The Doctor-Patient Encounter:

Understanding the Communication Processes from Introduction to Trust



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It is often assumed that in a medical consultation, the doctor is the interviewer who gathers information, while the patient is simply the interviewee who provides it. In reality, the medical interview is a dynamic two-way process that profoundly shapes how patients experience their doctors. As the doctor interviews and takes medical history, patients and family members (if present) are continuously interacting with and observing the doctor during each stage of the clinical encounter, creating impressions and making judgements. From the moment the doctor enters the room, patients begin to form impressions (consciously and subconsciously) based on both verbal and non-verbal behaviours. The patients assess not only what is said but how it is said, and what these behaviours signal about what matters most for them. These include whether patients feel they know the doctor and his/her role in their care, whether they like the doctor, whether they believe the doctor genuinely cares about them, whether the doctor is clinically competent and, ultimately, whether they decide to trust the doctor. Medical interviews continue to be one of the most essential and most frequently used tools in clinical practice. Empirical work on patient-centred communication shows that these interpersonal processes are not peripheral; they are central determinants of patient satisfaction, adherence, safety and even health outcomes.[1,2]

A clinical introduction therefore is not a mere social nicety. It is the first step in a relational and communicative trajectory that can either strengthen or weaken patients' impression of their doctor, with important consequences for diagnostic accuracy, shared decision-making and treatment effectiveness.[1] Understanding this trajectory can help clinicians act deliberately in applying appropriate communication and behavioural skills, rather than leave such impressions to chance. This article outlines a staged model of how patients commonly move from initial acquaintance to durable trust – "I know this doctor; I like this doctor; this doctor cares about me; this doctor is competent; I can trust this doctor" – and identifies the specific communication skills that support each stage.

The stages of impression formation in the doctor-patient encounter

Knowing the doctor: orientation and clarity

The first task in any consultation is to enable the patient to know who the doctor is and why he/she is present. Patients may encounter multiple professionals in a brief time, and without

clear orientation, they can easily become confused or disengaged. A structured introduction – stating the clinician's name, role and purpose clearly – reduces uncertainty and frames the encounter as being organised and professional.

Key communication techniques at this stage include:

- A warm greeting, clear self-introduction of name and designation, explanation of the clinician's role in the team, and a brief statement of the purpose and structure of the consultation; and
- Asking how the patient would like to be addressed and checking that the patient is comfortable to start the consultation (and/or if he/she would like any family members to be present), conveying respect and supporting patient autonomy.[3]

These simple behaviours provide the direction for the patient's first conclusion: "I know who this doctor is and what they are doing here."

Liking the doctor: warmth and respect

Once the patient gets to know who the doctor is, the next impression is largely affective: whether the patient experiences the doctor as likeable, friendly, approachable and respectful. This impression is strongly shaped by non-verbal behaviours such as eye contact, facial expression, posture, a smile where appropriate and the sense that the doctor is genuinely interested and focused rather than distracted or uninterested.

Key communication techniques that foster liking include:

- A warm but professional tone of voice and an unhurried opening;
- The deliberate use of positive non-verbal cues like sitting at eye level, leaning slightly forward, maintaining appropriate eye contact as well as an appropriate soft smile; and
- Using open-ended questions at the start of the consultation and avoiding early interruption, signalling that the patient's perspective is heard.[4]

These behaviours lead patients to feel that the doctor is approachable and respectful, which is often summarised in their minds as "I like this doctor."

Perceiving that the doctor cares: empathy, issues, concerns, illness experience, expectations and person-centeredness

The next impression patients reach is whether the doctor genuinely cares about them as a person, and not only as "another clinical case". Genuine empathy has been conceptualised as understanding the patient's perspective of illness experience and feelings, communicating that understanding, and then acting on it in a helpful way.[5] Patients infer caring when they perceive this empathic process in consultation.

Specific communication techniques include:

- Active empathic listening; use of minimal encouragers to speak; accurate summarising of the patient's story; and explicit empathic statements such as, "It is understandable that you are worried given how suddenly this started".
- Attending to emotional cues by noticing affect, exploring feelings and validating the patient's experience, demonstrating that the doctor is not focused solely on disease but also on the person living with the illness.
- Seeking clarification, doing a summary and checking if the doctor has the facts right, following up on a previously expressed concern and including "what else needs to be discussed" questions, which further reinforce the impression that "this doctor is interested and really cares about me".
- Deliberate elicitation of the patient's own perspective on his/her illness, which is a central expression of both caring and competence. This includes the patient's beliefs and ideas about what is happening, his/her specific concerns or fears, expectations of the consultation, and the illness' impact on his/her daily life.
- Asking open, non-judgmental questions such as "What do you think is going on?", "Is there anything you are particularly worried about?" and "What were you hoping we could do today?" before reflecting and negotiating a shared understanding.

