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中國患者對醫生的信任：普遍信任與特定信任之間的動態關係

李紅梅、湯潞

摘要

本文旨在建立一個以普遍信任和特定信任之間動態關係為核心的理論模型，來研究中國患者對醫生的信任議題。該模型考慮了宏觀層面的因素（如醫療改革、健康消費主義與資訊環境）和個體層面的因素（如患者特點、醫患交流以及疾病性質等）如何影響患者對醫生的信任。我們使用智慧交互法（phronetic iterative approach）對多年的研究項目收集的數據進行分析。我們的研究表明，普遍信任和特定信任都包括了對於能力和道德的信任，病人對醫生的信任是一個動態過程，普遍信任和特定信任之間相互影響。小城鎮、農村和大城市的居民，由於社會經濟地位和獲得醫療資源的差異，對醫生的信任有所不同。本

李紅梅，美國邁阿密大學媒體、新聞與電影系副教授、戰略傳播專業主任。研究興趣：國際傳播、廣告與消費文化、健康傳播（尤其是資訊信任方面的研究）、文化研究、中國媒體與社會研究、亞裔社區研究、新技術等。電郵：lih19@miamioh.edu

湯潞，美國德州農工大學傳播與新聞系健康傳播教授。研究興趣：健康傳播、社交媒體、社會污名，特別關注少數族裔和未受服務群體。電郵：ltang@tamu.edu

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文還研究了醫生和患者應對信任缺失的策略，顯示出即使在信任不足的情況下，醫患互動仍然可以進行，積極的醫患溝通和制度規範可以幫助醫患雙方重新獲取信任。

關鍵詞：醫患溝通、健康傳播、信任、中國醫療改革、消費主義

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Chinese Patients' Trust in Physicians: Dynamics Between General and Particular Trust

Hongmei LI, Lu TANG

Abstract

This study examines patients' trust in physicians in China through the establishment of a theoretical model centered around the dynamic relationship between general trust and particular trust. The model accounts for how macro-level factors (such as medical reforms, health consumerism, and the information environment) and individual-level factors (such as patients' attributes, their encounters with physicians, and the nature of illnesses) contribute to patients' trust in physicians. Data collected through a multi-year research project were analyzed through the phronetic interactive approach. We found that trust in physicians is a dynamic process, with general and particular trust mutually influencing each other, and that both types of trust comprise perceived competency and perceived ethics. We also found that people in small towns and big cities trusted physicians differently due to their different socioeconomic

Hongmei LI (Coordinator and Associate Professor of Strategic Communication). Department of Media, Journalism and Film, Miami University. Research interests: global communication, advertising and consumer culture, health communication (especially concerning information trust), cultural studies, Chinese media and society, Asian American community, new technologies.

Lu TANG (Professor). Department of Communication and Journalism, Texas A&M University; Director of the Data Justice Lab affiliated with the Texas A&M Institute of Data Science. Research interests: health communication, social media, stigma, with a special emphasis on minority and underserved populations.

status and access to medical resources. Furthermore, we identified the strategies that physicians and patients used to manage the lack of trust, demonstrating that physicians and patients could still function even when there was insufficient trust. Our research implies that trust can be regained through effective doctor-patient communication and well-regulated institutional arrangements.

Keywords: Doctor-patient communication; health communication; trust; China's medical reforms; healthcare; consumerism

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中國社會飽受醫患關係緊張的困擾，針對醫務人員暴力事件不斷增加。60%的醫務人員曾遭受過言語虐待，13%的醫務人員遭受過身體攻擊（孫樂琪，2015）。2018年，中國媒體報導了至少12起針對醫生和護士的典型暴力傷醫事件（蟻坊軟件，2018）。在新冠疫情期間，儘管前線醫務人員被媒體稱讚為民族英雄，醫患關係有所改善，但即使在這期間，對醫務人員的人身攻擊仍有發生（Zhou et al., 2021）。導致醫患關係問題重重的原因有：醫療資源不足、高昂的醫療費用、主觀認為的和實際發生的醫生失德行為、醫生和患者之間的訊息不對稱、醫療的不確定性，以及患者和其他人不切實際的期望等（趙麗等，2013）。此外，醫療的市場化和健康消費主義的興起也導致了中國醫患關係緊張（Tang & Guan, 2017）。上述極端暴力案例可以看出醫患人際層面出現了很多信任問題；同時，最近的全國醫療系統反腐，數百家醫院被查，導致很多醫院的院長和黨委書記落馬，也曝露出來系統的信任問題（Huang, 2023）。儘管信任對於醫患關係而言至關重要，但是很少有系統研究來理解患者對醫生的信任問題，以及患者和醫生針對信任缺失問題所採取的應對策略。

本文有兩個目的：（一）建立一個解釋多種因素如何影響中國醫患信任的概念模型，並運用實證數據加以說明；（二）探索醫生和患者如何在醫患信任不足的情況下進行風險管理。本研究提出的概念模型可以解釋醫患信任的動態變化，也可以被應用於其他國家和文化背景下的研究。

據我們所知，中國的學術領域目前還沒有建立一個考慮到宏觀和微觀因素的整合信任模型，更不用說從溝通角度來建立整合模型，以研究患者對醫生的信任了。很多關於信任的研究（Han et al., 2022; Sun et al., 2018）通常是由醫務人員進行的，往往對技術層面的考慮比較多，而很少提供廣泛的視角。並且在研究方法上，一般是量化的調查研究。不論如何，信任的惡化讓許多醫療專業人士和當局感到擔憂。2013年，醫學期刊《柳葉刀》（*The Lancet*）發表的兩篇文章表達了悲觀的情緒，比如一篇文章的標題為〈中國醫學生的黯淡未來〉（“A Gloomy Future for Medical Students in China”）（Zeng, Zeng, & Tu, 2013）而另一篇題為〈中國醫生呼籲結束暴力〉（“Appeal from Chinese Doctors to End Violence”）

（Yang et al., 2013）。這些文章將中國的醫療人員描述為體制的邊緣化人群和受害者，不出意外，許多人擔心醫療專業人員流失。另一方面，大眾媒體中流傳著許多關於病人如何被醫生虐待的故事。因此，整合醫生和患者的觀點有助於累積知識，以提供潛在的建議和解決方案。

文獻回顧

中國的醫療改革：構建三級醫療體系

中國的醫療體系是分層級的，偏重於大城市和經濟較為發達的沿海省份，這是中國醫療改革和歷史上將城鄉醫療體系分開的結果。1949年後，中國建立了由政府運營的醫療體系，其特點是以戶口為基礎，區別對待城鄉居民。在這一體系中，90%的醫療資源分配給了城市，城市居民可以享受由政府聘用的醫生、行政人員和其他僱員組成的國營醫院和診所的服務。相比之下，農村居民主要由缺乏正規的現代醫學培訓的鄉村醫生（或赤腳醫生）服務（Hesketh & Wei, 1997）。

隨著1979年開始的經濟改革，中國的醫療體系發生了巨變，中央政府大幅削減了醫療投入，並將財政責任下放給省級和地方政府。這致使較富裕的沿海省份和欠發達的內陸省份之間的醫療資源差距進一步擴大（Hesketh & Wei, 1997）。20世紀80年代初，衛生部開始要求醫院承擔財務責任（Zhao & Feng, 2010）。在農村地區，政府解散了公社，將農業經濟私有化，從而摧毀了農村居民的醫療保健安全網（Blumenthal & Hsiao, 2005）。1989年，中國頒布了《醫院分級管理辦法（試行）》，正式確立了中國的三級醫療體系：基層醫院（如鄉村地區或城鎮的基層和社區醫院/診所）、縣級或區級的二級醫院和大城市的三級醫院，並根據醫院的等級分配醫療資源和人員。大城市的醫院享有的資源最多，而鄉村或城鎮的小診所和醫院分得的資源最少。

20世紀90年代，醫療系統進一步去中心化，醫院採用更多措施以彌補政府資金的不足。醫生通過給患者開高價新藥和進行昂貴的診斷檢查以增加個人收入和醫院利潤（Zhao & Feng, 2010）。同時，醫藥公司用回扣鼓勵醫生開他們的藥物處方。私人行醫也在20世紀90年代出

現，並在2000年後蓬勃發展。公立醫院和私營機構的這些變化導致過度治療和醫療費用上漲。在此期間，政府資金投入不足，醫務人員和機構所獲的支援減弱，民眾獲得醫療服務的機會減少、不平等加劇、患者費用上升、醫療人才開始流失（X. Li et al., 2017）。

在2003年急性呼吸系統綜合症（SARS）爆發後，中國政府認識到醫療系統應該為全民服務，從而將重點轉向兼顧公平和效率的原則（H. Li et al., 2017）。2006年，中央政府宣佈建立以保障公民獲得基本醫療保健為宗旨的全民醫療保健體系。隨之而來的改革有三個目標：擴大醫療保險覆蓋面、改革公立醫院、取消醫藥產品集中定價（清華—布魯金斯公共政策研究中心、長策智庫，2012）。農村居民首次獲得了由國家補貼的基本醫療保險，政府則同時禁止公立醫院向醫生和科室下發已經存在了幾十年的創收配額任務。

從2015年開始，中國開始進一步發展其三級醫療體系來更好地利用醫療資源並緩解醫療資源緊張的情況，鼓勵患者首先向基層醫院尋求基本護理或治療輕症，然後再轉至較高級別的醫院治療疑難雜症（Gao et al., 2021）。本文正是在這樣一種醫療行業不斷變化的背景下，來研究患者對醫生的信任議題。

信任

雖然各學科對信任有著不同的定義，但信任通常被定義為「基於對他人意圖或行為的積極預期而接受自身脆弱性的一種心理狀態」（Rousseau et al., 1998, p. 395）。信任的來源包括：通過過去接觸發展起來的熟悉感、基於利益追求下的算計，以及制度規範（Adler, 2001）。其他學者將信任分為基於關係的信任和基於能力的信任（Earle, 2010; Rousseau et al., 1998）。基於關係的信任建立在價值相似性的基礎上，側重於長期目標，對風險的容忍度更高。相比之下，基於能力的信任是由另一方的過往記錄和才能決定的，更傾向於規避風險，具有短期性和算計性（Earle, 2010）。因為信任是基於關係而建立的，所以涉及到信任方和被信任方（H. Li et al., 2022; H. Li et al., 2023）。信任雙方的特徵，如個性、族群特徵、個人的經濟文化地位、社會、文化和政治觀念

以及過往的經歷，都會影響人們的信任傾向；特定的環境因素，如涉及的利害關係、感知到的風險和可供選擇的方案也會影響信任（Freimuth et al., 2014; Kalichman et al., 2021; Larson & Broniatowski, 2021; H. Li et al., 2022）。

患者對醫生的信任：普遍信任與特定信任之間的動態關係

患者對醫生的信任是一個多維度、多層次的概念，涵蓋了對醫生的信念、期望和情感（Pearson & Raeke, 2000）。它包括兩個組成部分：對醫療體系和醫生職業的普遍信任、對特定情境中個體醫生的特定信任。這兩種類型的信任都包括對體系和個人的能力與道德的信任（例如：開放性、關懷、誠信、可靠性、可信度和公平性）（Metlay, Cvetkovich, & Löfstedt, 1999）。

具體來說，普遍信任可以理解為患者對醫療體系及其代表（如醫院和醫生）的信心，相信這些醫療機構和醫務人員有能力、可靠，能對患者仁慈、負責任地診治病人（Devos, Spini, & Schwartz, 2002; Spadaro et al., 2020）。患者是否具有監督某個具體醫院或醫生行動的能力，並不會影響普遍信任（Gambetta, 1998）。這種信任是基於對監管機構和體系的結構性保障的信心（例如：保證、合同、規定、承諾、法律資源、流程或程序等）（McKnight & Chervany, 2000），以及個人對機構及其代表的普遍認知（Lahno, 2001）。換句話說，在醫療保健領域，普遍信任源於對醫生和醫院的普遍看法，這些看法基於法律規則、政策、規範和道德原則，並與所在社會對陌生人的信任緊密相關（Uslaner, 2002）。

另一方面，特定信任是情境性的，患者通過與特定醫生直接或間接接觸，來評估醫生的溝通內容、態度、專業知識，以及醫生是否正直、誠信和具有責任感，來決定他們對該醫生的信任。這種信任主要是人際之間的，可能在一次接觸中產生（如果患者只看過某位醫生一次），也可能隨著時間的推移而逐漸形成（如果患者多次看同一醫生，或從家人、朋友和社會關係中聽到針對該醫生的評價）。

