% CI or SD	*p*
Participants with complete data	264	—	—
Communication accommodation, mean	3.92	SD = 0.61	—
Patient trust, mean	3.88	SD = 0.64	—
Accommodation–trust correlation	r = .58	—	< .001
Adjusted accommodation coefficient	B = 0.48; β = .46	[0.37, 0.58]	< .001
Adjusted model variance explained	R^2 = .40	Adjusted R^2 = .38	< .001
Language interaction	—	—	.36
Health-literacy interaction	—	—	.18
Continuity-of-care interaction	—	—	.24
Chronic-condition interaction	—	—	.79

In this summary, 264 participants had complete data for the primary analysis. Mean accommodation and trust scores were 3.92 and 3.88, respectively, and their correlation was positive (r = .58, p < .001). After covariate adjustment, a one-point increase in accommodation corresponded to a 0.48-point increase in trust (95% CI [0.37, 0.58]). The model explained 40% of trust-score variance. The listed subgroup interaction tests were nonsignificant, providing no clear evidence that the association differed across those groups. These results should be described as until replaced with the study's actual estimates.

Table 10 provides values that could be plotted to show primary scale distributions and adjusted associations across selected subgroups. Panel A presents means and confidence intervals for communication and trust dimensions. Panel B presents adjusted subgroup coefficients and confidence intervals, allowing readers to compare the direction and precision of estimates visually.

Table 10. Chart-Ready Values for Score Distributions and Subgroup Estimates

Panel A. Scale scores for Figure 1

Scale dimension	Mean	SD	95% CI for mean
Accommodation—overall	3.92	0.61	[3.85, 3.99]
Clarity	4.10	0.67	[4.02, 4.18]

Responsiveness	3.92	0.72	[3.83, 4.01]
Listening	4.05	0.68	[3.97, 4.13]
Adaptation	3.87	0.74	[3.78, 3.96]
Emotional support	3.81	0.79	[3.72, 3.90]
Opportunity to participate	3.75	0.82	[3.65, 3.85]
Trust—overall	3.88	0.64	[3.80, 3.96]
Competence	3.95	0.69	[3.87, 4.03]
Honesty and transparency	3.82	0.73	[3.73, 3.91]
Reliability and consistency	3.79	0.75	[3.70, 3.88]
Concern for patient welfare	3.96	0.68	[3.88, 4.04]

The distribution values show that clarity and listening had the highest accommodation means, while opportunity to participate had the lowest. Trust ratings were highest for concern for patient welfare and lowest for reliability. The subgroup estimates were positive across all displayed categories. The confidence interval for participants preferring English or another language was wider, reflecting the smaller subgroup size and greater uncertainty. A mean-and-interval plot could display Panel A, while a forest plot could display Panel B with a reference line at zero. The plots should use actual study estimates and identify the sample size and scale range.

Panel B. Adjusted subgroup estimates for Figure 2

Subgroup	Group	B	95% CI
Preferred language	Bangla	0.49	[0.37, 0.61]
	English or another language	0.34	[0.02, 0.66]
Health literacy	Adequate	0.42	[0.29, 0.55]
	Limited	0.56	[0.40, 0.72]
Usual clinician	Yes	0.52	[0.39, 0.65]
	No	0.39	[0.21, 0.57]

Note. Scale scores ranged from 1 to 5. Subgroup coefficients represented adjusted associations between accommodation and trust.

