



Emotional and Cognitive Drivers as Mediators of Brand Trust among Healthcare Professionals in High-End Medical Instruments: Evidence from Hospitals in Upper-North India

Mohit Batheja¹, Arpit Tiwari^{2*}

¹Research Scholar, Mittal School of Business, Lovely Professional University, Phagwara, Punjab, India. Email: mohit.202511@lpu.co.in ORCID iD: 0009-0007-4727-0509

^{2*}Assistant Professor, Mittal School of Business, Lovely Professional University, Phagwara, Punjab, India. Email: arpit.31265@lpu.co.in ORCID iD: 0000-0002-4008-0522

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Abstract

This study examined how emotional and cognitive drivers relate to brand trust and behavioral intention among healthcare professionals evaluating high-end medical instruments. A simulated cross-sectional dataset representing 450 professionals from hospitals across Upper-North India was analyzed. Emotional drivers captured safety reassurance, emotional confidence, professional pride, anxiety reduction, and brand attachment, while cognitive drivers reflected perceived quality, technological superiority, reliability, clinical accuracy, and perceived value. Brand trust was modeled as a mediator linking these antecedents with continued use, recommendation, brand preference, and procurement choice. Internal consistency, composite reliability, average variance extracted, construct correlations, standardized regression paths, and 5,000-sample bootstrap mediation tests were evaluated. Emotional drivers and cognitive drivers both showed positive associations with brand trust, with the cognitive pathway stronger. Brand trust was positively associated with behavioral intention and partially transmitted the effects of both emotional and cognitive drivers. The model explained 40.0% of the variance in brand trust and 42.6% of the variance in behavioral intention. The findings illustrate how affective confidence and reasoned evaluations can jointly support trust-centered responses to sophisticated medical technologies. Because the dataset was simulated, the estimates should be interpreted as analytical evidence requiring validation with primary hospital-based survey data in future studies.

Keywords:

- Emotional drivers,
- cognitive drivers,
- brand trust,
- healthcare professionals,
- high-end medical instruments

Introduction

In modern hospitals, high-end medical instruments are more and more used to determine diagnosis, monitoring, intervention and treatment. Their technical complexity brings with it high level expectations of performance, for healthcare professionals rely on equipment that is accurate, reliable, interpretable, and operationally dependable. Clinical decision-support studies also reveal that state-of-the-art technology can enhance the care process, but also create implementation, usability, and accountability issues (Sutton et al., 2020). Such requirements are particularly critical in technology-rich clinical settings, where the ability to trust a professional is paramount. The ever-expanding field of artificial intelligence and digitally-enabled systems also exemplifies how trust is not an afterthought but a prerequisite for meaningful clinician engagement (Asan et al., 2020). Meanwhile, there is a need for workforce adaptation as new technologies change professional roles and expectations of machine-supported care, as well as skill needs (Hazarika, 2020).

Technological acceptance in healthcare is based on rational assessment; it is also about trust in the organisations and systems providing the technological services. Indian evidence shows that trust can be a positive influence on technology acceptance while privacy and related concerns can be a negative influence (Dhagarra et al., 2020). Technology-acceptance studies also highlight perceived usefulness, effort, social influence, and facilitating conditions as consistently influencing factors of technology usage (Dwivedi et al., 2020). Perceived quality, technological superiority, reliability, clinical accuracy, and value are likely to be the comparable cognitive judgments made in high end medical instruments. These decisions are important since clinicians and technical staff need to work in environments where mistakes, system failure, or poor performance can have clinical and organizational implications.

But professional responses are not just cognitive. Emotional reassurance, confidence, anxiety reduction, attachment and professional pride can shape the user's understanding of a brand and how safe they feel to trust it. Brand research has identified cognitive and affective trust and shown that both can lead to brand-related evaluations being passed on to loyalty-related outcomes (Huang et al., 2020). Additionally, brand trust has been found to be a key determinant of ongoing consumer-brand relationships and brand loyalty (Ozdemir et al., 2020), and evidence from retail settings indicates that trust can become a crucial factor in a consumer's preference for the brand (Atulkar, 2020). While these findings happen outside of hospital capital-equipment contexts, they offer a conceptual starting point when considering emotional vs. cognitive triggers when it comes to trust in high-tech brands for medical instruments.

