Turkish Journal of Neurology

Turk J Neurol 2026;32(4):267-274
Doi: 10.55697/tnd.2026.669

ORIGINAL ARTICLE

Trust in physicians and artificial intelligence among patients with neurological disorders: A cross-sectional study

Aydan Topal[1], Nazlı Durmaz Çelik[2]

[1]Department of Neurology, Samsun University Faculty of Medicine, Samsun, Türkiye
[2]Department of Neurology, Eskişehir Osmangazi University Faculty of Medicine, Eskişehir, Türkiye

ABSTRACT

Objectives: This study aimed to compare levels of trust in, and information-seeking preferences regarding, physicians and artificial intelligence (AI)-based systems among individuals with neurological disorders.

Patients and methods: This cross-sectional survey included 129 patients with various neurological disorders. Data were collected using a researcher-developed questionnaire based on a literature review. The instrument assessed trust in physicians and AI-based systems using single-item measures rated on a 5-point Likert scale and included items on sociodemographic characteristics, prior AI exposure, and attitudes toward AI in healthcare. Content validity was established through expert evaluation.

Results: Trust in physicians was significantly higher than trust in AI systems [median (interquartile range): 4 (3-4) *vs.* 2 (0-2); Wilcoxon signed-rank test, $p < 0.001$, r = 0.82]. Trust differences were not significantly associated with age, sex, or educational level. Participants with prior AI exposure demonstrated a significantly narrower trust gap between physicians and AI ($p = 0.003$). Linear regression analysis did not identify significant predictors of AI trust ($R^2 = 0.073$, $p = 0.152$). Most respondents perceived AI primarily as an informational resource (60.5%) or a decision-support tool (31.0%).

Conclusion: Physicians remain the primary source of trust in neurological care. Prior AI exposure was associated with a narrower trust gap. These findings support patient-centered and transparent integration of AI into neurological practice.

Keywords: Artificial intelligence, clinical decision support systems, information seeking behavior, nervous system diseases.

In contemporary healthcare systems, increasing patient demand and limited clinical resources have intensified the need for scalable and innovative solutions. Consequently, individuals increasingly rely on digital platforms for rapid access to medical information.[1] This shift has accelerated the integration of artificial intelligence (AI) into healthcare delivery, particularly with the rapid development of generative AI technologies.[2]

A major advancement within AI has been the development of large language models, which have demonstrated substantial clinical applicability. These systems, built upon deep learning architectures, exhibit advanced capabilities in natural language processing, contextual reasoning, and data interpretation.[3] Their capacity to process large volumes of medical information has positioned them as promising tools in diagnosis, triage, treatment planning, decision support, and medical education.[2,4] Beyond generative applications, machine learning has also been investigated in neurology for objective assessment and differentiation of neurological disorders, including the discrimination of gait parameters in patients with multiple sclerosis and Parkinson's disease.[5] In addition, AI systems have been reported

Correspondence: Aydan Topal, MD. Samsun Üniversitesi Tıp Fakültesi, Nöroloji Anabilim Dalı, 55080 Canik, Samsun, Türkiye.
E-mail: aydantopal@hotmail.com
Received: February 17, 2026 **Accepted:** September 29, 2026 **Published online:** November 16, 2026
Cite this article as: Topal A, Çelik ND. Trust in physicians and artificial intelligence among patients with neurological disorders: A cross-sectional study. Turk J Neurol 2026;32(4):267-274. doi: 10.55697/tnd.2026.669.

© Copyright 2026 by the Turkish Neurological Society. This work is licensed under the Creative Commons Attribution-NonCommercial-NoDerivatives 4.0 International License (CC BY-NC-ND 4.0). To view a copy of this license, visit https://creativecommons.org/licenses/by-nc-nd/4.0/

to generate guideline-consistent recommendations, identify potential drug interactions, and support treatment adherence.[6,7] Given persistent global disparities in healthcare access, such technologies are increasingly viewed as instruments to enhance efficiency and accessibility.[8]

Despite these technological advancements, concerns regarding ethical boundaries, safety, reliability, and accountability remain under active discussion.[6,9] While evidence supporting AI's diagnostic performance and cost-effectiveness continues to expand, research exploring patients' trust in and attitudes toward AI remains comparatively limited.[10,11] Trust constitutes a fundamental element of medical practice, shaping physician-patient relationships, shared decision-making, and treatment adherence.[12,13] Whether AI systems can adequately replicate or complement these human-centered dimensions of care remains uncertain.[14-16]