普遍信任和特定信任相互影響。有研究發現，中國患者對醫生的信任過去是基於他們對政府運營的醫療機構的普遍信任，但是由於中

國醫療體系的市場化，患者與醫生之間的交易關係屬性（例如一次性交易、信任的普遍缺失和對短期利益的追求）導致患者對醫生的信任度下降（Tang & Guan, 2017）。事實上，中國患者對醫生的信任度一直在下降：比如，在2011年的一次全國範圍的調查中，約83%的受訪者表示對醫生信任或非常信任，而這個數字在2016年下降到了64%（Zhao & Zhang, 2019）。影響這種情況的因素可能還包括患者的群體和情境特徵（收入、教育水平、健康情況、疾病持續時間等）、不愉快的治療經歷、媒體報導，以及醫生的溝通技巧和向患者提供的資訊（Tam, 2012; Tang & Guan, 2017; Zhao & Zhang, 2019）。為了進一步了解患者對醫生信任的動態變化，我們提出了第一個研究問題：

RQ1：中國患者對醫生的信任是由甚麼構成的？普遍信任和特定信任之間是如何相互作用的？

研究表明，當患者信任醫生以及他們提供的醫療資訊時，他們會對醫療護理的品質更加滿意，從而會更好地遵守醫囑（Hall et al., 2001）。另一方面，面對信任下降，醫生和患者需要共同應對相關挑戰，以便讓醫生能有效地治療患者，讓患者能得到所需的醫療服務。但是，現有的研究很少考慮信任關係的雙方如何積極塑造和管理信任的問題（Mollering, 2006）。了解醫生和患者的應對策略可以進一步說明信任是如何被建立、維持、失去或重新獲得的動態過程。這引出了我們的第二個研究問題：

RQ2：在對醫生的信任缺乏的情況下，中國的醫生和患者如何應對這種挑戰？

研究方法

數據收集

本研究是中國醫患溝通一個多年研究項目的一部分，得到了兩位作者各自所在大學倫理委員會的批准。本文報告的大部分訪談都完成於2018年夏天。兩位作者分別前往中國，採訪了醫院管理人員和擁有

不同專業背景的醫生（n = 21）以及患者／普通消費者（n = 25）。[1]為了更好地了解中國的醫療體系，我們還訪問了保險代理人（n = 3）、醫療保健行業從業者，如保健品、中藥和醫療設備的銷售人員（n = 3）和政府官員（n = 1）。這些受訪者有不同的社會經濟背景，從擁有研究生學位的醫生和教授，到只完成小學或中學教育的保姆、赤腳醫生、退休工人和農民工等。我們通過個人聯絡和滾雪球抽樣方式招募受訪者。採訪在不同的地域進行，包括北京（首都）、南京（東部大城市）、重慶（西南部大城市），以及中小型城鎮如奉節、鎮平、無錫和竹園等。鑒於地理位置與醫療資源分配以及居民的社會經濟地位相關，本研究旨在通過與來自不同地域的患者進行訪談，以便更好的了解各式各樣的患者在醫療體系中的經歷以及信任問題的細微差別。

本文採用了半結構式訪談，採訪問題包括個人對醫療系統、醫患互動和醫患信任的一般看法和體驗。徵得受訪者同意後，我們對一些採訪進行了錄音，然後轉錄成文字稿。如果受訪者不願被錄音，我們就採用了速記辦法，並在採訪中做了大量筆記。我們還分析了醫患互動的相關媒體報導、社交媒體上的相關內容，以及在線醫生評論網站（如中國最大的在線醫師評論網站「好大夫在線」〔https://www.haodf.com〕，此網站曾被多次用於醫患關係和患者滿意度的研究，例如：Hao & Zhang, 2016和Wu & Tang, 2021）。

數據分析

我們用智慧交互方法進行數據分析（Tracy & Hinrichs, 2017）。與基於歸納理論構建的傳統紮根理論方法相比，智慧交互方法結合了演繹與歸納兩種方式，可以整合已有研究中已經確定的理論並從新數據中建構出新的理論。這個方法分為幾個步驟：（一）我們從訪談文字記錄和筆記開始進行自由編碼分析，以識別重要的代碼（Glaser & Strauss, 1967）；（二）基於現有文獻中提取的主題，我們進行二級編碼分析；（三）我們梳理現有理論和數據，通過軸向編碼分析將這些重要概念之間的關係進行分類。在討論患者對醫生的信任時，我們特別關注了影響信任的因素、動態的醫患溝通，以及醫生和患者如何應對信任的缺

失的應對策略。數據收集和分析均以中文進行，並由作者將選定的引文翻譯成英文。我們旨在通過全面深入的分析，來建立一個患者對醫生的信任問題的概念模型。

研究發現

我們的數據分析顯示，多個因素共同影響著患者對醫生的信任，包括結構性因素（如中國的醫療改革、健康消費主義、變化的資訊環境等）、患者個人屬性（如地理位置、教育程度、社會經濟地位等），以及情境因素（包括治療時間、疾病性質、醫患溝通等）。患者對醫生信任的關鍵是普遍信任和特定信任之間的動態關係：普遍信任通常影響特定信任，而特定信任可以加強、挑戰或削弱普遍信任。

RQ1：普遍信任與特定信任之間的動態關係

我們認為普遍信任與特定信任之間的關係是動態的，二者相互影響，從而在彼此之間形成循環、交互作用。

普遍信任

普遍信任是指這樣的普遍信念：中國的醫療體系會保護個人健康，醫生在治療患者時通常是有能力和有道德的。普遍信任指向醫療體系和醫生的職業能力（醫術）和誠信（醫德）兩方面。結構性因素，例如醫療改革、健康消費主義和變化的訊息環境，深刻影響著中國患者對醫生和醫療機構的普遍信任。同時，患者的個人特徵，特別是地理位置、社會經濟地位和教育程度，也會影響他們對醫生的普遍信任。

I. 中國的醫療改革

在20世紀90年代的醫療改革之前，政府擁有並管理公立醫院，醫生是政府僱員，從政府領取固定工資，所以沒有動機去過度診斷和過度治療，社會上對醫療機構和醫生這個職業普遍很信任。然而，隨著醫療改革的進行，醫院開始以盈利為目標，醫生的個人收入與他們通過看病、進行診斷檢查和開處方所產生的收入掛鉤。患者擔心醫生榨

取他們的金錢，這導致患者對醫療體系的普遍信任度下降。在我們的訪談中，醫生和患者都懷念那個人們普遍信任醫生的黃金時代。一些醫生表示，過去他們與患者的關係「更加純粹」，有更多的信任。例如，重慶的一名43歲的女醫生（L05）表示：「二十年前，醫患關係很好。那時候，簽字也少，雙方勇於承擔責任。醫改以後，政府投入太少，由市場主導，尤其是私立醫院，小病大治，激化了醫患矛盾。」患者們也懷念以前的醫患關係。例如，一位來自小城鎮的83歲的農村居民（L32）指出：「醫生本來受人尊敬，但是現在醫生心地不好，希望人生病才能弄到錢。如果都不生病，醫生就弄不了錢。」城市居民特別懷念過去的醫患關係，因為現在的醫療費用比以前要高得多。

醫患雙方都認為，現有的醫療制度既不能保護醫生也不能保護患者。一方面，醫院資金短缺，卻同時被要求保持財務穩健並提供低價的醫療護理。因此，醫院不得不尋找新的創收模式。醫生們覺得自己是弱勢群體，因為體制未能為他們提供足夠的個人、財務和法律保護；政策的持續變化也意味著醫生和醫院必須不斷調整做法。另一方面，雖然患者普遍認可醫生的技能和專業素養，同時也認可自己獲得醫療服務的機會得到了改善，但是很多患者，特別是社會經濟地位比較低的患者，仍然擔心被當前的體系佔便宜。

在制度上，醫療改革加強了三級分層制度。大城市的醫院比小城市和農村醫院擁有更多資源和有資質的醫生，從而加劇了沿海大城市與欠發達的小城鎮／農村地區之間的差距。前面討論過的最近實施的三級治療制度也更讓人們認為基層醫院的醫生水平不夠高、醫療設備不夠先進，並致使患者更信任大城市的大醫院和醫生。例如，一位來自小城市的54歲的退休政府員工（L38）表示：「我是以醫院來判斷醫生的：我對大醫院相信，市級以上的比較相信，縣級小醫院沒有條件（人員和設備）。」小城鎮醫院通常對重病無能為力，患者經常不得不轉院到更大、設備更先進的醫院。然而，一些患者對轉診制度懷有深深的不信任，認為醫生建議轉診是為了拿到回扣。例如，一位來自小城鎮的34歲女性（L26）說：「竹園（一個小鎮）不行就轉到奉節（一個縣級市、縣政府駐地），奉節給竹園回扣。奉節辦私人醫院，辦自己的診所給回

扣，哪個醫院回扣高就往哪轉。甚麼都有回扣，主要是經濟利益，當然也有想治好的因素。」

中國的醫療系統以前還存在另一個主要問題，就是缺乏規範處理醫療紛爭和醫患衝突的正式法律框架。受訪醫生們表示，這種缺失加劇了患者與醫生之間的緊張關係和衝突。過去由於缺乏正式的爭端解決管道，當患者及其家屬感覺自己受到不公正對待時，有時會採取極端措施，如示威或暴力攻擊。由於中央政府強調維穩，院方通常不得不對這類擾亂秩序的抗議作出讓步，給予患者和家屬大額賠償。例如，一家縣級醫院的副主任(L01)描述了這種情況：「以前是大鬧大賠，小鬧小賠，不鬧不賠。中國存在很多問題，比如法制不健全，政策沒有上升到一個高度，害得老百姓要自我保護，醫生也要自我保護，或者不願冒風險。」

許多受訪醫生對政府近期規範醫療糾紛仲裁、改善醫患關係的努力表示讚賞。政府通過一些法律規範來處理醫患糾紛，明確了醫生和患者的權利和責任以及處理醫療問題的法律程序。[2]很多醫院，包括縣級醫院，建立了處理醫患糾紛的正式程序，包括調查、仲裁和法律解決方案的指南。這些措施能更好地保護醫患雙方，並增加了患者對醫療系統和醫生的信任。這表明程序、規則和規範有助於建立信任。

II. 健康消費主義的興起

自上世紀90年代以來，隨著消費文化在中國的興起，健康消費主義也成為一個突出現象。健康消費主義關注個人健康，認為健康是一種可以像其他服務一樣進行買賣的商品。中國的醫院要求患者及其家人在治療前付款，進一步強化了醫生與患者之間的交易關係。許多訪談對象都提到，如果患者無法支付醫療費用，醫生和醫院就會立即停止治療。一位來自重慶的25歲男性計程車司機(L22)聲稱自己從未在醫院看過醫生，他表示：「公立和私立醫院都不可信。醫生都是騙人的，你知道很多檢查是沒有必要的。我沒進過醫院，反正醫院騙人。不給錢，就不給人治病，難道讓病人去死？」這段話和其他類似的表述都表明，一部分公眾認為醫生和醫院是以盈利為目的的。

另一方面，醫療市場化，讓患者可以在不同醫生和醫院之間進行比較，給了他們更多的選擇。有人形容看醫生就像是「照顧他們的生意」(T03)。醫生也承認市場化促使他們以更友好的方式對待患者。例如，一位來自重慶的32歲女醫生(L04)說：「患者意識到自己是一個消費者，是一件好事情。我們的想法都是按照行醫制度做的。好的行醫模式就是要和患者溝通。有時患者不理解，多溝通才好。」然而，只有那些具備更好經濟和社會資本的人才能獲得優質、稀缺的醫療資源。有強大關係網、經濟富裕和受教育程度較高的人更容易到條件設備更好、醫生水準更高的醫院就醫，甚至可以選擇去看外資醫院和醫生；而經濟條件較差的患者只能負擔起缺乏經驗或資質較低的醫生的服務。這可能會進一步加深健康服務方面的不平等。