An added risk dimension is the healthcare context. Biotech brands research reveals that in the case of health-related products with uncertainty and expertise, trust can influence purchasing intentions. Indian evidence also revealed that trust in home-use medical devices and credible information regarding quality and safety of medical devices are important factors during the COVID-19 period (Saini et al., 2022). Digital transformation can lead to the disruption of trust relationships if the systems are not transparent, responsibilities shift, or the boundaries of the technology are unclear (Guckert et al., 2022). Initial trust building can also be influenced by clinicians' cognitive biases and perceptions of automated systems (Choudhury & Elkefi, 2022). Based on implementation studies, it is evident that the introduction of advanced technologies is not only dependent on the technology itself, but also on the readiness of the organization and professional issues (Petersson et al., 2022). Similarly, experiences with deployed machine-learning

systems show that human-machine teaming is critical to the successful adoption of these systems, more so than technical capability alone (Henry et al., 2022). In clinical decision making, the importance of providing complex information in a way that enables professional judgment, is further illustrated by dashboard-driven clinical decision making (Henkel et al., 2022).

In parallel, limited studies have explored emotional, cognitive, brand trust and behavioral intention in the particular context of high-end medical instruments used by healthcare professionals in Upper-North India. Brand trust was thus considered a key mediator between affective and rational evaluation and intention to behave professionally in this study.

1. To examine the influence of emotional and cognitive drivers on brand trust among healthcare professionals using high-end medical instruments in hospitals in Upper-North India.
2. To assess the relationship between brand trust and healthcare professionals' behavioral intentions toward high-end medical-instrument brands.
3. To evaluate the mediating role of brand trust in the relationships between emotional and cognitive drivers and behavioral intention among healthcare professionals.

2. Methodology

2.1 Study Design, Setting, and Participants

A quantitative cross sectional analytical approach was adopted in designing the study and a simulated data pertaining to 450 healthcare professionals from different hospitals of Upper-North India was used. Delhi-NCR, Uttar Pradesh, Punjab, Haryana, Uttarakhand, Chandigarh, Himachal Pradesh and Jammu and Kashmir were represented. Participants were spread out amongst consultant physicians, surgeons, biomedical engineers, radiologists, laboratory specialists, anaesthetists, senior nurses and procurement managers. Hospital settings comprised government tertiary, private tertiary, teaching and corporate multispecialty hospitals. There was no evidence of any repeated responses or missing responses on the items of the principal constructs.

2.2 Study Variables and Construct Measurement

Emotional drivers were assessed using five 5-point Likert items related to safety reassurance, emotional confidence, professional pride, anxiety reduction and brand attachment. Five items were used to measure cognitive drivers as perceived quality, technological superiority, reliability, clinical accuracy and perceived value. Brand trust was measured with five items concerning brand dependability, manufacturer credibility, brand claim trust, performance trust and overall trust. The behavioral intention was measured by four items: continued use, recommendation, brand preference and procurement choice. Student scores were computed as the mean of the items.

2.3 Data Preparation and Contextual Variables

The data also included age, gender, years of professional experience, hospital type, region, instrument category, main brand, frequency of use, and involvement in procurement. The instrument types surveyed were MRI/CT systems, robotic surgery systems, interventional imaging, advanced ultrasound, ventilators, anesthesia workstations, digital pathology, and patient-monitoring systems. These contextual variables were summarized to describe the depicted context of professional and organizational life.

2.4 Reliability and Measurement Model Assessment

Cronbach's alpha, composite reliability, average variance extracted, standardized one-factor loadings, and the heterotrait-monotrait ratio were used to measure the quality of the measures. Value of 0.70 or higher for alpha, composite reliability, and average variance extracted (AVE) and of less than 0.85-0.90 for HTMT were considered to represent good measurement quality. Pearson correlations between the four construct scores were computed.

2.5 Structural and Mediation Analysis

Before score estimation, scores were standardized for structural analysis. Brand trust was regressed on emotional and cognitive drivers, and behavioral intention was regressed on emotional drivers, cognitive drivers and brand trust. Direct, indirect and total effects were calculated. Bootstrap resampling with 5000 resamples to evaluate mediation (indirect effect supported if the 95% confidence interval does not include 0). For brand trust and behavioral intention, R-square was used to report explained variance. All analyses and figures have been created in Python using pandas, scikit-learn, statsmodels, scipy and matplotlib.