Neurological disorders, including headache disorders, epilepsy, multiple sclerosis, and other neurological conditions, often prompt patients to seek additional health information beyond routine clinical encounters. The complexity, recurrence, and uncertainty associated with many neurological symptoms may increase reliance on digital health resources and emerging AI-based technologies. As the use of these tools continues to expand, understanding how patients with neurological disorders perceive and trust AI-generated information relative to physician-provided guidance has become increasingly important. However, data specifically examining trust and information-seeking preferences regarding AI within neurology outpatient populations remain scarce.

Although previous studies have examined patients' trust in and attitudes toward AI in healthcare, important gaps remain regarding how patients with neurological disorders position AI relative to physicians as a source of medical information and guidance. In particular, it remains unclear whether familiarity with AI through prior health-related use is associated with greater trust in AI and whether such familiarity reduces the difference in trust between physicians and AI-based systems. Addressing these questions may provide a more clinically relevant understanding of how AI is likely to be used by patients in neurological care, where AI may function as an accessible informational resource while physicians remain responsible for individualized clinical judgment. Therefore, this study aimed to directly compare trust in physicians and AI-based systems among patients with neurological disorders and to examine the association between prior health-related AI use and differences in trust between physicians and AI-based systems. We hypothesized that patients would demonstrate higher trust in physicians than in AI-based systems, while prior AI exposure would be associated with a smaller difference in trust between the two.

PATIENTS AND METHODS

This cross-sectional study was conducted among patients followed at neurology outpatient clinics of the Samsun Training and Research Hospital, Department of Neurology between September 01, 2025 and October 01, 2025. A total of 129 individuals diagnosed with neurological disorders, including migraine, epilepsy, and multiple sclerosis, were recruited using convenience sampling. Eligible participants were aged 18 years or older, literate, and without cognitive impairment that could interfere with independent survey completion.

Data were collected through face-to-face interviews using a structured questionnaire developed by the researchers based on a comprehensive review of the relevant literature (Appendix 1). The questionnaire comprised four domains: *(i)* sociodemographic characteristics (age, sex, education level, and diagnosis); *(ii)* health information-seeking behaviors (primary source of information and prior AI use); *(iii)* trust in physicians and AI-based systems assessed using single-item measures rated on a 5-point Likert scale (1 = no trust, 5 = complete trust); and *(iv)* attitudes toward the perceived role of AI in healthcare. The questionnaire was developed based on a review of the relevant literature and underwent expert evaluation to assess content validity prior to administration. The original questionnaire was administered in Turkish, and the English translation is provided in Appendix 1. Written informed consent was obtained from all participants. The study protocol was approved by the Samsun University Clinical Research Ethics Committee (Date: August 06, 2025; decision No.: 2025/16/12). The study was conducted in accordance with the principles of the Declaration of Helsinki. No clinical interventions or biological samples were involved. There were no missing data for the variables included in the analyses.

Statistical analysis

A priori power analysis was the IBM SPSS version 26.0 software (IBM Corp., Armonk, NY, USA) conducted to determine the required sample size. Assuming a medium effect size (Cohen's d = 0.5), a significance level of 0.05, and 80% statistical power, a minimum of 128 participants was required. Accordingly, the target sample size for the study was planned as at least 128 participants.

Data were analyzed using IBM SPSS version 25.0 software (IBM Corp., Armonk, NY, USA). Continuous variables were summarized as median (interquartile range, IQR) and categorical variables as frequencies and percentages. Normality was assessed using the Shapiro-Wilk test. Differences between trust in physicians and AI-based systems were analyzed using the Wilcoxon signed-rank test. The Mann-Whitney U and Kruskal-Wallis tests were applied for subgroup comparisons, and categorical associations were examined using the chi-square test. For subgroup analyses, a trust difference score was calculated by subtracting AI trust scores from physician trust scores (physician trust - AI trust). This difference score was used as the outcome variable in comparisons across demographic and clinical subgroups. Spearman's rho was used to evaluate correlations. Multiple linear regression analysis was performed to identify independent predictors of AI trust. Statistical significance was defined as $p < 0.05$. Because subgroup analyses were exploratory and involved a limited number of predefined comparisons, no formal adjustment for multiple comparisons was applied.