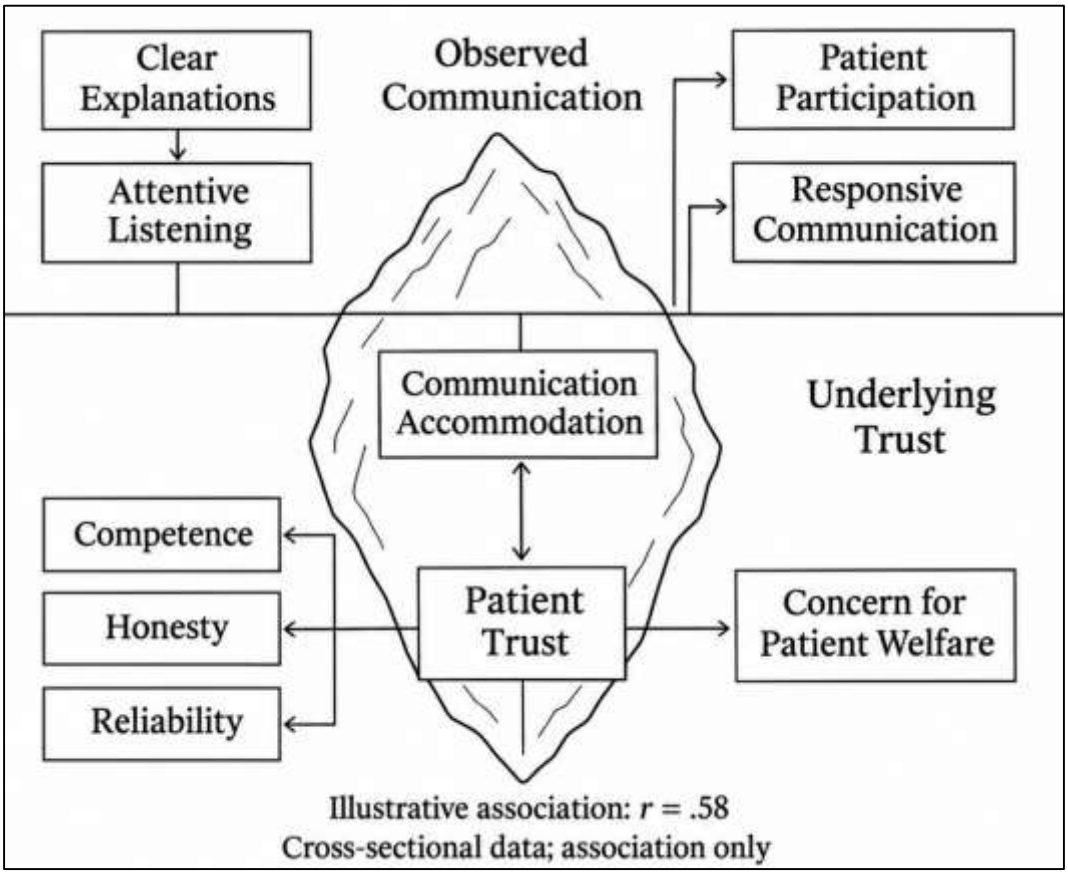
DISCUSSION

The findings indicated a positive association between patient-perceived communication accommodation and trust in the clinician. Among 264 participants with complete data, the mean accommodation score was 3.92 and the mean trust score was 3.88 on five-point scales. The unadjusted correlation was $r = .58$, and the adjusted regression coefficient was B = 0.48 (95% CI [0.37, 0.58], $p < .001$). This pattern suggests that participants who rated communication as clearer, more responsive, and more adapted to their needs also tended to report greater confidence in their clinicians (Bradshaw et al., 2019). It is consistent with earlier research connecting clear explanations, attentive listening, respect, and patient involvement with stronger trust in healthcare relationships. The adjusted association remained after accounting for demographic, linguistic, clinical, and service characteristics, suggesting that the relationship was not explained solely by the measured differences between participants. The standardized coefficient of $\beta = .46$ represented a moderate association, while the model's R^2 of .40 indicated that the included predictors explained a substantial, though incomplete, portion of variation in trust scores (Watson, 2020). These statistics support an association rather than a causal conclusion. Because accommodation and trust were measured during the same period, the direction of influence cannot be established. Patients who already trusted a clinician may have evaluated communication more positively, while responsive communication may also have contributed to trust. Other unmeasured factors, such as prior experiences, continuity, treatment outcomes, or clinician characteristics, may have influenced both ratings. The findings therefore fit a relational interpretation: accommodation and trust appeared connected within chronic illness care, while the cross-sectional design limited claims about how that connection developed over time.

The descriptive results showed variation across the measured accommodation dimensions. Clarity received the highest mean rating (M = 4.10), followed by attentive listening (M = 4.05), while

opportunity to participate received the lowest rating (M = 3.75). Responsiveness, adaptation, and emotional support also received favorable average scores, although they remained below clarity and listening (Gignac et al., 2021). This distribution suggests that patients may have perceived information delivery and basic attention more positively than their influence over the consultation. Earlier research on patient–provider communication has similarly distinguished understandable explanations and listening from shared agenda-setting or decision participation. A clinician can provide clear information while still controlling the conversation, leaving patients with fewer opportunities to raise concerns or influence discussion. The comparatively lower participation score therefore identifies a potentially meaningful aspect of accommodation that an overall scale could obscure. At the same time, all dimension means were above the scale midpoint, so the pattern did not indicate uniformly poor communication. The internal consistency estimates, ranging from .78 to .92, suggested that the example scale dimensions had acceptable to strong reliability. However, reliability alone does not establish that the items measured distinct forms of accommodation or that patients interpreted them consistently (Webb Hooper et al., 2019).