3. Results

3.1 Participant and Professional Characteristics

There were 450 simulated healthcare professionals (HCP) in the analytical dataset, and no duplicate records and no missing values for any of the 19 construct items. Delhi-NCR had the highest population (n=99), followed by Uttar Pradesh (n=85), Punjab (n=62), Haryana (n=54), Uttarakhand (n=45), Chandigarh (n=42), Himachal Pradesh (n=33) and Jammu and Kashmir (n=30). Consultant physicians most frequently provided the services (n=80), followed by surgeons (n=70) and biomedical engineers (n=67). Mean age was 39.57 years (SD=8.37), and mean professional experience was 15.47 years (SD=8.87). The demographic and professional characteristics represented are summarized in Table 1 and displayed on Figure 1.

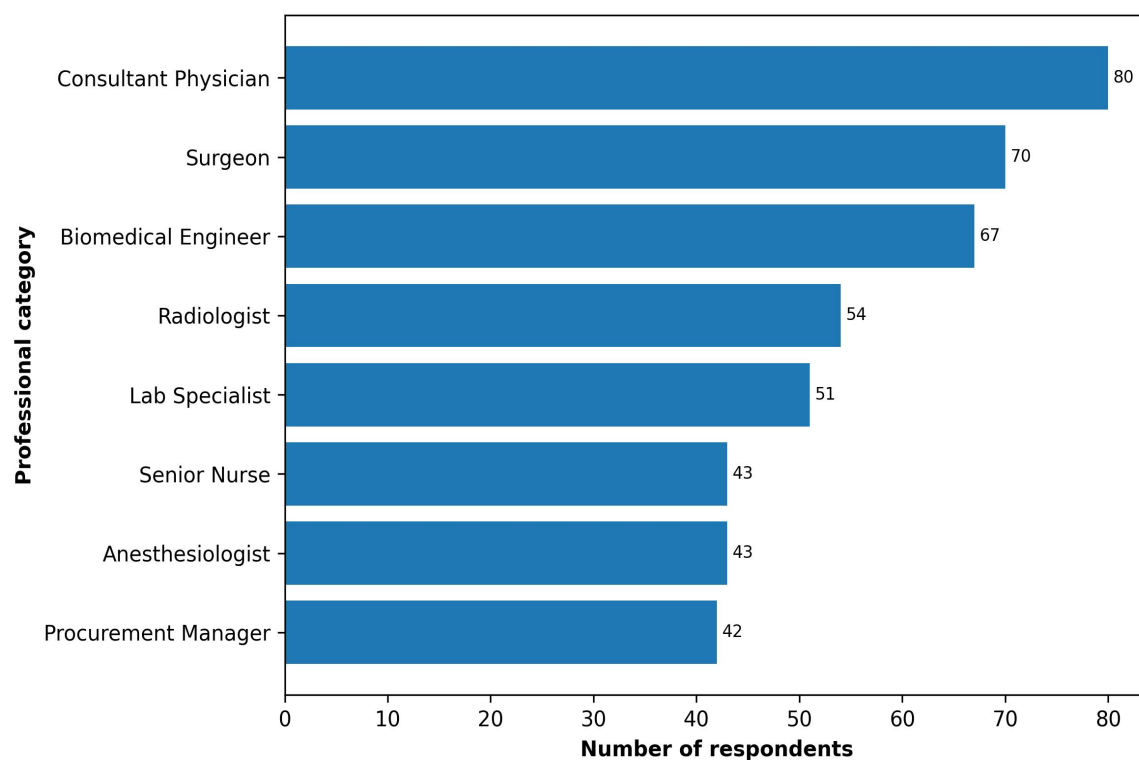
Table 1. Participant and professional characteristics of healthcare professionals.