III. 訊息環境的變化

中國的訊息環境不斷變化。互聯網和搜尋引擎使個人能夠在網上獲取與其疾病相關的資訊。大多數患者提到他們在百度上搜索醫學資訊。儘管研究人員和媒體對百度的醫學搜尋結果的質量已經提出很多質疑，但對於很多人來說，百度仍然是獲取醫學資訊的首選平台。例如，一位在大城市打工的37歲婦女(T05)說：「我在百度上搜索了糖尿病的資訊。又有圖片又有解釋。我相信。」人們常常會將醫生的診斷和治療計劃與在網上找到的訊息進行對比。一位46歲的大學教授(L21)表示：「因為人們更加有知識，他們可以質疑醫生，並對醫療體驗有一定的期望。」然而，醫生們則認為患者在網上獲取的資訊也是一把雙刃劍，因為互聯網上的資訊可能不完整或不準確。許多醫生表示，這些網上的醫學資訊讓他們的工作更複雜，並且使他們不斷受到患者的質疑和挑戰。

媒體報導也是影響患者對醫生的普遍信任的另一個因素。許多醫生認為，新聞和娛樂媒體中涉及醫生的報導以負面為主，導致了社會對醫生缺乏信任。例如，重慶的一名婦科女醫生(L03)評論道：「前幾年，負面消息多一點，媒體關注揭露行業真相，搞得矛盾好像很尖銳。需要多做正面宣傳，不可能只看壞的一面，就跟一個人一樣。」然

而，一些醫生也指出，在政府的引導下，近年來媒體對醫生的報導變得更加正面，這有助於改善醫患關係。

IV. 患者的個人特徵

患者的個人特徵，如他們的群體特徵（如年齡、性別、教育水準、社會經濟地位等）、性格和過去的經歷，都影響著他們對醫生的普遍信任。一般而言，受過較高教育的人比較不會完全信任醫療系統和醫生，雖然醫生們表示跟他們更容易就複雜的醫學情況和治療方案進行溝通。年輕患者更有可能質疑醫療系統和醫生，他們會將醫生的診斷和治療計劃與在線搜尋結果進行比較。同時，人們的社會經濟地位通常與他們所在地域有關：前往大城市就醫的農村和小城鎮居民可能更信任大城市醫院的醫生，而大城市的城市居民則對不認識的醫生沒有那麼高的信任度，而更傾向於信任他們利用社會關係（比如通過家人、朋友或親戚）找到的醫生。醫療保險的變化也會影響人們對醫生和醫院的普遍信任。例如，中國前段時間推出的農村合作醫療保險，為農村居民提供了基本的保障，不僅減輕了農村患者的經濟負擔，還增加了他們對醫療系統的普遍信任。這種信任水準的提高也可能轉移到對公立醫院的具體醫生身上。

特定信任

特定信任是指患者對具體醫生或醫院的信任。這種信任主要受特定環境的影響，如醫生與患者之間的溝通（例如醫生的態度、溝通內容、技巧、醫術和醫德）、醫療護理、疾病類型（慢性還是急性病、重症還是輕症、住院還是門診等），以及患者的個人屬性。

I. 醫生的態度與溝通技巧

患者和某個醫生的互動會影響他們對這個醫生的信任。由於現在許多患者有選擇權，他們會更在乎醫生的態度和溝通技巧。如果醫生態度不好，他們就會換醫生。我們對「好大夫在線」網站上的醫生評論

所做的研究也表明，醫生的交流方式是在線評論中最常被提及的主題。當醫生態度友好，傾聽患者的訴求，並「像對待家人一樣對待患者」時，患者就會更信任他們。幾乎所有接受我們採訪的醫生都強調了良好溝通技能的重要性。小城鎮的醫生在門診期間通常有更多的時間與患者交流。在擁擠的大城市醫院中，醫生平均在每個患者身上花的時間通常只有兩到三分鐘；但即使這樣，醫生仍然強調良好的溝通的重要性，並希望能有更多時間與每位患者進行交流。

II. 患者對醫術的評價

醫生的醫術影響患者對他們的信任。例如，當被問及是否信任醫生時，一位58歲高中文化的退休女性（T08）表示：「我信任他們，特別是有經驗的醫生。」然而，由於患者通常沒有能力來直接評估醫生的專業能力，他們經常只能根據治療結果來判斷是否應該信任醫生的醫術。許多患者表示，如果治療有效，他們會信任醫生；否則，他們可能會對醫生的能力產生懷疑。醫生們也普遍感覺患者是根據治療結果來評判他們的。一位來自重慶康復醫院的31歲男醫生（L07）表示：「從病人的角度，花錢了，如果效果好，能接受、尊重醫生，如果效果不好，就不尊重醫生，這樣這堵牆就越來越高、矛盾越來越對立。」我們基於網上針對醫生評論的分析也證實了這點。一些醫生甚至覺得他們的服務被（誤）認為是像買衣服或在餐館裏吃飯一樣的普通服務，並且認為患者對治療結果有不切實際的期望。一位來自重慶的35歲女藥劑師（L03）表示：「當患者成為消費者時……許多有錢人認為醫院應該給他們提供服務；很多人沒有錢也有這種想法；但醫療領域是一個關乎拯救生命的特殊職業，不像飲食行業，出售食品或者服裝行業〔……〕雙方都應該互相信任，如果不信任，但是患者生病了又要找醫生，就出現矛盾了。」

中國醫療的分級制也意味著在大城市的知名醫院工作的醫生被認為更有能力，由此也更容易得到患者的信任。這會導致大城市和小城鎮的患者對醫生的信任關係有所不同。在大城市，排名高的醫院人滿為患，患者要等待數小時才能見到隨機掛號分配的醫生。因此，患者與醫生的關係往往是一次性的交易。患者對醫生的信任通常是基於對

醫院或對醫療行業的專業知識和聲譽的信任。只有住院患者才有時間與醫生建立長期關係。相比之下，在小城鎮或城市中不那麼擁擠的醫院，患者有時可以選擇自己已經認識的醫生或通過朋友和熟人結識的醫生。因此，患者更有可能與醫生建立長期關係，他們對醫生的信任是基於反覆交流或人際關係而形成的。根據我們的訪談，與城市(大城市和小城鎮)的患者相比，農村地區的患者擁有最少的醫學知識和社會教育資源，但他們對醫生的信任最高，顯示出信任受到患者自身的醫學知識和社會地位的影響。

III. 患者感知到的醫德

患者對醫生醫德的感受也會影響他們對醫生的信任。醫德通常包括兩個方面：不接受暗箱操作(例如收紅包)和醫生對患者節約費用的考量。雖然政府明確規定禁止醫生收紅包，但許多患者認為他們必須行賄醫生才能得到良好的治療，同時他們也認為拒絕收取紅包的醫生更有醫德。例如，一位兒科患者的家長在網上寫道：「我給徐醫生送紅包，但他不收。他真正值得我們尊重。」

IV. 護理類型

其他情境因素包括疾病類型、護理類型和患者的社會經濟地位也可能影響患者對具體醫生的特定信任。住院患者往往會與醫生建立更長期的關係，從而建立信任的關係，而單次門診通常表現為更多的交易關係。輕症患者，面臨的風險較小；相比之下，重症患者，面臨更大風險。例如，許多接受訪談的患者認為，如果他們的疾病是輕微的，他們可以通過自我診斷，並使用非處方藥物治療，那麼信不信任醫生並不重要。

V. 患者的情境屬性

有時，患者的個人屬性會影響他們在特定情況下對醫生的信任。例如，一些患者表示，當看到與自己性別或年齡相匹配的醫生時，他們更容易信任特定醫生或其診斷和治療計劃。許多年長的患者表示，他們更信任年長的醫生。

建立綜合的信任模型

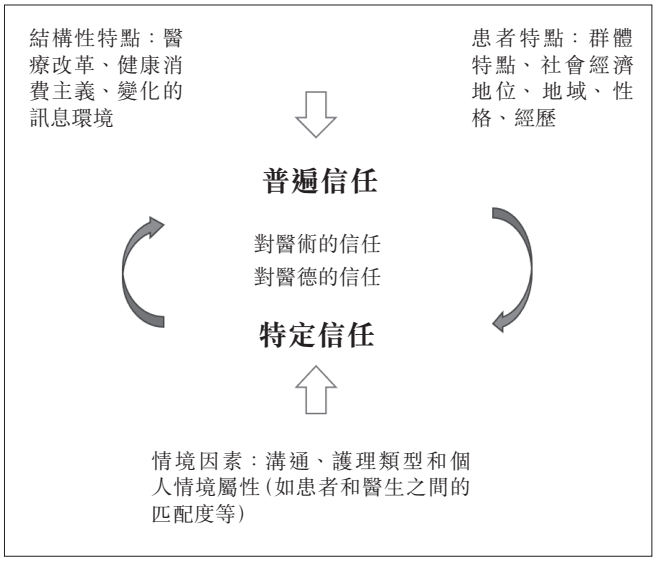
我們根據以上的分析總結了一個綜合模型（圖一）。該模型多層次和多維度地考慮了中國患者對醫生的信任問題，以及普遍信任與特定信任之間的動態關係。總體來看，宏觀的結構因素，如醫療改革、健康消費主義、不斷變化的資訊環境，以及患者的特點（如年齡、教育水準、社會經濟地位和地理位置）影響普遍信任；而醫生的溝通技巧、疾病的性質和患者的情境屬性影響患者對特定醫生的信任。患者對醫院和醫生的醫術和醫德對於兩種類型的信任都是至關重要的。

正如前文討論過的，現有研究表明，除了社會經濟地位和教育水準外的其他群體因素，比如個人性格、年齡、性別等，以及社會、文化和政治價值觀也影響人們的信任傾向；相類似地，醫生的群體特徵（如性別、年齡、教育水準等）也會影響患者對他們的信任或信任水準（Freimuth et al., 2014; Kalichman et al., 2021; Larson & Broniatowski, 2021）。雖然我們沒有研究這些因素，但我們仍將它們納入本文的模型以使該模型更全面。

我們的數據表明，普遍信任和特定信任相互影響。那些對醫療體系和醫療行業表現出普遍信任的人更有可能在臨床接觸時對特定醫生表現出特定信任。有時候，這種影響可以被解釋為確認偏差，即對於那些總體信任度較高的患者來說，他們可能更容易原諒與某個醫生的一次性的負面經歷。而那些對醫療系統持有總體負面態度、普遍信任度較低的人更有可能在與個別醫生互動時持懷疑態度。

同時，患者與業務能力強和有誠信的醫生的良好的就醫體驗，可能會增加他們對整個行業的信任。例如，一位患者在醫生評論網站上寫道：「他耐心解釋了手術的所有細節。既不高冷，還很風趣。他完全改變了我對所有醫生的印象。」相反，負面經歷則可能使患者對整個行業產生負面印象。例如，之前提到的計程車司機（L22）因為他的朋友受到醫生的待遇而決定不信任醫療系統。

圖一　對醫生信任的動態模型



RQ2：醫生和患者如何處理與信任相關的問題

醫生和患者都採用了長期策略和短期策略來處理信任不足的問題。醫生使用的策略包括：廣泛的文件記錄，按照流程進行全面的診斷、進行自我保護性的溝通和預期管理。對患者來說，他們通過積極管理自己的健康，來降低自己的脆弱性和就醫風險。

醫生

I. 詳盡的文件記錄

醫生們詳細記錄他們的診斷過程和治療計劃，並要求患者和家屬在所有文件上簽字；而過去，除了重大手術外，很少需要這樣的書面協定。重慶一位52歲的重症女醫生（L19）表示：「我們現在的操作是根據醫保政策，病歷歸檔，進行醫院病歷書寫，包括醫保用藥，問病史，制定手術計劃、包括出院等，然後和家人和病患溝通。」這樣的廣泛文件記錄旨在發生爭議時保護醫生。例如，上面引用過的另一位醫

生（L07）表示：「在保護自己的情況下看合適的方案。首先是保護自己，再把事情做好……能接受條件和效果才治療。」現在，即使是在村衛生所工作的醫生也使用電腦來記錄醫療資訊。

然而，過度的文件記錄也有潛在問題。它迫使醫生花費大量時間記錄文件，而不是花時間治療患者或進行專業培訓。基層醫院因此面臨人才流失。一位在重慶接受培訓的43歲婦產科女醫生（L05）抱怨道：「醫療人員在文字工作上投入太多，有各種各樣的考核，這樣醫生並沒有太多的時間真正花在看病上……最關鍵的是基層斷檔，下面沒有發展前景，忙於文字工作，基層留不住人。」另一方面，一些患者認為要求他們簽署許多文件是醫生或醫院逃避責任的手段。上面引述過的一位47歲的男性患者（L33）表示：「現在任何事情，大小手術，讓患者簽字，把所有責任推到患者身上，太要不得了。」