RESULTS

The participants' ages ranged from 21 to 79 years and were categorized into four groups: 18-30, 31-45, 46-60, and ≥ 61 years. The largest age group was 31 to 45 years (37.2%), followed by 18 to 30 years (27.9%), 46 to 60 years (23.3%), and ≥ 61 years (11.6%). Most participants were female (n = 76, 58.9%), and 45.0% were university graduates (Table 1). Migraine was the most common diagnosis (33.3%), followed by tension-type headache (24.8%) and epilepsy (8.5%; Table 2).

Nearly half (47.3%) of the participants reported physicians as their primary source of health-related information, whereas 20.2% preferred AI-based systems and 20.9% preferred internet searches. The majority (65.9%) reported prior use of AI for health-related purposes (Table 3).

TABLE 1
Demographic characteristics of the participants (n = 129)

Characteristic	n	%
Age group (year)		
18-30	36	27.9
31-45	48	37.2
46-60	30	23.3
≥ 61	15	11.6
Sex		
Female	76	58.9
Male	51	39.5
Not specified	2	1.6
Education level		
Primary school	4	3.1
Secondary school	9	7.0
High school	38	29.5
University	58	45.0
Postgraduate	20	15.5

Percentages may not total 100 due to rounding.

TABLE 2
Distribution of neurological diagnoses among participants (n = 129)

Diagnosis	n	%
Migraine	43	33.3
Tension-type headache	32	24.8
Epilepsy	11	8.5
Multiple sclerosis	8	6.2
Vertigo	8	6.2
Neuropathic pain	6	4.7
Other neurological disorders*	21	16.3

* Includes cerebrovascular disease, hemifacial spasm, lumbar neuropathy, essential tremor, cervicogenic hernia, cluster headache, demyelinating disease, plexopathy, and pituitary microadenoma.

TABLE 3
Health information-seeking preferences and AI experience (n = 129)

Variables	n	%
Primary source of health information		
Physician	61	47.3
Artificial intelligence systems	26	20.2
Internet search	27	20.9
Family/Friends	14	10.9
Other	1	0.8
Previous AI use for health-related information		
Yes	85	65.9
No	43	33.3
Uncertain	1	0.8

AI, artificial intelligence.

TABLE 4
Subgroup analyses of trust difference (physician - AI)

Variables	Groups	Test	*p*
Sex	Female *vs.* Male	Mann-Whitney U	0.070
Age group	18-30 / 31-45 / 46-60 / ≥ 61	Kruskal-Wallis	0.222
Education level	Primary-Postgraduate	Kruskal-Wallis	0.140
AI experience	Yes *vs.* No	Mann-Whitney U	0.003

AI, artificial intelligence. Statistical significance was defined as $p < 0.05$.

Trust in physicians [median (IQR): 4 (3-4)] was significantly higher than trust in AI-based systems [median (IQR): 2 (0-2); Wilcoxon signed-rank test, $p < 0.001$], with a large effect size (r = 0.82; Figure 1).

Subgroup analyses revealed no statistically significant differences in trust according to sex ($p = 0.070$), age group ($p = 0.222$), or education level ($p = 0.140$). However, prior AI use was associated with a significantly smaller trust difference between physicians and AI-based systems ($p = 0.003$; Table 4).

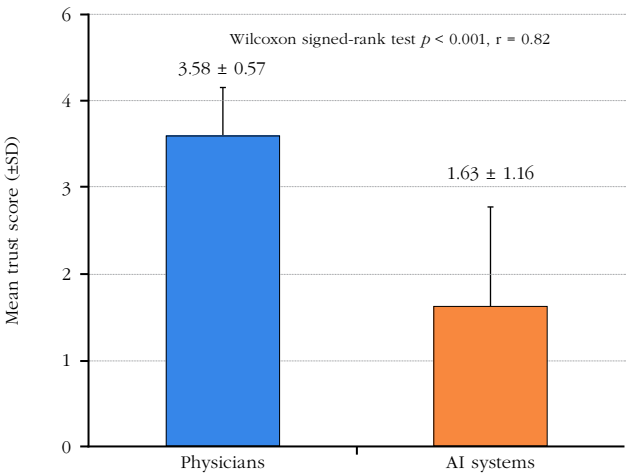


Figure 1. Comparison of mean trust scores toward physicians and AI systems. Trust in physicians (3.58 ± 0.57) was significantly higher than trust in AI systems (1.63 ± 1.16; Wilcoxon signed-rank test, $p < 0.001$). The effect size was large (r = 0.82).
SD, standard deviation.