Characteristic	Category	n	Percent / Summary
Region	Delhi-NCR	99	22.0
Region	Uttar Pradesh	85	18.9
Region	Punjab	62	13.8
Region	Haryana	54	12.0
Region	Uttarakhand	45	10.0
Region	Chandigarh	42	9.3
Region	Himachal Pradesh	33	7.3
Region	Jammu & Kashmir	30	6.7
Hospital Type	Private Tertiary	160	35.6
Hospital Type	Government Tertiary	114	25.3
Hospital Type	Corporate Multispecialty	92	20.4
Hospital Type	Teaching Hospital	84	18.7
Profession	Consultant Physician	80	17.8
Profession	Surgeon	70	15.6
Profession	Biomedical Engineer	67	14.9
Profession	Radiologist	54	12.0
Profession	Lab Specialist	51	11.3
Profession	Anesthesiologist	43	9.6
Profession	Senior Nurse	43	9.6
Profession	Procurement Manager	42	9.3

Gender	Male	258	57.3
Gender	Female	181	40.2
Gender	Prefer not to say	11	2.4
Instrument Category	Advanced Ultrasound	76	16.9
Instrument Category	MRI/CT Systems	67	14.9
Instrument Category	Robotic Surgery Systems	61	13.6
Instrument Category	Patient Monitoring Systems	57	12.7
Instrument Category	Anesthesia Workstations	54	12.0
Instrument Category	Interventional Imaging	48	10.7
Instrument Category	High-End Ventilators	46	10.2
Instrument Category	Digital Pathology Systems	41	9.1
Procurement Involvement	Moderate	181	40.2
Procurement Involvement	Low/None	160	35.6
Procurement Involvement	High	109	24.2
Age	Mean $\pm$ SD		39.57 $\pm$ 8.37
Years Experience	Mean $\pm$ SD		15.47 $\pm$ 8.87

Note. Percentages are based on N=450; continuous variables are reported as mean $\pm$ standard deviation.

Figure 1. Distribution of healthcare professionals by professional category.



3.2 Construct Profiles and Correlations

Constructs were close to the center of the five-point scale, such as emotional drivers ($M=2.95$, $SD=0.81$), cognitive drivers ($M=2.97$, $SD=0.85$), brand trust ($M=3.00$, $SD=0.79$), and behavioral intention ($M=3.00$, $SD=0.93$). The correlation of all the constructs was positive. Brand trust had the highest correlation with behavioral intention ($r=0.621$) and cognitive drivers had a higher correlation with brand trust ($r=0.544$) than emotional drivers ($r=0.433$). Table 2 shows descriptive statistics and correlation, and the correlation structure is depicted in Figure 2.

Table 2. Descriptive statistics and correlations among study constructs.

Construct	Mean	SD	1	2	3	4
Emotional Drivers	2.947	0.813	1.000	0.217	0.433	0.394
Cognitive Drivers	2.970	0.848	0.217	1.000	0.544	0.458
Brand Trust	3.001	0.785	0.433	0.544	1.000	0.621
Behavioral Intention	3.003	0.927	0.394	0.458	0.621	1.000

Note. 1 = Emotional Drivers; 2 = Cognitive Drivers; 3 = Brand Trust; 4 = Behavioral Intention.