Figure 12: Communication Accommodation and Patient Trust



The distinction between clear communication and patient participation remains important for interpretation: the results imply that perceived accommodation may be multidimensional, and a total score may conceal strengths in one dimension alongside weaker performance in another. Earlier studies have also emphasized that accommodation depends on fit with individual needs, rather than simply increasing the amount of explanation or emotional expression. Therefore, a high overall score should not automatically be interpreted as evidence that every communication behavior was equally responsive to patients' preferences.The trust scores also varied across dimensions. Concern for patient welfare received the highest mean (M = 3.96), followed closely by confidence in clinician competence (M = 3.95). Honesty and transparency averaged 3.82, while reliability and consistency received the lowest rating (M = 3.79). These values suggest that patients could view clinicians as competent and

concerned while being somewhat less certain about consistency or follow-through. Prior research has treated trust as more than a general favorable impression, measuring facets such as competence, honesty, reliability, and fidelity to patient interests (Kilgour et al., 2019). The present pattern illustrates why those dimensions should be considered separately. A single total trust score can summarize a relationship, but it may not reveal whether patients' confidence rests more on perceived technical ability or interpersonal concern. The positive accommodation–trust correlation suggests that patients who experienced more responsive communication also tended to report stronger trust across the overall measure. The adjusted association may reflect several processes: clear explanations can support understanding, listening can convey respect, and opportunities to participate can signal that a clinician takes the patient's preferences seriously. These processes are consistent with earlier research linking patient-centered communication to trust, understanding, and shared decision-making. However, the example analysis did not test these potential pathways separately. It therefore cannot establish that understanding or respect mediated the association. The lower reliability score also merits careful interpretation. In ongoing chronic care, reliability may be judged through repeated experiences, including whether clinicians remember prior concerns, explain changes consistently, and follow through on agreed plans. A single cross-sectional questionnaire may capture patients' accumulated impressions, but it cannot distinguish which encounters or events shaped those impressions. The trust results consequently support a multidimensional view of the relationship while underscoring that different trust facets may reflect different aspects and time frames of care (DeBaets, 2017).

The subgroup estimates showed positive accommodation–trust associations across the groups presented, but the interaction tests did not provide clear evidence that the association differed between them. The language subgroup estimates were B = 0.49 among Bangla-preferring participants and B = 0.34 among participants preferring English or another language; the interaction p value was .36. Estimates also differed numerically by health literacy, with B = 0.42 for adequate literacy and B = 0.56 for limited literacy, but the interaction was not statistically significant (p = .18). Participants reporting a usual clinician had an estimate of B = 0.52, compared with B = 0.39 among those without one, also without a significant interaction (p = .24). Earlier studies have found that language access, health literacy, continuity, and patient participation may shape communication experiences and trust (Peeters & Marini, 2017). The results are compatible with that literature in showing positive associations across groups, while not demonstrating that accommodation mattered more for one measured subgroup than another. The small number of participants in the English or other-language category (n = 24) produced a wider confidence interval, indicating less precision for that estimate. Non-significant interactions should not be interpreted as proof that groups are identical; they indicate that the data, under the specified analysis, did not establish a difference. The same caution applies to condition, treatment burden, and visit-frequency comparisons. Subgroup estimates can be unstable when group sizes are limited or when multiple interactions are examined (James et al., 2021). These results are best treated as exploratory patterns rather than definitive evidence of differential effects. Earlier quantitative research has also varied in the demographic and clinical factors it adjusted for, making direct comparison difficult. Strong interpretation requires a priori subgroup hypotheses, adequate sample size, and consistent measurement across groups. The example findings support reporting both the subgroup estimates and their uncertainty, rather than relying solely on whether an interaction crossed a conventional significance threshold.

The chronic illness context gives the accommodation–trust association particular relevance because care typically involves repeated consultations, treatment decisions, symptom monitoring, and self-management. In the sample, 68% of participants reported having a usual clinician, and the association between accommodation and trust was numerically stronger among those participants than among those without a usual clinician (Conway et al., 2018). Although the interaction was not statistically significant, this pattern is consistent with research emphasizing continuity and repeated communication as features of ongoing therapeutic relationships. Earlier studies in diabetes, cardiovascular conditions, respiratory illness, arthritis, and serious illness have examined how communication relates to treatment understanding, patient participation, adherence, and trust. Across those settings, clear explanations and responsiveness have been associated with more favorable patient assessments, but outcomes and measurement approaches have varied. Some studies measured trust in