TABLE 5
Multiple linear regression analysis predicting trust in AI

Variable	β	SE	t	*p*
Constant	1.608	-	-	0.049
Age	−0.002	-	-	0.986
Sex	0.259	-	-	0.164
Education level	0.039	-	-	0.749
AI experience	−0.386	-	-	0.101
Trust in physicians	−0.023	-	-	0.903
"AI could replace doctors"	0.111	-	-	0.208

AI, artificial intelligence; Model statistics: $R^2 = 0.073$, $F(6,122) = 1.60$, $p = 0.152$.

Multiple linear regression analysis did not identify significant independent predictors of trust in AI-based systems ($R^2 = 0.073$, $F(6,122) = 1.60$, $p = 0.152$). None of the variables included in the model reached statistical significance (all $p > 0.05$; Table 5).

Most participants perceived AI as an informational resource (60.5%) or a decision-support tool (31.0%), whereas only small proportions indicated that AI should replace physicians (2.3%) or function as an autonomous diagnostic system (4.7%). No significant correlations were observed between trust in AI-based systems and the perceived role of AI in healthcare ($\rho = -0.054$, $p = 0.543$) or perceived physicians' attitudes toward AI ($\rho = -0.050$, $p = 0.571$).

DISCUSSION

This study provides evidence on the relationship between patients' trust in physicians and AI-based systems within a neurological outpatient population. Three findings are particularly relevant. First, trust in physicians was substantially higher than trust in AI-based systems, indicating that patients continue to place greater confidence in human clinical expertise despite increasing exposure to AI technologies. Second, participants with prior health-related AI use had a significantly smaller trust gap between physicians and AI, suggesting that familiarity with AI may be associated with greater acceptance, although it did not eliminate the overall preference for physicians. Third, most participants viewed AI primarily as an informational or decision-support tool rather than as a replacement for physicians. Together, these findings suggest that patients

may increasingly incorporate AI into their health-related information-seeking behavior without transferring the level of trust traditionally placed in physicians to AI systems. Thus, our findings extend previous research by showing that AI exposure may influence the degree of trust patients place in AI relative to physicians, while physician-centered trust remains predominant in neurological care.

The substantially higher level of trust in physicians observed in our study is consistent with previous research suggesting that trust in healthcare extends beyond perceived technical accuracy to include accountability, contextual judgment, communication, and the human relationship between patients and clinicians. Patients have reported that acceptance of AI depends not only on its perceived performance but also on physician oversight, transparency, and preservation of individualized care.[17,18] Our findings extend these observations to patients receiving neurological care by demonstrating a large and directly measured gap between trust in physicians and AI-based systems. This distinction is important because neurological care frequently requires interpretation of symptoms within an individual clinical context, longitudinal assessment, and shared decision-making. Thus, even when patients recognize the informational or analytical capabilities of AI, these capabilities may not translate into the same form of trust that patients place in physicians. Rather than indicating rejection of AI, the observed trust gap may reflect patients' preference for AI to function within, rather than outside, the physician-patient relationship.

The association between prior health-related AI use and a smaller physician-AI trust gap provides an additional insight into how familiarity may shape patients' perceptions of AI. Participants who had previously used AI for health-related purposes showed a significantly smaller difference in trust between physicians and AI-based systems, suggesting that direct exposure may reduce uncertainty and increase willingness to consider AI as a useful source of health information. This finding is broadly consistent with research indicating that repeated interaction with AI can influence the development of trust and acceptance, while patient trust may also depend on the transparency of AI use and the availability of information about how AI systems are developed and overseen.[19,20] However, prior AI exposure did not eliminate the overall difference in trust between physicians and AI in our cohort. Moreover, the multivariable regression model did not identify prior AI use or other measured characteristics as independent predictors of AI trust. Therefore, our findings should be interpreted as an association between previous exposure and a narrower relative trust gap rather than evidence that AI use directly increases trust. This distinction suggests that familiarity may facilitate acceptance of AI without replacing the established trust patients place in physicians.