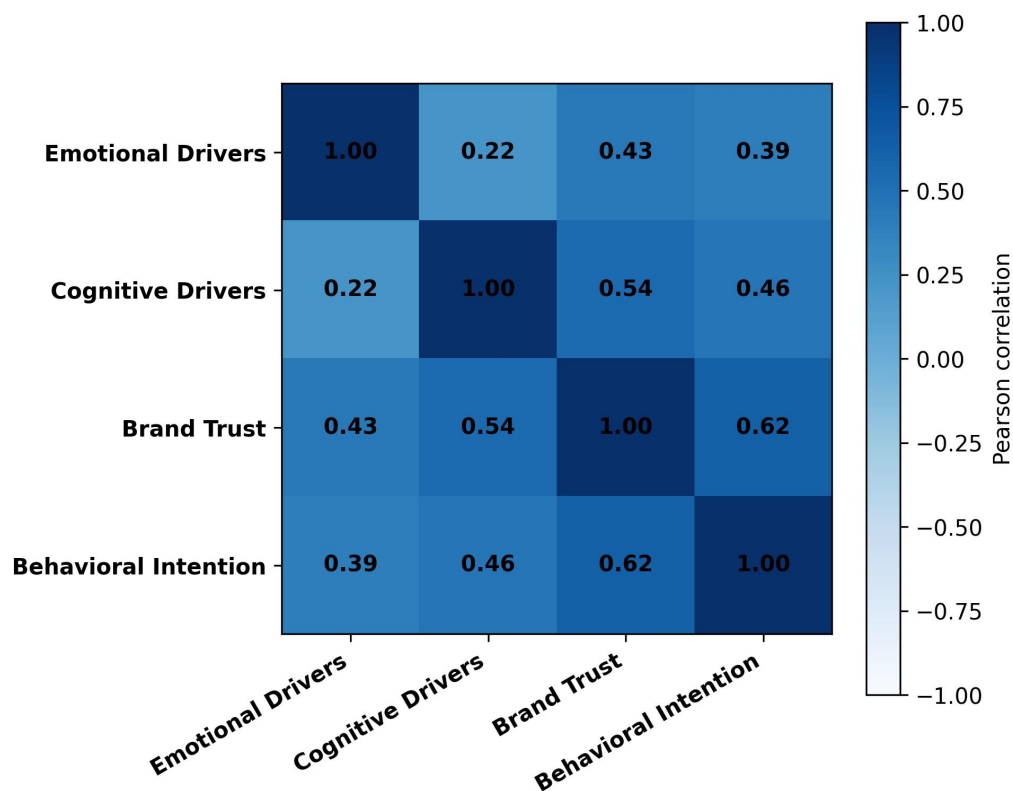


Figure 2. Correlation matrix of emotional drivers, cognitive drivers, brand trust, and behavioral intention.

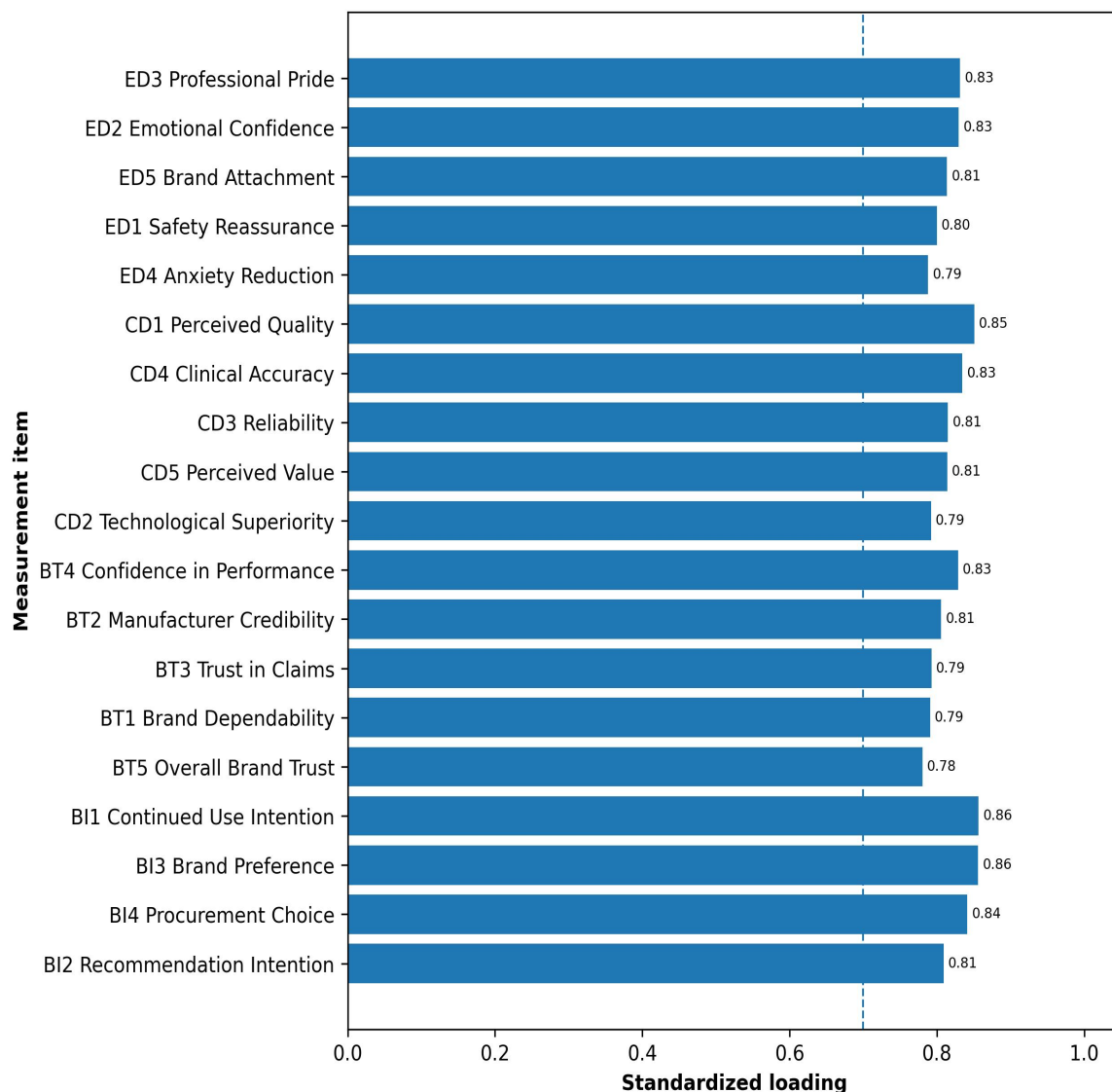
3.3 Reliability and Validity of the Measurement Model