II. 廣泛使用診斷測試

除了大量的文件記錄，醫生通常會進行廣泛的診斷測試以避免責任。例如，上面引述過的一位醫生（L01）表示：「以前做基本檢查就可以做手術，比如血常規。現在要做很多其他檢查，不敢隨便斷定，因為老百姓意識提高了。要做的檢查有血常規、凝血、心電圖、照片、愛滋、梅毒病等篩選，要規範些。以前不規範但是現在規範很多。以前門診費七八百塊現在是四五千塊，醫療費用提高了很多。」這種過度使用診斷測試，使費用迅速增加，讓患者覺得醫生之所以要進行這些測試，只是為了賺更多的錢，反而會進一步削弱了患者對醫生和醫院的信任。之前提到的那位女性農民工（T05）也表示：「我沒多少錢。我怕醫生會開太多檢查。所以我只在藥店買藥。」

III. 拒絕治療

有時，醫生會拒絕給某些患者治療來規避風險，尤其是當患者患有預後不良的疾病時。小型私人診所尤其小心，不去接收患有嚴重疾病和慢性病的患者，以保護自己。不斷增加的醫療糾紛也促使小診所和醫生開始購買醫療事故保險，這是一個全新的現象。

IV. 開放友好的溝通

醫生通過開放友好的溝通來建立信任。醫生向患者介紹治療計劃，讓患者了解情況。大多數接受訪談的醫生都認識到他們對患者的影響，並強調了理解患者觀點很重要。他們提到了溝通內容和風格。例如，重慶的一位康復醫生 (L07) 表示：「我們應該實事求是，儘量不隱瞞，特殊情況特殊處理，多換位思考。病人生病，身體和心理都有壓力，把該講的講清楚，在本院能達到哪些東西，哪些達不到。這樣就給出一個比較符合期望值的範圍。」上文引用過的另一位在重慶一家重症病房工作的52歲的女醫生 (L19) 也同意這一點，她說：「多關心、多溝通，從而建立一種信任關係和朋友關係，病人會很感謝醫生。溝通主要包括兩方面：從技巧上，讓病人信任；站在病人的角度，用專業知識去引導他們理解醫治目的和方案。」

醫生們還強調在與患者溝通時要有耐心，把他們當作朋友，有些醫生會與患者聊家常。上文引用過的一位小鎮的醫生 (L10) 表示：「理想的醫患溝通像談家常一樣就行了，不需要刻意，不呆板才好。我們的很多患者是農民，農村人囉唆，必須要及時引入正題，必須解釋清楚，一遍不行就說兩遍。」相比之下，大城市或知名醫院的醫生通常會十分繁忙，作為解決方案，醫院會培訓護士與住院患者溝通。前面提到的一位醫生 (L20) 也表示同意：「中國有句諺語：『欲速則不達』。你越是想儘快把事解決掉，今後越會出問題。」

V. 增加透明性

醫生與患者的溝通更加透明，即使在涉及絕症的時候。過去醫生為了讓患者更好的配合醫生治療，往往只向患者的家人透露癌症等絕症，以免病人情緒崩潰。然而，現在他們更加強調患者的知情權。大多數接受訪談的醫生更傾向於和患者開誠布公地討論診斷、治療計劃、費用和涉及的風險。[3] 然而，醫患雙方都明白，由於醫療的複雜性，透明度總是有限。一位上面引述過的醫生 (L19) 表示：「患者應該相信我們是受到職業道德約束的，藥不可能在患者面前配 (即醫療做到完全透明)。」這句話表明建立醫生和病人的信任關係是處理醫患關係的關鍵。

患者

I. 長期策略

對醫生和醫療系統普遍缺乏信任的患者通常會避免就醫。很多受訪者談到了他們採用健康的生活方式（如飲食健康、定期鍛煉）來避免看醫生。一些受訪者表示，他們經常吃營養品（包括傳統中藥、複合維生素或人參）來增強體質，以避免看醫生。老年人和生活在農村地區和小城鎮的人往往更信任傳統中醫，通常通過中醫和食療來調理、綜合治療。例如，一位53歲的農村女居民（L31）自豪地表示，她用傳統中醫來進行保健，在她生過孩子以後的26年裏，她從未住院或看過醫生。因為信任別人會使得自己面對他人時具有脆弱性（Rousseau et al., 1998），管理自己的健康可以使自己不被無良醫生和醫療體系傷害。

人們還通過不斷學習來了解疾病的癥狀和治療方法，以便質疑和挑戰醫生。許多接受訪談的患者表示，他們經常在百度和微信上閱讀有關健康和醫學的資訊，看關於保健的電視節目。通過這些學習，患者可以不斷評估他們的資訊和經驗，確定甚麼可以信任、甚麼不可以信任、生病了該怎麼辦等。這些都顯示了他們在自我健康管理方面的思考和行動能力。

II. 短期策略

當患者對醫生缺乏信任時，他們在就診時會採取短期策略來保護自己的利益。例如，當患者生病時，他們會上網搜索資訊，並將搜索的結果與醫生的診斷和治療進行比較。有時，患者會向多家醫院徵求意見。上文引用過的一位男性患者（L38）表示：「我看病時，至少找兩家醫院；如果他們說的一樣〔診斷和治療方案〕，我就相信他們；如果不同，我會找第三家醫院。」有時，患者甚至會用錄音機記錄醫療諮詢的過程。然而，醫生們憎惡這種做法，因為它會使醫生更易受傷害。

患者應對信任缺失的另一種方式是使用昂貴的產品或測試。例如，在將政府提供的免費年度體檢與自費體檢進行比較時，一位66歲的退休小企業主（T03）說：「我們退休人員每年都有免費的體檢，但我

不相信它。」當被問及原因時，她說：「因為免費體檢不徹底。」暗示高價格與高品質醫療服務質量的關聯。

向醫生支付「紅包」也是患者應對信任缺失的一種方式。一位65歲的退休人員（T07）表示：「鄉鎮醫院，小地方（收紅包）。南京現在不收紅包了。我們老家還是收，比如你生寶寶你不送紅包，你再怎麼痛他也不理你了。」這樣的評論在患者中很普遍，他們感到在當前的醫療體系中他們很脆弱，對醫療機構和醫生普遍沒有信任。

在中國這樣一個以關係為基礎的社會中，患者還通過個人關係網來控制風險。在小城鎮，患者去看他們直接或間接認識的醫生。即使在大城市，患者也試圖通過他們的關係網來找醫生。與醫生有個人關係意味著醫療就診不那麼具有短期交易性，而更加注重長期關係，從而將風險降低。對於沒有個人關係的患者，依靠醫院的聲譽是另一種控制風險的方式，那些在聲譽良好的醫院工作的醫生被認為擁有更高的醫術和醫德。這也顯示了對機構的信任可以轉化為對某個醫生的信任。

討論與結論

患者對醫生的信任是臨床醫患關係中的一個關鍵因素，對患者的滿意度和臨床結果有重要影響。本文研究了中國患者對醫生的信任問題。我們考慮了不斷變化的醫療政策、法律規範，以及公眾對醫療體系和醫生這個職業的看法。我們的研究有以下獨特貢獻：首先，我們的模型顯示了患者對醫生信任是非線性的並具有動態性質，同時我們也考慮了塑造當前醫患關係的歷史背景和特定的醫患互動。我們的模型採用了辯證的方法，將患者對醫生的信任概念化為兩個層面：一是對醫療體系和醫療行業的整體信任，二是對臨床互動中特定醫生的情境信任；此外，我們的模型也認識到了個人身份的變動性。大多數人只有在臨床環境中與醫生進行交流時才是患者，在此期間，他們對醫生的信任是基於具體醫生的交流方式、能力和道德。而在非醫療的環境中，他們仍然可以以廣義上的患者／消費者身份對醫療體系進行評

價。我們的模型強調，患者對醫生的信任既受特定交流的影響，也受他們對醫療行業整體信任的影響。

中國的社會背景，包括醫療市場化、醫療消費主義和資訊環境的變化，都會影響患者對醫療體系和醫生這個職業的普遍信任。醫院籌資模式的變化導致了過度治療和高額費用，從而削弱了公眾對醫療保健體系和醫生職業的整體的信任。此外，醫療保健體系的市場化（Tang & Guan, 2017）和消費主義的興起（Li, 2016）也創造了一種觀念：醫療服務可以根據市場價格來購買，價格越高，服務越好，有錢人更應該享受更好的服務。作為消費者，人們需要不斷關注自己的利益，避免被佔便宜。這種心態也導致人們對醫療保健系統和醫療專業人員缺乏普遍信任。新聞和娛樂媒體也顯著影響患者對醫療保健系統和從業人員的普遍信任。自 20 世紀 90 年代以來，媒體對不道德醫療行為的報導不斷增多，與此同時，人們對醫療保健系統的信任度普遍下降。相比之下，最近政府法規要求媒體減少對醫療行業的負面報導，也增強了公眾對醫生和醫院的信任。

患者對於醫生的道德和能力的看法在普遍和特定信任之間的動態關係中起著核心作用。不同地域的醫生會受到不同的評價：在大城市知名醫院工作的醫生往往被認為更有能力，而小城鎮或農村地區的醫生則被認為能力低一些。患者會通過醫生的態度、行為和治療效果來不斷評估醫生是否有道德或能力。

本研究採集並分析了患者和醫生的數據，使我們能夠了解雙方的觀點。總體來說，二者對當前患者對醫生的信任狀態的評價以及影響信任的主要因素看法類似。但是，他們的一個分歧是：醫生通常認為網上的醫學資訊不可靠，有損患者對醫生的信任，而患者普遍信任網上醫療資訊。患者感覺通過閱讀網上醫療資訊會令自己變得更有知識，對這些資訊源也產生了整體的信任，但是醫生則更清楚地意識到網上醫學資訊的誤導性或對其的錯誤理解可能阻礙有效的醫患交流，從而進一步削弱患者對診斷和治療的信任。儘管之前的研究表明，在搜尋引擎百度上獲取的醫學訊息品質存在問題，人們依然普遍依賴該搜尋引擎獲取醫學資訊（Zou & Tang, 2021）。另一個小小的分歧是，醫生常常認為患者不切實際地期望他們能治癒自己的疾病；然而，我們採訪的大多數患者對醫生能做甚麼和不能做甚麼有更理性的認識。

此外，我們的研究模型還考慮到了大城市和小城鎮及農村地區之間的差異，並用宏觀和微觀層面的因素解釋了為甚麼存在這些差異。現有的中國醫患交流研究主要在大城市進行，可能是為了方便數據收集 (Tang & Guan, 2017; Zhao, Rao, & Zhang, 2016)；但是，我們的研究表明，地理位置會影響患者對醫生的普遍和特定信任，以及醫生和患者如何應對信任缺失的策略。小城鎮和農村地區的居民對醫療保健的態度與大城市居民不同。這些差異不能完全通過傳統的社會經濟地位和教育背景等傳統變數來解釋。相反，不同地域中的醫療體系的結構導致了人們對於醫療保健的不同看法。小城鎮的患者基於人際關係和反覆互動而信任個別醫生，而大多數大城市的患者基於對醫院質量的總體評價而信任醫生。當然，有關係的患者仍然會嘗試看認識的醫生。當小鎮患者因小病去看醫生時，他們希望醫生有良好的交流禮儀並有時間為他們服務。相比之下，在大城市看名醫的患者信任醫生的專業知識，因此對溝通方式和態度沒有太高的期望。

最後，我們的研究展示了醫生和患者如何戰略性地應對信任缺失所產生的相關挑戰。管理個人在醫療體系中的脆弱性是醫生和患者的首要目標。醫生通過細緻的文檔記錄、廣泛甚至有時過度使用診斷測試和開誠布公的溝通來保護自己。患者則採取長期策略和短期戰術來管理健康問題，以儘量降低自己的脆弱性。另外一個方法是嘗試去看與他們有私人關係的醫生或在大醫院工作的醫生。我們的研究結果表明，醫生和患者在塑造自己的溝通和醫療環境方面也表現出了主觀能動性和適應力。

本研究的實際意義

雖然目睹對中國醫生的信任度下降令人沮喪，但我們的模型表明，可以通過積極的醫患溝通和良好的監管制度安排來讓患者重新獲得和維持對醫生和醫療體系的信任。我們的研究還表明，小城鎮和大城市的人們表現出不同類型和程度的信任，這意味著應該針對不同社區實施不同的醫療培訓計劃和不同的溝通方式。