An important finding in our study was the discrepancy between prior AI use and overall trust in AI-based systems. Although 65.9% of participants reported previous use of AI for health-related purposes, trust in AI remained substantially lower than trust in physicians. This suggests that patients may use AI primarily due to its accessibility, speed, and informational convenience without considering it equivalent to a physician as a source of clinical judgment. Similar patterns have been described in other patient populations, in which individuals recognize the potential technical benefits of AI while continuing to prefer physicians for diagnosis and treatment decisions.[17,21] Our findings therefore suggest that AI use and AI trust should not be considered interchangeable constructs. Patients may incorporate AI into their health-information seeking behavior while maintaining a substantially higher level of trust in physicians for individualized clinical decisions. This distinction is particularly relevant for the implementation of patient-facing AI, as increased use alone should not be interpreted as evidence of high trust or readiness for autonomous clinical decision-making.

The participants' preferred role for AI further supports the interpretation that patients are receptive to AI when it complements rather than replaces physicians. Most participants considered AI primarily an informational resource (60.5%) or a decision-support tool (31.0%), whereas only a small minority viewed AI as capable of replacing physicians (2.3%) or functioning as an autonomous diagnostic system (4.7%). This preference is consistent with previous patient-centered research showing that patients generally support AI when it enhances clinical care but expect physicians to retain responsibility for interpreting AI outputs and making individualized decisions.[18,22] Similarly, patient involvement and human oversight have been

proposed as important conditions for developing appropriately calibrated trust in AI in healthcare settings.[23] Our findings extend this perspective to neurological patients by demonstrating that their preference for physician involvement persists despite substantial exposure to AI-based health information. This pattern supports an augmentative model of AI integration in neurology, in which AI may improve access to information and support clinical reasoning while physicians remain central to contextual interpretation, accountability, and patient-centered decision-making.

We found no significant differences in AI trust according to age, sex, or educational level. This finding suggests that, within our cohort, sociodemographic characteristics were not major determinants of patients' trust in AI-based systems. Previous research similarly indicated that attitudes toward AI in healthcare were influenced by factors beyond basic demographic characteristics, including prior experience, perceived usefulness, transparency, and the clinical context in which AI was used.[10] However, these findings should be interpreted cautiously since our study was not designed or powered to investigate demographic determinants of AI trust. Further studies with larger and more diverse neurological populations may clarify whether demographic characteristics influence trust under specific clinical or technological conditions.

From a conceptual standpoint, these findings can be interpreted through the distinction between epistemic and relational trust. While AI-based systems may increasingly satisfy informational and analytical expectations, trust in healthcare extends beyond accuracy to encompass empathy, accountability, and perceived shared intent.[1,2] The persistent trust advantage for physicians observed in this study supports the view that technological competence alone is insufficient to supplant relational trust in clinical settings. As emphasized in prior work, the future of AI in medicine may depend on achieving synergy between epistemic reliability and relational credibility.[3,13]

Several limitations should be acknowledged. The cross-sectional design precludes causal inference, and the single-center sample limits the external validity of the findings. In addition, headache disorders constituted the majority of the study population, with migraine and tension-type headache accounting for more than half of the cohort. This diagnostic predominance is important when interpreting the generalizability of our findings because patients with headache disorders may have distinct patterns of symptom monitoring, health-information seeking, and engagement with digital health resources compared to patients with other neurological conditions. Accordingly, the observed patterns of AI use and trust may partly reflect the characteristics of this headache-predominant cohort and should not be assumed to be representative of the broader neurological population. Patients with epilepsy, multiple sclerosis, movement disorders, neurodegenerative diseases, and other neurological conditions may differ in disease course, symptom burden, healthcare experiences, and information needs, which could influence their perceptions of and trust in AI-based systems. Therefore, the trust gap observed in our study should not be assumed to be uniform across neurological disorders. The combination of single-center recruitment, convenience sampling, and the overrepresentation of headache disorders further limits the generalizability of the findings beyond the population represented in this study. Future multicenter studies including larger and more diagnostically diverse neurological cohorts are needed to determine whether the observed trust gap and its association with prior AI exposure are consistent across different neurological conditions.