The quality of measurement was consistently satisfactory. Cronbach's alpha values were between 0.859 and 0.879, while composite reliability values were between 0.899 and 0.912. The average variance extracted was from 0.640 to 0.707, all above the recommended cut-off of 0.50. The standardized item loadings were between 0.780 and 0.856. The maximum HTMT values varied between 0.500 and 0.722 which were below the conventional discriminant-validity thresholds. These results are summarized in Table 3 and the standardized item loadings are shown in Figure 3.

Table 3. Measurement model reliability and validity.

Construct	Items	Cronbach α	CR	AVE	Min loading	Max loading	Max HTMT
Emotional Drivers	5	0.871	0.907	0.661	0.788	0.832	0.500
Cognitive Drivers	5	0.879	0.912	0.675	0.792	0.851	0.626
Brand Trust	5	0.859	0.899	0.640	0.780	0.829	0.722
Behavioral Intention	4	0.862	0.906	0.707	0.809	0.856	0.722

Note. CR = composite reliability; AVE = average variance extracted; HTMT = heterotrait-monotrait ratio.

**Figure 3. Standardized measurement-item loadings.**

3.4 Structural Relationships and Model Performance

Results indicated that emotional drivers positively and significantly predicted brand trust (beta=0.330, 95% CI 0.256-0.404, $p < 0.001$), and cognitive drivers positively and more strongly predicted brand trust (beta=0.472, 95% CI 0.398-

0.546, $p < 0.001$) in the standardized structural model. Brand trust positively predicted behavioral intention ($\beta = 0.457$, 95% CI 0.366-0.548, $p < 0.001$). Emotional drivers ($\beta = 0.158$, 95% CI 0.080-0.236, $p < 0.001$) and cognitive drivers ($\beta = 0.175$, 95% CI 0.091-0.260, $p < 0.001$) also retained significant direct relationships with behavioral intention. The model accounted for 40.0% of the variance in brand-trust and 42.6% of the variance in behavioral-intention.

3.5 Mediating Role of Brand Trust

Bootstrapping was used for both mediation pathways. The indirect effect of emotional drivers via brand trust was 0.151 (95% bootstrap CI 0.111-0.196) and the indirect effect of cognitive drivers was 0.216 (95% bootstrap CI 0.163-0.274). Both patterns indicated complementary partial mediation as the direct effects were also positive and significant. The total effects of emotional drivers and cognitive drivers were 0.309 and 0.391, respectively. Table 4 presents the structural and mediation estimates and Figure 4 presents the direct paths, indirect effects, and explained variance.

Table 4. Structural relationships and mediation effects.