考慮到醫生和患者對在線醫療資訊的不同理解，中國需要進行健康素養和媒體素養教育，以便公眾了解如何批判性地評價在線醫療資訊。百度等網上資源因醫療資訊造假醜聞而受到損害。考慮到患者和

醫生都認識到溝通的重要作用，將溝通課程納入醫學學位和培訓計劃也非常重要。中國醫療領域正在進行的反腐敗運動可能會進一步削弱人們對醫療領域的普遍和特定信任，我們的模型可以指導如何針對醫療系統和醫務人員的信任進行重建。

未來研究方向

我們的研究有助於了解小城鎮和農村地區的醫患溝通，但這方面的研究很少。考慮到大多數中國人仍然生活在小城鎮和農村地區，有必要對小城鎮和農村居民進行更多的研究，以滿足他們的醫療需求。我們的研究是基於定性數據，未來的研究應該使用定量研究來檢驗這個模型。還需要對不同文化和國家背景下的醫生信任度進行比較研究，以測試我們概念模型的外部有效性。此外，新冠疫情期間公眾對醫生的看法可能在某種程度上恢復了醫生在中國的聲譽，但是目前進行的醫療反腐運動則可能對於醫患信任產生負面影響。未來可以研究這些變化如何影響公眾對醫生的信任。

註釋

1 本文中，「患者」這個詞寬泛地指代「已經就醫或可能就醫的非醫務人員」。當個人代表自己或家人與醫生進行交流時，他們被稱為「患者」；即使在非醫療環境下，個人在考慮與醫生在醫療場所的關係時也可以被稱為「患者」。

2 《中華人民共和國刑法修正案（九）》（2015年）的第31條規定，組織妨礙醫療服務的抗議活動的人可面臨最高七年的監禁。2016年3月，中國國家衛生和計劃生育委員會、中央綜治委員會、公安部和司法部發佈了一份聯合通知，明確指出「在醫療糾紛責任未認定前不得賠錢給患者，未停止擾亂秩序行為前不得進行調解」，以及其他措施（人民網，2016）。

3 當然如果患者的家人不希望把絕症病情告訴患者，醫生通常也會尊重家人的意見。

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Chinese Patients' Trust in Physicians: Dynamics Between General and Particular Trust

Hongmei LI, Lu TANG

Chinese society has experienced escalating tensions between doctors and patients, accompanied by a surge in violence against medical staff. According to the Chinese Medical Doctors Association (2015), 60% of medical personnel have suffered verbal abuse, and 13% have been physically attacked. In 2018, at least 12 high-profile violent attacks on physicians and nurses were reported in Chinese media (Eefung Software, 2018). Even amidst the celebration of frontline physicians and nurses as national heroes during the COVID-19 pandemic and the overall improvement of physician-patient relationships, physical attacks against clinicians continued to occur (Zhou et al., 2021). The problematic doctor-patient relationship has been attributed to several reasons, including insufficient healthcare resources, high medical costs, (perceived and actual) unscrupulous behaviors of physicians, information asymmetry, uncertainty in medical treatment outcomes, and unrealistic expectations from patients (Zhao et al., 2013) as well as the marketization of healthcare and the rise of health consumerism (Tang & Guan, 2017). It is common to hear the discussion that China is experiencing a trust crisis in the medical field at the interpersonal level, as demonstrated by the extreme cases involving violence discussed above, and at the systemic level about medical corruption, as revealed by a recent nationwide anti-corruption campaign during which hundreds of hospitals were investigated and administrators fell into disgrace (Huang, 2023). Even though trust is central to the doctor-patient relationship, little systematic research has been conducted to understand patients' trust in physicians and the strategies physicians and patients use to address the challenges associated with the lack of trust.

This paper has two main objectives: (1) to understand the major factors contributing to trust in physicians in China and to establish an integrated model that accounts for the dynamic process of trust building; and (2) to investigate how doctors and patients manage the lack of trust. The proposed model aims to elucidate the dynamics of patients' trust in physicians and may be applied to other cultural or national contexts.

To our knowledge, there is no existing theoretical model of patients' trust in physicians in China that integrates both macro- and micro-level factors, not to mention a model from a communication perspective. Some studies (Han et al., 2022; Sun et al., 2018) conducted by medical professionals had a limited scope, primarily focusing on the technical aspects of trust generally using surveys to gather data without offering an integrated perspective. Nevertheless, the decline in trust has worried many medical professionals and authorities. In 2013, *The Lancet* published articles delivering pessimistic views with titles such as "A Gloomy Future for Medical Students in China " (Zeng, Zeng, & Tu, 2013) and "Appeal from Chinese Doctors to End Violence" (Yang et al., 2013). These articles depicted Chinese medical professionals as marginalized and as victims within the system and expressed concerns about a potential exodus of medical professionals. On the other hand, there were numerous stories in popular literature about how patients were mistreated by medical professionals. Thus, integrating the perspectives of both doctors and patients will provide cumulative knowledge about potential recommendations and solutions.

Literature Review

China's Medical Reforms: Building a Hierarchical Three-Tier Healthcare System

China's hierarchical healthcare system favors large cities and more economically developed coastal provinces, and this is the result of China's medical reforms and the history of the dual medical system that has divided the city and countryside. After 1949, China developed a government-run healthcare system characterized by a city-country divide based on *hukou* (戶口). This system allocated 90% of healthcare resources to cities and state-run hospitals and clinics. In contrast, rural residents were served mainly by village doctors (or barefoot doctors 赤腳醫生) with little formal modern medical training (Hesketh & Wei, 1997).

China's healthcare system has undergone considerable changes since the economic reforms started in 1979. In the early 1980s, the central government drastically reduced healthcare funding and relegated financial responsibility to provincial and local governments, which led to a deepened

disparity in healthcare resources between coastal and inland provinces (Hesketh & Wei, 1997). Hospitals were required to be fiscally accountable (Zhao & Feng, 2010). In rural areas, the government dismantled communes to privatize agriculture, thus destroying the healthcare safety net for rural residents (Blumenthal & Hsiao, 2005). In 1989, China issued the *Tentative Hierarchical Management Measure of Hospitals* (《醫院分級管理辦法(試行)》), formalizing China's three-tier hospital structure that consisted of basic hospitals/clinics in rural areas or small towns, intermediate, county- or district-level hospitals, and top-level hospitals in large cities. Medical resources and personnel were distributed based on a hospital's tier, with small clinics and hospitals in rural areas or small towns having the least resources.

Further decentralization of the healthcare system occurred in the 1990s, accompanied by measures to compensate for declining government funding. Physicians were incentivized to prescribe expensive new drugs and diagnostic tests to increase their income and hospitals' profits (Zhao & Feng, 2010). Pharmaceutical companies offered physicians kickbacks for adopting their products. Private practices also emerged in the 1990s and thrived after 2000. These changes in the public and private sectors led to overtreatment and rising healthcare costs. During this period, China's healthcare system was characterized by inadequate government funding, weakened support for medical providers, increasing inequality, decreasing access to medical care, rising patient costs, and the exodus of the healthcare workforce (X. Li et al., 2017).

After the severe acute respiratory syndrome (SARS) outbreak in 2003, China shifted its focus toward balancing fairness and efficiency by aiming to provide healthcare to all residents (H. Li et al., 2017). In 2006, the central government announced the establishment of a healthcare system aiming to guarantee citizens' access to basic healthcare, including expanding medical insurance coverage, reforming public hospitals, and decentralizing the pricing system of pharmaceutical products (Brookings-Tsinghua Center for Public Policy & Changce Zhiku, 2012). Rural residents began to receive basic healthcare coverage subsidized by the state for the first time. Public hospitals were also forbidden from issuing income-generating quotas to their doctors and departments.

In 2015, China further developed its three-tier care system, aiming to better utilize medical resources and relieve strained high-tier urban hospitals

by encouraging patients to seek basic care from primary doctors in lower-tier hospitals first and then be transferred to higher-tier hospitals for more complicated illnesses (Gao et al., 2021). Within this context, we study patients' trust in physicians in China.

Trust

While different definitions exist across disciplines, trust is commonly defined as "a psychological state comprising the intention to accept vulnerability based upon the positive expectations of the intentions or behavior of another" (Rousseau et al., 1998, p. 395). There are three sources of trust: familiarity developed through previous contact, calculations based on the pursuit of interest, and institutional norms (Adler, 2001). Some scholars have classified trust into relation-based trust and competence-based trust (Earle, 2010; Rousseau et al., 1998). Relation-based trust focuses on long-term goals and is more tolerant of risk because it is built on value similarities. In contrast, competency-based trust is more risk-averse, short-term, and calculative since it is based on the track record and abilities of the other party (Earle, 2010). Since trust is relational, it involves the party that trusts and the party that is trusted (H. Li et al., 2022; H. Li et al., 2023). Characteristics of both parties, such as personality, demographics, social, cultural, and political values, and past experiences, all influence people's propensity to trust. Specific contexts, such as stakes involved, perceived risk, and alternatives available, also affect trust (Freimuth et al., 2014; Kalichman et al., 2021; Larson & Broniatowski, 2021; H. Li et al., 2022).

Patients' Trust in Physicians: Dynamics between General and Particular Trust

Patients' trust in physicians is a multidimensional and multilevel construct that can incorporate beliefs, expectations, and emotions toward physicians (Pearson & Raeke, 2000). It includes two components: general trust in the medical system and profession, and particular trust toward individual physicians in specific encounters. Both types of trust encompass perceived competence and ethics (e.g., openness, caring, integrity, reliability, credibility, and fairness) (Metlay, Cvetkovich, & Löfstedt, 1999).

General trust can be understood as the patient's confidence that the medical system and their representatives (hospitals and physicians) are competent, benevolent, reliable, and responsible toward patients (Devos, Spini, & Schwartz, 2002; Spadaro et al., 2020), regardless of their ability to monitor the actions of specific hospitals or doctors (Gambetta, 2000). It is based on the confidence in the structural assurance that governs the institutions (e.g., guarantees, contracts, regulations, promises, legal recourse, processes, or procedures) (McKnight & Chervany, 2000) as well as individuals' general perception of the institutional actors and representatives (Lahno, 2001). In the healthcare context, general trust arises from a prevalent perception of physicians and hospitals based on legal rules, policies, norms, and ethical principles and is closely associated with trust in strangers in a given society (Uslaner, 2002).

On the other hand, particular trust is situational in that patients develop it when they directly or indirectly encounter doctors and when they can evaluate a doctor's communication, attitude, expertise, honesty, integrity, and fiduciary responsibility. Such trust is primarily interpersonal and can develop on one occasion (if patients only see the doctor once) or over time (if they see the same doctor repeatedly or have heard about the doctor from family members, friends, and their social networks).

General and particular trust can influence each other. An earlier study found that while Chinese patients' trust in physicians was historically based on a general trust in government-operated medical institutions, the transactional relationship between patients and physicians (such as one-time exchanges, lack of trust, and short-term interests) due to the marketization of China's medical system has eroded patients' trust in physicians (Tang & Guan, 2017). Patients' trust in physicians in China has been declining. For instance, a study shows that while around 83% of participants in a national survey expressed strong trust or trust in physicians in 2011, this figure dropped to 64% in 2016 (Zhao & Zhang, 2019). Other contributing factors might include a patient's demographic and situational characteristics (income, education, health status, length of illness), unpleasant treatment experience, media coverage, as well as physicians' communication skills and information provided to patients (Tam, 2012; Tang & Guan, 2017; Zhao & Zhang, 2019). However, the dynamic relationship between general and particular trust, especially in the Chinese context, must be further explored. Thus, we ask the first research question:

RQ1: What constitutes patients' trust in physicians in China? How do general trust and particular trust interact with each other?

Research shows that trust in doctors and medical information is positively related to patient satisfaction and perceived care quality, resulting in better medical compliance (Hall et al., 2001). However, declining trust requires both physicians and patients to manage the associated challenges so that doctors can effectively treat patients and patients can get the care they need. Past research rarely considers how the two sides actively shape and manage (the lack of) trust (Mollering, 2006). Understanding the strategies of physicians and patients can further illustrate the dynamic process through which trust is created, maintained, lost, or regained. This leads to our second research question:

RQ2: How do physicians and patients in China manage the lack of trust in physicians?