Trust was assessed using single-item measures, which capture global perceptions but may not adequately reflect the multidimensional nature of trust, including domains such as reliability, competence, transparency, and accountability. Although single-item measures may provide a practical estimate of overall trust, they cannot distinguish between these distinct dimensions or determine which aspects of trust most strongly influence patients' acceptance of physicians or AI-based systems. Therefore, our findings should be interpreted as reflecting an overall perception of trust rather than a comprehensive assessment of the construct. Future studies should employ validated multidimensional trust instruments to examine the specific dimensions of trust that shape patients' perceptions of physicians and AI-based systems.

In addition, although examples of AI-based systems were provided in the questionnaire, participants may have interpreted the concept of AI differently. Finally, the cross-sectional design does not allow us to determine how trust in AI develops or changes with repeated exposure over time. Although prior AI use was associated

with a smaller trust gap in our cohort, this association should not be interpreted as evidence that repeated AI interaction increases trust. Longitudinal studies assessing changes in trust before and after repeated AI exposure, ideally using validated multidimensional measures and behavioral outcomes, are needed to determine whether familiarity with AI leads to sustained changes in trust and acceptance.

Despite these limitations, this study provides empirical evidence from a neurological outpatient cohort demonstrating that trust in physicians remains substantially higher than trust in AI-based systems, while prior health-related AI exposure is associated with a narrower physician-AI trust gap. These findings support the responsible integration of AI tools as complementary resources that can assist patients and clinicians without displacing physician-centered clinical judgment and the relational foundations of medical care.

In conclusion, in this single-center neurological outpatient cohort, trust in physicians was substantially higher than trust in AI-based systems, underscoring the continued importance of human clinical expertise and the relational dimensions of medical care. Prior health-related AI exposure was associated with a narrower trust gap, although this cross-sectional association should not be interpreted as evidence that AI exposure increases trust. Most participants viewed AI as a complementary rather than substitutive resource, suggesting that patients may incorporate AI into health-information seeking while continuing to place greater trust in physicians for individualized clinical decisions. These findings support the responsible integration of AI into neurological care as a complementary tool that enhances access to information and clinical decision support without displacing physician-centered judgment and the relational foundations of medical practice.

Data Sharing Statement: The data that support the findings of this study are available from the corresponding author upon reasonable request.

Author Contributions: A.T.: Conceptualization, methodology, investigation, data collection, formal analysis, and writing-original draft; N.D.Ç.: Investigation, data collection, writing-review and editing. Both authors reviewed and approved the final version of the manuscript.

Conflict of Interest: The authors declared no conflicts of interest with respect to the authorship and/or publication of this article.

Funding: The authors received no financial support for the research and/or authorship of this article.

AI Disclosure: The authors declare that artificial intelligence (AI) tools were not used, or were used solely for language editing, and had no role in data analysis, interpretation, or the formulation of conclusions. All scientific content, data interpretation, and conclusions are the sole responsibility of the authors. The authors further confirm that AI tools were not used to generate, fabricate, or 'hallucinate' references, and that all references have been carefully verified for accuracy.

REFERENCES

1. Zandi R, Fahey JD, Drakopoulos M, Bryan JM, Dong S, Bryar PJ, et al. Exploring diagnostic precision and triage proficiency: A comparative study of GPT-4 and Bard in addressing common ophthalmic complaints. Bioengineering (Basel) 2024;11:120. doi: 10.3390/bioengineering11020120.
2. Takita H, Kabata D, Walston SL, Tatekawa H, Saito K, Tsujimoto Y, et al. A systematic review and meta-analysis of diagnostic performance comparison between generative AI and physicians. NPJ Digit Med 2025;8:175. doi: 10.1038/s41746-025-01543-z.
3. Thirunavukarasu AJ, Ting DSJ, Elangovan K, Gutierrez L, Tan TF, Ting DSW. Large language models in medicine. Nat Med 2023;29:1930-40. doi: 10.1038/s41591-023-02448-8.
4. Shekar S, Pataranutaporn P, Sarabu C, Cecchi GA, Maes P. People overtrust AI-generated medical advice despite low accuracy. NEJM AI 2025;2:AIoa2300015. doi: 10.1056/AIoa2300015.
5. Gül S, Soylu E, Terzi M, Türkoğlu M, Aslan Koca K. Making the discrimination in the walking parameters of individuals with multiple sclerosis and Parkinson's disease with machine learning. Turk J Neurol 2023;29:277-81. doi: 10.4274/tnd.2023.73658.
6. Stokel-Walker C. AI bot ChatGPT writes smart essays - should professors worry? Nature 2022. doi: 10.1038/d41586-022-04397-7.
7. Sarraju A, Bruemmer D, Van Iterson E, Cho L, Rodriguez F, Laffin L. Appropriateness of cardiovascular disease prevention recommendations obtained from a popular online chat-based artificial intelligence Model. JAMA 2023;329:842-4. doi: 10.1001/jama.2023.1044.
8. Fanous A, Steffner K, Daneshjou R. Patient attitudes toward the AI doctor. Nat Med 2024;30:3057-8. doi: 10.1038/s41591-024-03272-4.
9. Perlis RH. Research letter: Application of GPT-4 to select next-step antidepressant treatment in major depression. medRxiv [Preprint] 2023:2023.04.14.23288595. doi: 10.1101/2023.04.14.23288595.
10. Nong P, Platt J. Patients' trust in health systems to use artificial intelligence. JAMA Netw Open 2025;8:e2460628. doi: 10.1001/jamanetworkopen.2024.60628.
11. Longoni C, Bonezzi A, Morewedge CK. Resistance to Medical Artificial Intelligence. J Consum Res 2019;46:629-50.