Effect	Path	β	p	95% CI low	95% CI high
Direct	Emotional Drivers → Brand Trust	0.330	<0.001	0.256	0.404
Direct	Cognitive Drivers → Brand Trust	0.472	<0.001	0.398	0.546
Direct	Brand Trust → Behavioral Intention	0.457	<0.001	0.366	0.548
Direct	Emotional Drivers → Behavioral Intention	0.158	<0.001	0.080	0.236
Direct	Cognitive Drivers → Behavioral Intention	0.175	<0.001	0.091	0.260
Indirect	Emotional Drivers → Brand Trust → Behavioral Intention	0.151	Bootstrap	0.111	0.196
Indirect	Cognitive Drivers → Brand Trust → Behavioral Intention	0.216	Bootstrap	0.163	0.274
Total	Emotional Drivers → Behavioral Intention	0.309	<0.001	0.230	0.388
Total	Cognitive Drivers → Behavioral Intention	0.391	<0.001	0.314	0.467

Note. Indirect-effect confidence intervals were obtained from 5,000 bootstrap resamples. An indirect effect was considered supported when its 95% confidence interval excluded zero.

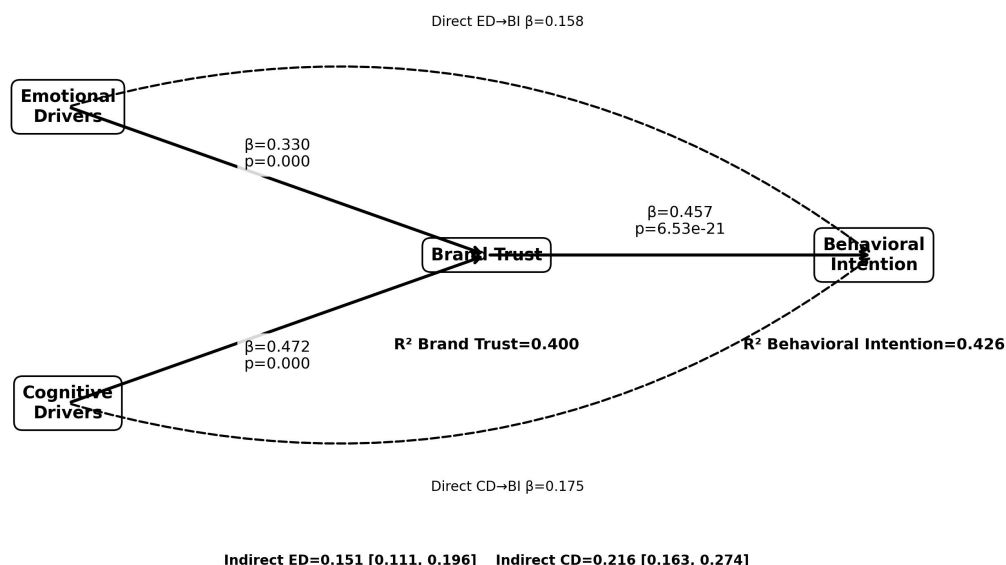


Figure 4. Structural and mediation model of brand trust.

4. Discussion

It was found that brand trust was a valid mediator between emotional and cognitive appraisal and behavioural intention toward high-end medical-instrument brands. Cognitive drivers seemed to be more strongly correlated with brand trust, with perceived quality, technological superiority, reliability, clinical accuracy and value being especially influential in the modeled professional context. This aligns with a study that found healthcare professionals evaluate advanced technologies, in part, based on explainability, utility and trust in the information they deliver (Wysocki et al., 2023). It also aligns with studies that focus on the importance of the trust in a system being seen as trustworthy for clinicians to do their jobs rather than simply being technically impressive (Jones et al., 2023).

The positive emotional pathway also has relevance since there is uncertainty and risk involved, but also professional accountability, in clinical technology use. Emotional reassurance, confidence, lessened anxiety, professional pride and attachment can therefore be an addition to, rather than a substitute for, technical judgments. The TrAAIT framework also theorizes that clinician acceptance is tightly coupled to the development of trust in AI technologies (Stevens & Stetson, 2023). Clinician trust has also been reviewed and suggests that previous experience, reliability, transparency and technology fit with clinical practice are factors that affect confidence in advanced systems (Rojas et al., 2023). The modeled results of the present research therefore are consistent with a dual-route view where both affective security and reasoned evaluation are important contributors to trust, with the latter exerting the stronger standardized effect.