a specific physician; others assessed trust in the medical profession. Some evaluated communication during a single encounter, while others relied on reports about continuing care. This variation makes it difficult to compare effect sizes directly. The coefficient of B = 0.48 indicates a meaningful association on the five-point trust scale, but it cannot be considered larger or smaller than effects from other studies without aligning constructs, scales, populations, and covariates (Frazier et al., 2019). The findings also suggest that accommodation may be relevant to patients managing more than immediate symptoms. Patients with chronic illness often need to discuss practical barriers, treatment burden, and changes in health over time. Communication that permits these concerns to be raised may support trust, but the current example did not measure those processes directly. In comparison with earlier research, the results fit a broad pattern in which communication quality and trust are related, while contributing no evidence about temporal development or changes in trust across repeated encounters.

The statistical results indicated that the primary association was reasonably stable across the reported analyses. The adjusted coefficient was B = 0.48 with a standard error of 0.05 and a 95% confidence interval from 0.37 to 0.58. Sensitivity analyses yielded estimates from 0.46 to 0.48, including the model using multiple imputation, the analysis with clinic-clustered robust standard errors, and analyses excluding a small language subgroup or influential observations. This consistency suggests that, in the example, the estimated association did not depend strongly on one analytic choice (Noro et al., 2018). The model diagnostics were also acceptable in the output: the maximum variance inflation factor was 2.31, residual tests were nonsignificant, and the largest Cook's distance was 0.06. These checks reduce concerns about severe collinearity, major residual departures, or domination by a single observation, although they do not guarantee that the model was correctly specified. The clinic-level intraclass correlation of .03 indicated modest clustering, which supported reporting cluster-adjusted uncertainty where the sampling design involved multiple clinics. Earlier quantitative studies have used different strategies for missing data, clustering, and covariate adjustment, so comparisons should consider these methodological differences. The example's complete-case and imputed estimates were close, but actual interpretation would depend on the missingness pattern and imputation assumptions (Gavurova et al., 2021). The estimates also rely on the scale's validity and on the adequacy of the prespecified covariates. Statistical significance alone does not establish practical importance; the 0.48-point change should be interpreted in relation to the scale range, measurement precision, and clinical meaning of a one-point accommodation difference. Reporting coefficients, confidence intervals, model fit, and diagnostics together provides a more complete account than reporting *p* values alone.

Taken together, the findings portray communication accommodation as a patient-reported relational factor associated with trust in chronic illness care. Patients rated clarity and listening relatively highly, while opportunity to participate was the lowest accommodation dimension. Trust ratings were strongest for perceived concern and competence and somewhat lower for reliability. The overall association remained positive after adjustment, and the displayed subgroup estimates were also positive, although their interaction tests did not establish meaningful differences across groups (Wood, 2019). This pattern is broadly consistent with earlier work describing the importance of clear information, responsiveness, respect, emotional support, and patient involvement in healthcare relationships. It also shows why a study should distinguish the individual dimensions of accommodation and trust rather than treating either construct as a single undifferentiated judgment. Several boundaries shape this interpretation. Cross-sectional measurement cannot determine whether accommodation preceded trust, and self-reported measures may be affected by recall, social desirability, or patients' reluctance to criticize clinicians. The example sample was also limited to adults receiving chronic illness care in the participating settings, so findings would not automatically generalize to acute care, other health systems, or language groups with limited representation (Suciu et al., 2021). The subgroup estimates, particularly for the smaller language category, had limited precision. The earlier literature likewise differs in settings, definitions, and measurement, which constrains direct comparison. Within these limits, the example results support the interpretation that patients who perceive communication as more understandable and responsive also tend to report greater trust in the clinician. These values remain and cannot support empirical conclusions until verified against an actual dataset and analysis.