Method

Data Collection

The study was approved by the respective institutional review boards of both authors' institutions. It was part of a multi-year project on physician-patient communication in China. Most of the interviews reported here were conducted in the summer of 2018. Both authors traveled to China and conducted interviews with hospital administrators and physicians with a wide range of specialties (n = 21) and patients/general consumers (n = 25).[1] We also interviewed insurance agents (n = 3), healthcare industry practitioners (such as those who sold food supplements, traditional Chinese medicine, and medical equipment, n = 3), and governmental officials (n = 1) to gain a better understanding of China's healthcare system and context. Participants came from diverse socioeconomic backgrounds, including doctors and professors with graduate degrees, nannies, migrant workers, barefoot doctors, and retired factory workers with only elementary or middle school education. Participants were recruited through personal contacts and snowball sampling. Interviews were conducted in different geographic locations, including Beijing (the capital of China), Nanjing (a large city on the East Coast),

Chongqing (a large city in the Southwest), and small cities and towns such as Fengjie, Zhenping, Wuxi, and Zhuyuan. Given that geographic location is related to medical resource distribution and socioeconomic status, interviews with patients from diverse geographical locations enable us to understand a broad range of patients' experiences within the healthcare system and the nuances of trust.

Semi-structured interviews were conducted. Interview questions included individuals' general experience and perceptions about the healthcare system, physician-patient interactions, and trust between physicians and patients. Some interviews were recorded and transcribed. Copious notes were taken when interviewees declined to be recorded. We also analyzed media coverage of physician-patient interactions, social media content, and online physician review websites such as "Good Doctors Online" (好大夫在線; https://www.haodf.com), the largest online physician review website in China. Multiple research projects (such as Hao & Zhang, 2016; Wu & Tang, 2021) used "Good Doctors Online" to study the doctor-patient relationship and patients' satisfaction with medical care.

Data Analysis

We used the phronetic interactive approach for data analysis (Tracy & Hinrichs, 2017). Compared with the traditional grounded theory building approach based on induction, the phronetic interactive approach incorporates theoretical constructs identified from prior research (deduction) and allows new constructs and relationships to emerge from the data (induction). We started with open coding of interview transcripts and notes to identify important codes (Glaser & Strauss, 1967). We then conducted secondary-cycle coding by drawing themes from existing literature. Afterward, we classified the relationship among these important concepts (both from existing theories and our data) through axial coding. When exploring patients' trust in physicians, we paid particular attention to factors contributing to trust, the dynamics of physician-patient communication, and how doctors and patients managed the lack of trust. Data collection and analysis were conducted in Mandarin Chinese. Selected quotes were translated into English by the authors. A conceptual model of patients' trust in physicians was established after extensive analysis.

Results

Our data analysis revealed that multiple factors contributed to patients' trust in physicians, including structural factors (such as China's medical reforms, health consumerism, and the changing information environment), patient attributes (such as geographic location, education, and socioeconomic status), and situational factors (including length of care, nature of the illness, and doctor-patient communication). The structural factors constituted the context for patients' general trust in physicians, while situational factors composed the specific situation for patients to develop or manage their particular trust in individual physicians. At the center is the dynamic relationship between general and particular trust in that the former generally influenced the latter, while the latter could affirm, challenge, or undermine the former.

RQ1: The Dynamic Relationship Between General and Particular Trust

We view the relationship between general and particular trust as dynamic. General trust and particular trust mutually affect each other, thus forming cyclic interactions between each other.

General Trust

General trust refers to the general belief that China's medical system serves to protect individuals' health or that physicians overall are competent and ethical. Structural factors, such as China's medical reforms, health consumerism, and the changing information environment, have deeply influenced patients' general trust in physicians. These factors have conditioned how patients perceive medical institutions and doctors. At the same time, patients' personal attributes, especially geographic location, socioeconomic status, and education level also influenced their general trust in physicians.

I. China's Medical Reforms

The transformation of China's healthcare system through medical reforms in the 1990s marked a significant turning point in the doctor-patient relationship. In the pre-reform era, urban hospitals were government-owned

and run, and physicians were government employees receiving fixed salaries from the government. During this time, general trust in the medical institution and profession was high. Physicians were not financially motivated to overdiagnose or overtreat their patients, fostering an environment of trust and confidence in healthcare. However, as the healthcare landscape evolved, hospitals became profit-driven, and physicians' income became closely tied to the revenue they generated through patient consultations, diagnostic tests, and medication prescriptions. This transition raised concerns among patients, who began to worry that their physicians were driven by financial gain, potentially leading to overutilization of medical services. Consequently, general trust in the healthcare system experienced a sharp decline. In our interviews, both physicians and patients wistfully recounted a bygone era when there was greater general trust in physicians. Doctors said that their relationship with patients then "was purer" with more trust. According to one physician (a 43-year-old female doctor in Chongqing, L05), "*Twenty years ago, the doctor-patient relationship was excellent. There was also little [need for] documentation, and both parties were brave enough to shoulder their responsibilities. After the medical reforms, the government has insufficient funding, and [medical care] is market-oriented, especially for private hospitals. [As a result,] some minor illnesses are overtreated, thus intensifying the doctor-patient conflicts*." Patients also shared similar sentiments. For instance, an 83-year-old rural resident in a small town (L32) remarked, "*In the past, doctors were much respected.… But now some doctors are dark-hearted and only care about money; doctors can only make money when people are sick.*" Urban residents, in particular, felt nostalgic for an era when they paid significantly less for medications and medical treatments as compared to the increased out-of-pocket expenses they face today. These reminiscences underscore the significant impact of the medical reforms on the doctor-patient relationship and the perception of trust within China's evolving healthcare system.

Both doctors and patients have voiced strong criticisms of the existing healthcare system, highlighting its shortcomings in safeguarding the interests of both parties. On the one hand, insufficient funding was provided to hospitals that were simultaneously required to be financially self-reliant and provide low-cost care. Thus, hospitals had to find alternative ways to increase revenues. Doctors stated they were vulnerable because the system did not provide them with enough personal, financial, and legal protection. Constant

policy changes also meant that doctors and hospitals had to adapt and change their practices continuously. On the other hand, patients acknowledged that doctors' skills and professionalism and their medical access had improved. However, patients, especially those of lower socioeconomic status, were still worried that the current system was exploitative.

Institutionally, the medical reforms reinforced the hierarchical three-tier system where large urban hospitals had more resources and more qualified doctors, exacerbating the disparity between big cities on the coast and less developed small towns/rural areas. As previously discussed, the implementation of the three-tier treatment system further solidifies the perception that doctors in lower-tier hospitals possess less competence and have limited access to advanced medical equipment. Consequently, patients were more likely to trust big urban hospitals and their doctors compared to small-town hospitals and their medical staff. For instance, a 54-year-old retired government employee in a small city (L38) stated, "*I evaluate doctors based on the hospitals they work in: municipal-level hospitals are more credible, but small county-level hospitals do not have adequate staff and equipment.*" The limited capacity of small-town hospitals often meant that doctors could do little about serious conditions, and patients often had to be transferred to larger and better-equipped hospitals. However, patients harbored a deep distrust toward the referral system, believing that kickbacks were often the motivation for such referrals. A 34-year-old woman in a small town (L26) conveyed this sentiment, asserting, "*When doctors transfer patients from Zhuyuan [a small town] to Fengjie [a medium-sized city where the county government is based], they will get kickbacks. The higher the kickbacks a hospital provides, the more likely it is that patients will be transferred there. Everything is about kickbacks. Referrals are mainly about monetary benefits, and only some consideration is given to patients' proper treatment plans.*"

Another significant issue arising from China's medical reforms was the absence of a robust legal framework to regulate the resolution of medical disputes and physician-patient conflicts. According to the interviewed physicians, this absence contributed to heightened tensions and physical conflicts between patients and physicians. In the absence of formal dispute-resolution channels, patients and their family members sometimes resorted to extreme measures, such as demonstrations or violent attacks, when they

felt wronged. Hospital administrators often yielded to pressure from such disruptive protests, driven by the central government's emphasis on social stability. This resulted in patients and families receiving disproportionately large settlements. For instance, the deputy director of a county-level hospital in a small city (L01) described this situation as follows, "*Those who caused significant disruptions often received substantial compensations, while those who caused small troubles only got small settlements, and those who did not cause any disturbances received nothing. China faced numerous issues, including inadequate protection through laws and policies, leaving ordinary people to fend for themselves.*"

Many physicians expressed appreciation for the recent governmental efforts to regulate the arbitration of medical disputes. Several laws were passed to address medical disputes by specifying the rights and responsibilities of doctors and patients, as well as the legal procedures for dealing with medical disputes.[2] Hospitals, including county-level hospitals, already established formal procedures to deal with medical disputes, including guidelines for investigation, arbitration, and legal solutions. These changes provided increased protection to both physicians and patients and contributed to higher levels of trust in the healthcare system and physicians. This highlights the role of procedures, rules, and norms in cultivating a trusting environment.

II. The Rise of Health Consumerism

The phenomenon of health consumerism has gained prominence since the 1990s in China alongside the broader rise of consumer culture. Health consumerism was characterized by a preoccupation with personal health and the belief that health was a commodity that could be bought and sold, much like other goods and services. The transactional relationship between doctors and patients was further reinforced when Chinese hospitals required patients and their families to make payments before receiving treatment. Many participants shared stories of doctors and hospitals ceasing medical treatments when patients were unable to make immediate payments. A 25-year-old male taxi driver in Chongqing, who claimed that he had never sought treatment in hospitals (L22), lamented, "*Neither public nor private hospitals are trustworthy. The doctors are here to take advantage of us. [...] I have never been to a hospital because hospitals always try to cheat*

[patients out of their money]. If you can't pay, they won't treat you. Isn't that abandoning patients to their fate?" This quote and many similar ones showed how a segment of the public perceived doctors and hospitals as profit-driven and untrustworthy.

On the other hand, the marketization of healthcare also gave patients more choices when it came to selecting doctors and hospitals. Some individuals described seeing physicians as "*providing them patronage*" (T03). Even physicians acknowledged that marketization incentivized them to adopt a more patient-friendly approach. A 32-year-old female doctor in Chongqing (L04) noted, "*It is beneficial that patients realize their role as consumers and that we have to act on good medical models, which requires us to communicate well with patients; even though patients sometimes do not understand us, we still need to be better communicators.*"

However, it is crucial to recognize that quality healthcare remains a scarce resource, with only those possessing financial and social capital having the privilege of access to it. Well-connected, well-to-do, and well-educated individuals had access to better hospitals, equipment, doctors, and even foreign hospitals/doctors, while the less fortunate could only afford to see less qualified doctors. This is likely to further deepen the health disparity.

III. Changing Information Environment

China's information environment has undergone significant and continuous changes, reshaping how individuals access medical information. The Internet and search engines allowed individuals to obtain information about their illnesses. Most patients mentioned that they searched for medical information on Baidu's search engine. Even though researchers and the media had long questioned the quality of Baidu's medical search results, Baidu was still the go-to place for medical information for most young Chinese consumers we interviewed. For instance, a 37-year-old female migrant worker living in a big city (T05) said, "*I often search for information about diabetes on Baidu. There are pictures. There are explanations. I trust the information.*" It was common for people to compare doctors' diagnoses and treatment plans with information they found online. A 46-year-old college professor (L21) also stated, "*Because people are more knowledgeable, they can question doctors and have certain expectations about their medical experience.*" However, physicians felt that patients' access to such information was a

mixed blessing because the Internet may not provide complete or accurate information. Many physicians expressed that such online medical information complicated their work and subjected them to constant challenges from patients about their diagnosis and treatment plans.

Media coverage of healthcare and medical issues played a significant role in shaping patients' general trust in physicians. Many doctors believed that negative coverage of physicians dominated the news and entertainment media and blamed the media for society's lack of trust in physicians. For example, a female gynecologist in Chongqing (L03) commented, "*There has been more negative news coverage in the last few years. While the media were mostly accurate about medical care, they sometimes sensationalized the conflicts and blew them out of proportion.*" However, some doctors pointed out that the media's portrayal of doctors has become more positive recently due to governmental guidance, which they believed has contributed to better doctor-patient relationships.