Brand trust alone was found to be significantly associated with behavioral intention and partially mediate the impact of both of the antecedent constructs. Professionals don't make an evaluation once; they will use it time and time again, they will recommend it, they will prefer it over a competitor, or they may be involved in procurement. Evidence from the hospital setting also indicates that the acceptance of AI depends on trust, perceived value, the system's usability, the organizational context, and professional expectations (Lambert et al., 2023). In the Indian medical-device landscape, postmarket surveillance research further shows the crucial role of healthcare professionals in monitoring the performance and safety of medical devices, thereby highlighting the importance of credibility and reliable manufacturer relationships (Shukla et al., 2024).

The mediation results indicate that, for high-end manufacturers of medical instruments, it is important to establish trust not only by evidence of performance, but also by confidence-boosting interaction. Cognitive assessments could be supported by technical evidence, service reliability, training, transparent communication and consistent device performance, and uncertainty around the adoption and routine use of devices could be lessened through responsive support and reassurance. A systematic review of the evidence suggests that explainability can foster or undermine clinician trust, depending on how it is conveyed, and whether it helps them make meaningful decisions (Rosenbacke et al., 2024). Other evidence of the lived experience of healthcare professionals also indicates that the perceived usefulness, compatibility with workflow, autonomy, and practical restrictions are factors that affect the acceptance of

technology in real clinical environments (Ayorinde et al., 2024).

The implications, however, should be taken with a grain of salt. Recent synthesis of trust in digital healthcare reveals that trust is multidimensional and driven by both technology attributes and institutional context, as well as user experience and interpersonal factors, which are all the more reason why it cannot be explained by simple unidirectional explanations (de Camargo Catapan et al., 2025). The evidence from Delhi-NCR also suggests that healthcare professionals may harbor conflicting attitudes towards digital tools, acknowledging their potential benefits while simultaneously expressing doubts on implementation and practical use (Malik et al., 2025). The present dataset is simulated and the coefficients illustrate analytical behaviour of the proposed model and not actually causal effects in real hospitals. Further studies are needed to test the measurement model with primary survey data, to implement probability or stratified sampling when possible, to compare the professional and hospital subgroups, to explore other mediation or moderation models, and to determine whether brand trust is a predictor of observed procurement behavior or continued use over time. Also, the distinction between trust in equipment brand, trust in manufacturer and local service support should be further explored as these may differ in terms of how they function with regard to adoption, maintenance and replacement decisions. Longitudinal designs would identify if positive emotional reassurance is maintained over a longer period of clinical exposure or if it becomes more reliant on objective experience of performance. Multigroup analysis between physicians, engineers, nurses, and procurement personnel could also help to determine if the same trust-building measures apply to users across each group. Last, research should be conducted that compares different categories of products, like imaging devices, robotic surgery devices, monitoring devices, and anesthesia devices, as the perceived risk, switching costs, and evaluation criteria may differ significantly from technology to technology.

5. Conclusion

A structured mediation model was created and tested between emotional drivers and cognitive drivers, brand trust and behavioral intention for high-end medical instruments, intended for use by healthcare professionals. The modeled results revealed that the emotional as well as the cognitive evaluation had a positive relationship with brand trust, with the cognitive being dominant. Brand trust in turn was positively correlated with continued-use, recommendation, brand-preference and procurement oriented intentions. The indirect effects showed that brand trust partially mediated the impact of both emotional and cognitive on the dependent variable, and there were also significant direct effects. These patterns place brand trust as a fundamental process that might mediate the effect of professional confidence and technical evaluation on reactions to sophisticated medical-instrument brands. Manufacturers need to make sure that, from a management point of view, they are not only looking at the technological specifications. By combining reliability, clinical accuracy, demonstrable quality, transparent claims, responsive technical support and confidence building user experiences, you can build professional trust. A purchasing and assessment strategy that incorporates objective evidence of performance and feedback from clinicians, engineers, and other users can also be helpful for hospitals. The findings are informative, but need to be understood in terms of the study design. The coefficients reported are not estimated populations but rather simulated coefficients, since this data was not derived from actual Upper-North Indian hospitals. Further primary multicenter validation, longitudinal follow-up and subgroup analysis must be completed before conclusions can be made about real-world health care professionals or institutional purchasing behavior. If it could be validated, the framework could progress from a simulated analytical model to evidence that could guide manufacturer strategy and hospital purchasing and technology-adoption research.

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