12. van Dijk N, Boer KR, Colman N, Bakker A, Stam J, van Grieken JJ, et al. High diagnostic yield and accuracy of history, physical examination, and ECG in patients with transient loss of consciousness in FAST: The Fainting Assessment study. J Cardiovasc Electrophysiol 2008;19:48-55. doi: 10.1111/j.1540-8167.2007.00984.x.
13. Tu T, Schaekermann M, Palepu A, Saab K, Freyberg J, Tanno R, et al. Towards conversational diagnostic artificial intelligence. Nature 2025;642:442-50. doi: 10.1038/s41586-025-08866-7.
14. Singhal K, Azizi S, Tu T, Mahdavi SS, Wei J, Chung HW, et al. Large language models encode clinical knowledge. Nature 2023;620:172-80. doi: 10.1038/s41586-023-06291-2.
15. Chen Z, Cano AH, Romanou A, Bonnet A, Matoba K, Salvi F, et al. MEDITRON-70B: Scaling medical pretraining for large language models. arXiv [Preprint] 2023.arXiv:2311.16079.
16. Toma A, Lawler PR, Ba J, Krishnan RG, Rubin BB, Wang B. Clinical Camel: An open expert-level medical language model with dialogue-based knowledge encoding. arXiv [Preprint]. 2023.arXiv:2305.12031.
17. Berger SA, Håland E, Solbjør M. Patient perspectives on trust in artificial intelligence-powered tools in prostate cancer diagnostics. Qual Health Res 2026;36:276-88. doi: 10.1177/10497323251387545.
18. Karger CR. Patients' perspectives on the implementation of AI in radiological diagnostics: Focus group study. J Med Internet Res 2026;28:e89178. doi: 10.2196/89178.
19. Kahr PK, Rooks G, Willemsen MC, Snijders CCP. It seems smart, but it acts stupid: development of trust in AI advice in a repeated legal decision-making task. In: Proceedings of the 28th International Conference on Intelligent User Interfaces. New York, NY: ACM; 2023. p. 528-539. doi: 10.1145/3581641.3584058.
20. Stroud AM, Minteer SA, Zhu X, Ridgeway JL, Miller JE, Barry BA. Patient information needs for transparent and trustworthy cardiovascular artificial intelligence: A qualitative study. PLOS Digit Health 2025;4:e0000826. doi: 10.1371/journal.pdig.0000826.
21. Maleki MS, Sahebi L, Shahvari Z, Samadi S. Attitudes of the Iranian public toward the clinical use of artificial intelligence in medicine: A cross-sectional survey. Patient Prefer Adherence 2026;20:563494. doi: 10.2147/PPA.S563494.
22. Maris MT, Koçar A, Willems DL, Pols J, Tan HL, Lindinger GL, et al. Ethical use of artificial intelligence to prevent sudden cardiac death: An interview study of patient perspectives. BMC Med Ethics 2024;25:42. doi: 10.1186/s12910-024-01042-y.
23. Banerjee S, Alsop P, Jones L, Cardinal RN. Patient and public involvement to build trust in artificial intelligence: A framework, tools, and case studies. Patterns (N Y) 2022;3:100506. doi: 10.1016/j.patter.2022.100506.