IV. Patients' Individual Attributes

Patients' individual attributes, such as their demographics (their age, gender, education level, socioeconomic status, etc.), personality, and past experience, affected their general trust in physicians. Patients with higher education levels were less likely to have complete trust in the system and doctors in general. However, doctors felt that people with higher education levels were easier to communicate with about complex medical conditions and treatments. Younger patients were more likely to compare doctors' diagnoses and treatment plans with online search results. At the same time, people's socioeconomic status was often associated with their geographical locations: rural and small-town residents who went to see doctors in large cities were likely to have more trust in doctors in large urban hospitals, while urban residents in large cities were more likely to use their social networks to find specific doctors that they, their families, friends, and relatives personally knew. Even the change in medical insurance affected trust. For example, China's recently launched state-subsidized basic medical insurance for rural residents, called Rural Collaborative Insurance (農村合作醫療保險), provided rural residents with a basic safety network, which not only lessened rural patients' financial burden but also increased their general trust toward the medical system. Such a heightened level of trust could also transfer to specific physicians working at state-run hospitals.

Particular Trust

Particular trust was patients' trust in individual physicians or hospitals. It was mostly influenced by situational factors such as the doctor's communication with patients (such as bedside manner/communication skills and perceived competence and ethics), types of care and illnesses (long-term vs. short-term, major vs. minor illnesses, hospitalized vs. non-hospitalized), and patient attributes.

I. Doctors' Bedside Manners/Communication Skills

Patients' particular trust in a physician was based on interpersonal encounters. The rise of health consumerism gave patients choices, and patients would pay more attention to doctors' bedside manners and communication skills. If patients were not treated well, they would switch to other doctors. An examination of patients' reviews of doctors on "Good Doctors Online" showed that the bedside manner of physicians was the most mentioned theme in online reviews. Patients tended to trust their physicians more when they were kind, listened to them, and "treated patients like their family." Almost all physicians interviewed stressed the importance of good communication. While doctors in small towns had more time to communicate with patients during consultations, doctors in large crowded urban hospitals generally had only two or three minutes for each patient. Nevertheless, even in large hectic urban hospitals, physicians still emphasized good communication practices and hoped that they would have more time for each patient.

II. Perceived Medical Competence

Patients mostly trusted individual physicians based on their medical competence. For instance, when asked whether she trusted physicians, a 58-year-old retired woman with a high school education (T08) said, "*I trust them, especially experienced doctors.*" However, since patients typically did not have the skills to assess doctors' medical competence, they often evaluated physicians based on their perceived competence. Patients often used treatment outcomes to justify whether they should trust doctors. Many patients stated that if the treatment was effective, they would trust the doctor; otherwise, they might question the doctor's competence. Physicians also generally felt that patients judged them based on treatment outcomes.

A 31-year-old male doctor at a rehabilitation hospital in Chongqing (L07) said, "*After patients spend money, if there is a good outcome, they will respect the doctor; if the outcome is not good, they will not respect the doctor, thus making the wall [between doctors and patients] increasingly thick and intensifying the conflict.*" Our analysis of online reviews of physicians also confirmed this pattern. Some doctors even felt that their services were (mis)perceived as ordinary service, like buying clothes or eating in restaurants, and that patients had unrealistic expectations of treatment results. A 35-year-old female pharmacist in Chongqing (L03) stated, "*When patients become consumers, […] many [with money] may think they deserve the service; even those without money may think so; but the medical field is a special profession about saving lives, not like the food or clothing industry.*" She continued, "*Both parties should trust each other; and if patients do not have trust in physicians, but still need to seek doctors' treatment, then there is a paradox.*"

The hierarchical structure of China's medical care system also means that doctors working in highly ranked large urban hospitals were perceived as more competent and enjoyed more trust because of their institutional affiliations, thus leading to different levels of trust in physicians in large cities and those in small towns. In large cities, highly ranked hospitals were packed, and patients had to wait for hours to be seen by randomly assigned physicians. As a result, patients' relationships with physicians were mostly one-time and transactional. Patients' trust in physicians was usually a general trust in the expertise and reputation of the hospitals or the medical profession. Only hospitalized patients had time to develop long-term relationships with doctors. In contrast, in small towns or less popular hospitals in cities, patients could sometimes choose their physicians, opting to see physicians they already knew or those with whom they had connections through friends and acquaintances. Consequently, patients were more likely to develop long-term relationships with physicians, and their relation-based trust in physicians was based on repeated interactions or interpersonal relationships. Compared with patients from cities (large and small), patients from rural areas had the least amount of knowledge and social and educational capital to evaluate their physicians. Nevertheless, based on our interviews, rural patients trusted physicians the most, showing that trust is influenced by patients' own medical knowledge and social positioning.

III. Perceived Ethics

Individual physicians' perceived ethics was another component of patients' trust in physicians, which included two parts: not accepting under-the-table payments (red pockets) and helping patients save money. Even though accepting red pockets was explicitly forbidden, many patients were under the impression that they had to bribe physicians to receive good treatments, and they perceived physicians who turned down red pockets as having more integrity. For instance, the parent of a pediatric patient wrote online, *"I tried to give Dr. Xu a red pocket, but he has such integrity [that he refused it]. He truly deserves our respect."*

IV. Types of Care

Other situational factors that may affect particular trust include the types of illnesses and care as well as the patient's socioeconomic status. Hospitalized patients tended to establish longer-term relationships with doctors and were more likely to develop trust, while one-time care was often characterized by more transactional relationships. Patients with minor illnesses had less stake in seeing what kind of doctor they saw than patients with major illnesses. For example, many interviewed patients felt trust was not important if they had minor illnesses that they could self-diagnose and get treated with over-the-counter medicines.

V. Patients' Situational Attributes

Sometimes, patient attributes could influence their particular trust in specific contexts. For instance, some patients expressed that they were more likely to trust a specific doctor or the doctor's diagnosis and treatment plan when they saw a doctor who matched their gender or age. For instance, many older patients said they would trust an older physician more.

Building an Integrated Model of General and Particular Trust

Based on the analysis, we summarized our findings in an integrated model that accounted for the multilevel and multidimensional dimensions of patients' trust in physicians in China and focused on the dynamic relationship between general and particular trust (Figure 1). While structural

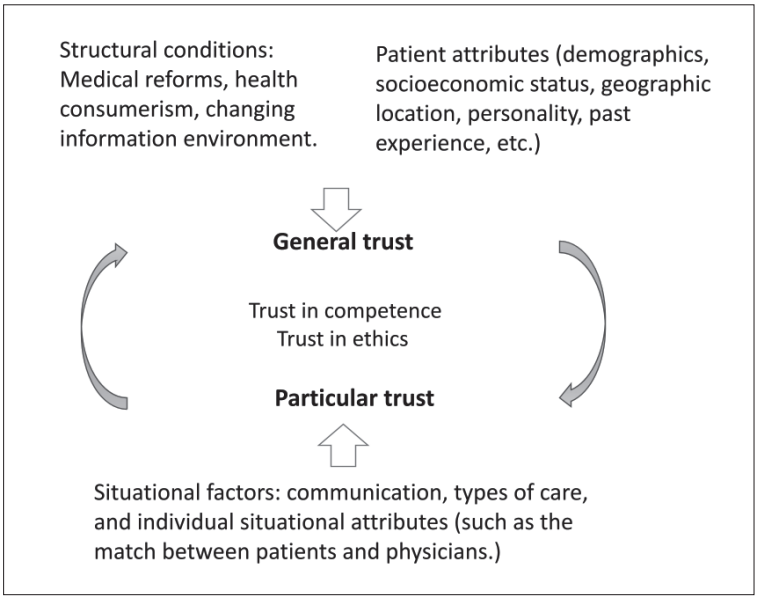
conditions such as medical reforms, health consumerism, the changing information environment, and patients' attributes (such as age, education, socioeconomic status, and geographic location) affected general trust, situational factors such as doctors' bedside manners/communication, the nature of illnesses, and patients' situational attributes influenced patients' specific trust in physicians. Perceived ethics and competence were essential for both types of trust.

As discussed before, past research has shown that personality, other demographics beyond socioeconomic status and education, and one's social, cultural, and political values often affect their propensity to trust; physicians' demographics also affect whether patients trust them or the level of trust (Freimuth et al., 2014; Kalichman et al., 2021; Larson & Broniatowski, 2021). While we did not study these factors, we still incorporated them to make the model more comprehensive.

Our data suggested that general trust and particular trust interacted with each other. Individuals who showed a general trust toward the healthcare system and medical profession were more likely to have particular trust in specific doctors during clinical encounters. Sometimes, this influence can be interpreted as confirmation bias, whereby patients with high general trust might be more forgiving of a single negative experience with a physician. Those with a generally negative attitude toward the system and low trust were more likely to be suspicious when interacting with individual physicians.

At the same time, particular trust can reinforce, challenge, or change general trust. Positive experiences with a highly competent and ethical physician could generate more trust in the medical profession, and negative experiences could have an adverse effect. For instance, one patient wrote about her surgeon on a physician review website: "*He patiently explained all the details about the surgery. He is not arrogant or aloof but has a good sense of humor. He completely changed my impression of all physicians.*" Alternatively, a bad experience in a physician-patient encounter could weaken patients' general trust and make them more cautious when dealing with other physicians. For instance, the taxi driver quoted earlier (L22) decided that he could not trust the medical system because of how a doctor treated his friend.

Figure 1. A Dynamic Model in Trust of Physicians



RQ2: How Doctors and Patients Manage Trust-Related Issues

Both doctors and patients used long-term and short-term strategies to manage the lack of trust. The tactics doctors used included extensive documentation, comprehensive diagnostic tests in the protocol, self-protective communication, and expectation management. Patients also tried to manage their health and minimize risks in medical and nonmedical settings to make themselves less vulnerable.

Physicians

I. Extensive Documentation

Doctors meticulously documented their diagnosis process and treatment plans, making sure all documents got signed by patients and their families, while in the past, such written agreements were rarely required except for major surgeries. A 52-year-old female critical care doctor in Chongqing (L19) stated, "*Our practice now is to document patients' medical records (e.g., medical history and medications) based on medical insurance policies to determine treatment and discharge plans and then communicate with the*

patients and their families." Such extensive documentation aimed to protect physicians when disputes arose. For example, a physician cited earlier (L07) stated, "*We design appropriate treatment plans aiming for self-protection. Only when we protect ourselves first can we do things well. We only start treatment when [patients] accept the treatment plan and results.*" All physicians, even those practicing in villages, used electronic communication records to document medical information.

However, excessive documentation came with potential problems. It forced doctors to spend an exorbitant amount of time documenting instead of treating patients or engaging in professional development. Lower-tier hospitals suffered a brain drain partly because of this. A 43-year-old female obstetrician-gynecologist receiving training in Chongqing at the time of data collection (L05) complained, "*Too much time is spent on paperwork and all kinds of evaluations, leaving very little time for doctors to improve their skills or treat patients. Lower-level hospitals find it difficult to retain doctors, and neither do doctors see a good career prospect, thus creating personnel drains in lower-level hospitals.*" Some patients, on the other hand, felt that asking them to sign a lot of paperwork was a way for physicians or hospitals to dodge responsibility and exploit patients. A 47-year-old man cited above (L33) stated, "*Now, all surgeries, big or small, require patients to sign, and it is wrong to push responsibilities onto patients.*"

II. Extensive Use of Diagnostic Tests

In addition to extensive documentation, doctors often ordered a wide range of diagnostic tests to avoid liability. For example, a doctor cited above (L01) stated, "*In the past, we used our judgment and only basic examinations such as blood tests before we conducted surgery. Now patients are more aware of their rights, and our standard diagnosis includes blood testing, coagulation, electrocardiogram, HIV testing, syphilis screening, and others. While patients only paid around 700 to 800 yuan in the past for diagnosis, now the cost often reaches 4,000 to 5,000 yuan.*" The overuse of diagnostic tests, the cost of which could add up quickly, further eroded patients' trust in physicians and hospitals because patients felt that physicians ordered these tests to make extra money. The female migrant worker cited previously (T05) remarked, "*I don't have much money. I am afraid that physicians are going to order too many tests. So I just buy medicine from a pharmacy.*"

III. Refusal of Treatment

Occasionally, physicians refused treatment to certain patients due to the lack of trust, especially when patients suffered from diseases with poor prognostics. Small private clinics were especially careful not to accept patients with severe illnesses and chronic conditions for self-protection. Increasing medical disputes also prompted small clinics and doctors to purchase malpractice insurance, a new phenomenon in China.