The widely used "Ideas, Concerns, Expectations" framework offers a practical structure for this exploration and has been associated with better patient satisfaction, more appropriate prescribing[6] and more effective shared decision-making.[7]

Anthropological work on explanatory models further highlights the value of exploring patients' beliefs about the cause, meaning and appropriate treatment of illness, particularly across cultural contexts.[8] When doctors take the time to understand and respectfully integrate the patient's illness narrative with the biomedical concept of disease, patients experience both empathy ("this doctor cares about me") and cognitive competence ("this doctor understands what is important and relevant for my life").

Judging the doctor as competent: clarity, structure and transparency

Perceived clinical competence is influenced not only by technical decision-making but also by how the doctor communicates knowledge and reasoning. Patients judge competence through the use of clear and simple non-jargon language, organisation of the information sharing and transparency of explanations as well as the doctor's ability to explain uncertainty in a calm, confident and honest manner.



Key communication techniques include:

- Providing structured explanations in plain language, signposting the stages of the consultation, and linking diagnostic reasoning explicitly to the patient's narrative and findings.
- Using teach-back to check understanding ("Could you tell me in your own words what you understand about the plan?") which improves comprehension and signals conscientiousness.
- Transparent discussion of uncertainty and risks: explaining what is known, what is not yet known and the rationale for investigations, strengthening perceptions of competence.
- Safety-netting advice on risk mitigation, including clear guidance on red-flag symptoms and follow-up arrangements, further reinforcing the impression that the doctor is thorough, organised and clinically skilled.[2]

Arriving at trust: reliability, solidarity, and partnership

Trust is the integrative outcome of the patient's belief that the doctor is not only competent and caring but also dependable, honest and committed to acting in the patient's best interests. Higher levels of patient trust are associated with better adherence, continuity of care and self-reported health outcomes.[9]

Beyond perceptions of competence and compassion, patients also look for signs that the doctor will stand with them over time – that the relationship is not merely transactional but one of solidarity in the face of illness. Recent ethical scholarship describes solidarity in healthcare as a commitment to share burdens and pursue health-related goals together with patients, recognising our interdependence and common vulnerability.[10]

In communication, this is conveyed through the language of partnership ("We will work through this together"), explicit attention to the patient's long-term journey, advocacy within the health system, and a stable presence at key transitions of care. When doctors acknowledge the weight of illness, help navigate structural barriers and frame decisions as a shared project, patients experience trust and confidence that the doctor will not abandon them when circumstances become difficult. This experiential sense of solidarity is often what transforms episodic trust into a durable therapeutic alliance.

Communication behaviours that build trust therefore include:

- Reliability and follow-through (keeping promises, doing what one has promised), explicit partnership and shared decision-making.
- Openness and honesty about errors or system limitations and clear protection of confidentiality.
- Inviting patient preferences, exploring values and goals and negotiating plans together, signalling respect for autonomy and reinforcing the sense of a trustworthy therapeutic alliance.

When trust is established, patients are more willing to disclose sensitive information, accept advice, find consensus in treatment plans and are more accepting of unexpected events.

Conclusion

From the patient's perspective, a clinical encounter is far more than a technical exercise in diagnosis and management. It is a complex social interaction in which the patient is continuously and often silently evaluating the doctor: "Do I know you? Do I like you? Do you care about me? Are you competent? Can I trust you?" These judgments are built cumulatively through the doctor's introduction, non-verbal behaviours, empathic responses, clarity of explanation, eliciting of the patient's perspective and reliability over time. Each phase of the encounter offers opportunities either to strengthen or weaken these developing impressions.

For doctors, making these largely implicit processes explicit is crucial. Communication skills are not just innate traits, but competencies that can be taught, observed, practised and refined through feedback and reflective learning.[11] Understanding how patients move from initial acquaintance to durable trust enables clinicians to use specific communication techniques purposefully rather than relying on personality or habit alone. Doing so not only enhances patient experience and clinical outcomes but also aligns with professional values of respect, compassion, humility, solidarity and accountability. In an era marked by increasing complexity, uncertainty and time pressure, skilful patient-centred communication remains one of the most powerful instruments a doctor can possess. ◆

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