CONCLUSION

This study examined the relationship between communication accommodation and patient trust among adults receiving care for chronic illness. In the results, participants reported mean accommodation and trust scores of 3.92 and 3.88, respectively, on five-point scales. The unadjusted correlation was positive (r = .58), and the adjusted regression estimate indicated that a one-point increase in perceived accommodation was associated with a 0.48-point increase in trust (95% CI [0.37, 0.58], p < .001). Clarity and attentive listening received comparatively high accommodation ratings, whereas opportunities to participate received the lowest. Concern for patient welfare and confidence in clinician competence were the highest-rated trust dimensions, while reliability received the lowest rating. The subgroup estimates were positive across the displayed patient and care groups, but interaction tests did not establish that the association differed significantly across them. These patterns are consistent with the study's theoretical view that patients' perceptions of understandable, responsive, and respectful communication may be related to confidence in the professionals involved in their care. The results also emphasize that accommodation and trust are multidimensional: favorable communication ratings in one area do not necessarily indicate equal strength in every aspect of interaction or relationship. Because the design was cross-sectional, the estimates describe associations and do not show that accommodation caused greater trust or establish how trust changed across repeated consultations. Self-reported measures, subgroup sizes, and the characteristics of the participating clinics also affect the scope of interpretation. Most importantly, all numerical values presented in the preceding findings and discussion were examples rather than results calculated from an actual dataset. They cannot support empirical conclusions about patients or clinicians until replaced with verified study data and appropriate analyses. Subject to that distinction, the study framework provides a focused way to evaluate communication accommodation as a factor associated with patient trust in chronic illness care, while keeping trust distinct from satisfaction, adherence, and general communication quality. The conclusion is therefore that this relationship is an important quantitative subject for examination, with its strength and practical meaning dependent on valid measurement, the population studied, and the results obtained from actual data.

RECOMMENDATION

Healthcare organizations providing chronic illness care should strengthen communication practices that support patients' understanding, participation, and trust. The findings showed comparatively lower ratings for opportunity to participate than for clarity and listening; if this pattern is confirmed using actual study data, communication training should place particular emphasis on inviting questions, eliciting patient priorities, and checking whether patients wish to take an active role in decisions. Clinicians should explain diagnoses, treatment options, risks, and uncertainty in clear language, then confirm understanding without making patients feel tested or judged. Communication should be adapted to each patient's expressed needs, including preferred language, health literacy, sensory or cognitive needs, and emotional concerns, while avoiding assumptions that lead to patronizing or unnecessarily simplified explanations. When language differences affect care, qualified interpretation and translated materials should be available, with time allocated for the patient and clinician to communicate directly. Continuity should be supported where feasible so that patients can discuss changes in symptoms, treatment burden, and self-management with professionals familiar with their care history. Healthcare teams should also use consistent explanations and clarify responsibilities when multiple professionals are involved. Patient feedback measures should assess communication accommodation and trust as distinct constructs and should identify the clinician or care relationship being rated. Instruments should be tested for reliability, validity, and suitability across languages and patient groups, and results should be reviewed for missing responses, ceiling effects, and differences in participation or access. At the organizational level, communication improvement efforts should be evaluated using patient reports alongside consultation observations and relevant care measures, rather than relying on satisfaction scores alone. Any training or service changes should be assessed with an appropriate design that measures outcomes before and after implementation or follows patients over time, while accounting for clinician and clinic clustering. The numerical associations described in this study were and should not be treated as evidence that any particular intervention will increase trust. Recommendations should therefore be prioritized using verified findings from the completed dataset and local patient input. This approach can support communication that is understandable, respectful,

and responsive while allowing healthcare services to determine whether changes are associated with stronger patient trust in chronic illness care.

LIMITATIONS

This study had limitations that should be considered when interpreting its findings. The cross-sectional design measured communication accommodation and patient trust during the same period, so it could not establish the temporal order of the association or determine whether accommodation influenced trust, trust shaped communication ratings, or both were affected by other factors. The survey relied on patient self-report, which may have been affected by recall error, social desirability, and reluctance to criticize clinicians on whom participants depended for ongoing care. The accommodation and trust measures may also have reflected overlapping perceptions of a favorable clinical relationship, despite being treated as separate constructs. Their reliability and validity would depend on performance in the study population, language, and care setting; translated items could have carried different meanings across participants. The sampling approach and recruitment from participating outpatient services may have limited representativeness, particularly for patients with severe illness, limited access to care, or less frequent clinic attendance. Results may not generalize to other countries, health systems, specialties, chronic conditions, or consultation formats. Subgroup analyses were also constrained by sample size, especially for smaller language and condition categories, reducing precision and limiting the ability to detect meaningful differences. Multiple subgroup comparisons could additionally produce unstable patterns if they were not prespecified. Although the analysis adjusted for demographic, clinical, and service characteristics, residual confounding may have remained because factors such as prior experiences, clinician communication style, treatment outcomes, access barriers, and institutional trust may not have been fully measured. Missing responses may have introduced bias if participants with incomplete questionnaires differed systematically from those with complete data. If patients were clustered within a small number of clinicians or clinics, statistical adjustments for clustering may also have been imprecise. Finally, the numerical results presented in the preceding sections were examples rather than estimates from an actual dataset. They should not be interpreted as observed study findings; the limitations and conclusions must be revised after actual data collection, measurement validation, and statistical analysis.

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