IV. Open and Friendly Communication

Physicians used open and friendly communication to build trust. Doctors educated patients about treatment plans and kept them in the loop. Most physicians recognized their power over patients and emphasized the importance of understanding the patients' perspectives. They discussed the content and style of communication. For example, a rehabilitation doctor in Chongqing (L07) stated, "*[We] should be factual and truthful without hiding any information. We need to think from the perspective of patients. When people are sick, they experience physical pain and mental pressure. We must discuss what we can and cannot do to manage their expectations.*" The 52-year-old female doctor in Chongqing cited earlier (L19) concurred, saying, "*Patients will feel very grateful toward doctors if doctors show more care and communicate better. It is important to build trust and friendship. Doctors have to make patients trust them from a technical view and use professional knowledge to guide them so that patients understand the treatment plan, process, and purpose.*"

Physicians also emphasized patience when communicating with patients and believed that patients should be treated as friends. They used small talks with patients to learn about their everyday lives. A physician cited earlier (L10) stated, "*The ideal doctor-patient communication is like a family conversation. There is no need to have a deliberate, formal conversation. It is important to have a natural conversation. Many of our patients are rural residents who are verbose. I have to guide them and explain the same information more than once.*" In contrast, doctors in large cities or prestigious hospitals were often overwhelmed by their workload. As a solution, hospitals trained nurses to communicate with hospitalized patients. A physician cited previously (L20) also concurred, saying, "*There is a Chinese saying, 'Haste makes waste.' The more hurried you are, the more likely you will face problems later.*"

V. Transparency

Doctors became more transparent when communicating with patients, even about terminal diseases. Traditionally, Chinese physicians kept the diagnosis of terminal illnesses such as cancer from patients to protect the patient's feelings and only disclosed such diagnoses to patients' family members. However, most of the interviewed physicians preferred to have open discussions with patients about diagnosis, treatment plans, costs, and risks involved. This change was mainly due to the increasing awareness of the patient's right to be informed.[3]

However, both doctors and patients understood that transparency could only go so far because of the complexity of medical practices. Ultimately, it was trust that governed the doctor-patient relationship. A doctor cited above (L19) remarked, "*Patients should trust that we are governed by our work ethics. We cannot mix medicine in front of patients [to be completely transparent].*" This remark indicated that trust was critical to managing doctor-patient relationships.

Patients

I. Long-Term Strategies

Patients who generally lacked trust in physicians and the healthcare system often avoided visiting physicians. Quite a few participants discussed how they avoided seeing doctors by adopting a healthy lifestyle. Some participants expressed that they regularly used food supplements (both Western and traditional Chinese, such as multivitamins or ginseng) to boost their health, so they did not need to see doctors. Because older people and those living in rural areas and small towns tended to trust traditional Chinese medicine more than Western medicine, they often used a holistic approach to care for their health through traditional medicine and diet. For example, a 53-year-old female rural resident (L31) proudly stated that she used traditional Chinese medicine for self-care and that, in the 26 years since she gave birth to her son, she had never been hospitalized or seen a doctor. Since trust is about making oneself vulnerable to the other party (Rousseau et al., 1998), managing one's health could make one less vulnerable to unscrupulous physicians and the perceived exploitative healthcare system.

Individuals also constantly educated themselves about the symptoms and treatment of diseases so that they could question and challenge doctors. Many patients interviewed stated that they regularly read about health and medicine on Baidu and WeChat and watched TV programs about self-care. In this way, patients constantly evaluated their information and experience to determine what to trust, what not to trust, and what actions to take, showing their reflexivity and agency in managing their health.

II. Short-Term Tactics

Patients also adopted short-term tactics in specific clinical encounters to protect their interests when there was a lack of trust. For instance, when patients realized they were sick, they would go online to look for information and compare results with physicians' diagnoses and treatment plans. Sometimes, patients would get a second opinion from a different hospital. A man cited above (L38) stated, "*When I see doctors, I compare at least two hospitals; if they provide the same information [of diagnosis and treatment], I trust them; if not, I do not trust them; and I will then find a third hospital.*" Occasionally, patients even recorded the consultation using a voice recorder. However, physicians detested such a practice as it made them more vulnerable.

Another way for patients to manage the lack of trust is to use expensive products or tests. For instance, in comparing free annual physical exams offered by the government with out-of-pocket physical exams from a doctor of her choice, a 66-year-old retired small business owner (T03) said, "*We retired folks are given free physicals every year [through the government], but I don't trust them.*" When asked why, she said, "*Because free physicals are not thorough*", suggesting that high prices were used to indicate medical service quality.

Giving physicians under-the-table payments was another way by which patients managed the lack of trust. A 65-year-old retiree (T06) stated, "*It is probably better in [big cities], but in our town, you have to give doctors red pockets when they deliver your baby.[...] If you don't give them a red pocket, they will ignore you no matter how much pain you have.*" Such comments were common among patients who felt vulnerable in the current medical system and lacked general trust in the medical establishment and physicians. In a relationship-based (*guanxi* 關係) society, patients also managed their risks by relying on personal connections. In small towns, patients saw

doctors they knew directly or indirectly. Even in large cities, patients tried to find doctors through their networks. Personal connections with physicians meant that a medical visit was less transactional but more long-term oriented, thus minimizing the risks. For patients without personal connections, relying on the reputation of hospitals was another way to control risks. Those working in reputable hospitals were perceived as having better skills and behaving more ethically, thus showing how institutional trust is transferred to the trust of physicians.

Discussion and Conclusion

Patients' trust in physicians has been studied globally, as it is central to the clinical-patient relationship and significantly impacts patient satisfaction and clinical outcomes. This study focuses on patients' trust in physicians in China due to its China's changing policies and legal requirements and shifting public opinions about the healthcare system and medical profession. Our study makes several unique contributions. First, our model shows the nonlinearity and dynamical nature of patients' trust in physicians, considering both the historical context that shapes the current doctor-patient relationship and specific doctor-patient encounters. It takes a dialectic approach and conceptualizes the trust in physicians as twofold: a general trust in the healthcare system and profession and a situational trust in specific physicians during clinical encounters. This model also recognizes the fluidity of an individual's identity. Most people are patients only when they are interacting with physicians in clinical settings, during which their trust is based on specific physicians' bedside manners, competence, and ethics. When individuals are not interacting with physicians, they are still patients/consumers in a broad sense since they still evaluate the medical profession in general. Our model highlights that specific encounters and general trust in the healthcare industry influence patients' trust in physicians.

The general trust in the healthcare system and the medical profession is influenced by the larger social context in China, including the marketization of healthcare, health consumerism, and the changing information environment. The shift in hospitals' funding models has led to overtreatment and high costs, eroding the public's general trust in the healthcare system and physicians. The marketization of the healthcare system (Tang & Guan, 2017) and the rise of consumerism in China (Li,

2016) have also fostered a mindset that healthcare services can be purchased based on market prices, that the higher the price, the better the service, and that richer people should enjoy better services. As consumers, individuals must constantly advocate for their interests and avoid exploitation. This mindset contributes to a general lack of trust in the healthcare system and medical professionals. News and entertainment media also significantly influence the public's perception and general trust in the healthcare system and its practitioners.

At the heart of the dynamic relationship between general and specific trust are perceived ethics and competence. Doctors from different geographic regions are evaluated differently. While physicians working in large, prestigious urban hospitals are deemed more competent, doctors in small towns or rural areas are not evaluated favorably. Patients constantly evaluate whether doctors are ethical or competent through their bedside manners, behaviors, and the effectiveness of their treatments.

Furthermore, the collection and analysis of data from both patients and clinicians provide us with insights from both perspectives. In most cases, physicians and patients concur on the present state of trust in physicians and the primary contributing factors. However, one point of contention arises as physicians often consider online medical information unreliable and potentially detrimental to patients' trust in physicians, whereas patients generally trust online medical information. While patients feel empowered by online medical information and have developed general trust toward these sources, physicians are keenly aware that misleading information online or the misunderstanding of online medical information can pose extra barriers to effective physician-patient communication and further erode patients' trust in the diagnosis and treatment. The predominant reliance on Baidu for medical information has been reported in previous studies (e.g., Zou & Tang, 2021), despite problems with the quality of medical information obtained through the search engine. Another minor point of disagreement is that doctors often believe that patients unrealistically expect physicians to cure their diseases. However, most interviewed patients show more understanding of what doctors can and cannot achieve.

Additionally, the model takes into account the differences between large cities and small towns/rural areas, utilizing both macro- and micro-level factors to elucidate the reasons behind these differences. Most previous studies on physician-patient communication and trust in China have been

conducted in large cities (Tang & Guan, 2017; Zhao, Rao, & Zhang, 2016), likely due to the convenience of data collection. However, our study shows that geographic location influences both general and particular trust in physicians as well as how physicians and patients manage the lack of trust. Individuals residing in small towns and rural areas approach healthcare differently from residents in big cities. Such differences cannot be entirely explained by traditional variables such as socioeconomic status and educational background. Instead, the structure of the healthcare system in these different geographic locations also contributes to the varying approaches to healthcare. In small towns, patients trust individual physicians based on interpersonal relationships and repeated interactions. Conversely, most patients from large cities trust physicians based on their general evaluation of the quality of the hospitals, even though well-connected patients still tend to see doctors they know personally or have some connections with. When patients see doctors in small towns for minor ailments, they expect doctors to have good bedside manners and have time for them. In contrast, patients who visit well-known doctors in large cities trust doctors for their expertise and thus do not have high expectations about these physicians' communication manners and attitudes.

Lastly, our study illuminates how physicians and patients strategically navigate the challenges associated with trust deficiency. Both physicians and patients share the common objective of mitigating their vulnerability. Physicians adopt measures to mitigate risks, such as maintaining meticulous documentation, employing extensive (and at times excessive) diagnostic testing, and promoting open communication. On the other hand, patients assume control of their well-being through the implementation of long-term strategies and short-term tactics designed to minimize their vulnerability. Patients also endeavor to see doctors with whom they have personal connections or those affiliated with large hospitals, underscoring their proactive role in addressing trust-related issues. Our findings highlight the agency and resilience exhibited by both doctors and patients in shaping their communication and healthcare environments.

Practical Implication

While it is disheartening to observe declining trust in doctors in China, our model suggests that trust can be restored and sustained through positive

doctor-patient communication and well-regulated institutional frameworks. Furthermore, our research underscores the divergence in trust patterns between residents of small towns and major cities, indicating a need for tailored medical training programs and distinct communication approaches for these different communities.

Given the variance in perceptions of online medical information between doctors and patients, there is a pressing need for health literacy and media literacy education in China. Such initiatives would empower the public to critically evaluate online medical information, particularly in light of the numerous scandals involving fraudulent medical content on platforms like Baidu. It is essential to include communication courses in medical education, considering the critical role of communication that both patients and doctors have recognized. The ongoing anti-corruption campaign in the Chinese medical field may further erode general and specific trust in the medical field. Our model can inform efforts to rebuild trust in the medical system and medical professionals.

Direction for Future Research

Our study examines physician-patient communication in small towns and rural areas, which remains an underexplored topic in the existing literature. Given the substantial portion of the Chinese population residing in such areas, there is a pressing necessity for more extensive research to address the unique medical needs of small-town and rural residents. Since our research is based on qualitative data, future research should use quantitative research to test the model. A comparative study of trust in physicians across different cultural and national contexts is also needed to test the external validity of our conceptual model. In addition, the changing perception of doctors during the COVID-19 pandemic may have somehow restored doctors' reputations in China. However, the ongoing anti-corruption campaign in the medical field can negatively impact the general and specific trust between doctors and patients. It would be interesting to see how the changing dynamics affect trust as an ongoing and dynamic process.

Notes

1 We use the term "patient" broadly to describe non-physician individuals and consumers who have used and may use healthcare services: individuals are patients when they interact with physicians either on behalf of themselves or their families; individuals in non-medical settings can also be patients even when they think about their relationships with physicians in medical settings.

2 Article 31 of *Amendment (IX) to the Criminal Law of the People's Republic of China* (2015) stipulates that organizers of a protest disrupting medical services can face up to a seven-year imprisonment. In March 2016, China's National Health and Family Planning Commission, the Central Public Security Comprehensive Management Commission, the Ministry of Public Security, and the Ministry of Justice issued a joint notice, specifying that "no monetary compensations should be made [to patients] without having identified which parties are responsible for medical disputes, no mediation should be offered without having stopped disruptive behaviors first," and other measures (Remin Net, 2016).

3 However, if the patient's family insists that the patient should not be informed, the doctor may still not disclose the information to the patient.

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