



Interpersonal and Social Factors Affecting Nurse Patient Communication and Shared Decision-Making

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ABSTRACT

Background: Effective communication between nurses and patients is essential for building trust, understanding patient needs, and promoting active participation in healthcare decisions. However, interpersonal and social factors may create barriers to effective communication and shared decision-making.

Objective: To explore the interpersonal and social factors affecting nurse-patient communication and shared decision-making among patients and nurses.

Methods: A descriptive, exploratory qualitative design was used. An open-ended, self-structured questionnaire was administered to ten purposively sampled participants (nurses and patients) at Mayo Hospital, Lahore, over a four-month period. Data were analysed thematically, with responses coded and grouped into recurring themes.

Results: Communication barriers (30%), patient misunderstandings (25%), and inadequate communication training (20%) were the main concerns. Time constraints and stress/burnout (25% each) also affected communication, while active listening and empathy (25%) were key to patients feeling heard.

Conclusion: Interpersonal and social barriers can limit effective communication and shared decision-making. Clear communication, active listening, empathy, and improved nurse training may enhance patient participation in care decisions.

Introduction

Communication is the process by which information, thoughts, and feelings are exchanged between people through a shared system of signs, symbols, or behaviors (1). It comprises a sender, a message, a medium, a receiver, and feedback, and it succeeds only when all parties arrive at a shared understanding of what has been communicated (2). In healthcare, this exchange is not incidental; it is the mechanism through which clinical information becomes usable by the patient, and through which the patient's preferences and concerns become visible to the care team (3). Among the many models developed to strengthen this exchange, patient-centered communication has emerged as central to the delivery of quality care, since it allows patients to build trust with their caregivers, manage the emotional weight of illness, understand what is happening to them, and take part meaningfully in decisions about their own treatment (4).

Nurses occupy a distinctive position in this exchange. They are typically the clinical staff who spend the most sustained time at the bedside, and the way they communicate shapes not only a patient's relationship with the healthcare team but the patient's own perception of the treatment process and its outcome (5). Effective communication skills allow nurses to recognize clinical symptoms as well as the psychological and emotional needs behind them, and they form the basis of the therapeutic relationship that lets a nurse apply a sensitive, collaborative approach to care (6).

Yet despite the well-documented benefits of patient-centered communication, barriers to it have been identified repeatedly across healthcare systems worldwide (7). Limited familiarity with a health system's language and culture on the part of patients restricts the communication process, and these barriers—shaped by cultural and linguistic diversity have measurable effects on health outcomes, care quality, patient safety, and patient satisfaction (8). In systems such as Saudi Arabia's, where a large share of the nursing workforce is expatriate and does not speak Arabic, this problem is especially visible; comparable dynamics are increasingly reported in countries such as the United States and Australia as migration increases the linguistic and cultural distance between nurses and the patients they serve (9).

Communication skill is, in this sense, a cornerstone of safe, high-quality care: it improves outcomes for patients and creates a more functional workplace for staff. Every message carries a layer of intended meaning, and for communication to succeed, sender and receiver must arrive at a shared interpretation of it (10). This is difficult even for skilled communicators once real-world conditions intrude: time pressure, emergencies, sudden changes in treatment plans, life-threatening illness, strained family dynamics, mental health concerns, or unrelieved pain and nausea all constrain the space available for thoughtful dialogue (11). How a nurse responds under these conditions depends on factors specific to that nurse's background, culture, experience, and personality layered onto a patient who is simultaneously coping with a disruption to their own normal functioning (12). Communication in this relationship is therefore inherently complex, shaped by the human responses of two people navigating a difficult situation together. Overcoming the practical barriers within the nurse-patient dyad is widely regarded as a first step toward patient-centered communication, and active listening in particular has been identified as essential to addressing many of the obstacles that stand in the way of patient-centered care.

Materials and Methods

This study used a descriptive, exploratory qualitative design to examine nurse-patient communication at Mayo Hospital in Lahore, Pakistan. Over a four-month period, participants comprising nurses and patients were selected via purposive sampling, starting with ten individuals and continuing until data saturation was reached. Inclusion focused on English-language accounts from the past five years centered on nurse-patient communication during decision-making in multicultural settings, excluding non-participatory patients, outdated material, and irrelevant content.

Data were collected through semi-structured interviews and focus groups conducted in private settings using a self-structured, open-ended instrument that captured demographics, communication challenges, clarity, and improvement suggestions. Audio recordings and field notes were analyzed through NVivo-assisted thematic analysis, involving verbatim transcription, systematic coding into themes (such as language barriers and environmental constraints), and participant cross-referencing for credibility. Ethical standards were strictly maintained using voluntary bilingual (English/Urdu) consent forms, guaranteed rights to withdraw, and complete anonymization of published data.

Results

Table 1. Demographic characteristics of study participants (n = 10)

Variable	Category	n	%
Age (years)	20–30	3	30.0
	31–40	5	50.0
	41–50	2	20.0
	Total	10	100.0
Gender	Male	3	30.0
	Female	7	70.0
	Total	10	100.0
Medical condition	No	9	90.0
	Yes	1	10.0

Total	10	100.0
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Table 1: Ten participants took part in the study. Half (50%) were aged 31–40 years, 30% were 20–30 years, and 20% were 41–50 years. Seventy percent of participants were female and 30% male. Ninety percent reported no medical condition, with 10% reporting one.

Table 2. Difficulty understanding nurse explanations of treatment options

Theme	Representative codes	%
Communication barriers	Language difficulties, lack of patient awareness, miscommunication	30%
Patient expectations & misunderstandings	Unclear nurse roles, high expectations, low health literacy	25%
Nurse training & preparedness	Inadequate communication training, limited skills	20%
Emotional & psychological challenges	Emotional distress, frustration, lack of support	15%
Other factors	General difficulty understanding procedures	10%

Table 2: Communication barriers language difficulties, limited patient awareness, and general miscommunication were the most common (30%), followed by patient expectations and misunderstandings, including unclear perceptions of the nurse's role and low health literacy (25%). Nurse training and preparedness, reflecting perceived gaps in nurses' communication training, accounted for 20%; emotional and psychological challenges accounted for 15%; and general difficulty understanding complex procedures made up the remaining 10%.

Table 3. Perceived obstacles to clear treatment discussions

Theme	Representative codes	%
Time constraints	Limited time, overwhelming pace, constant patient movement	25%
Stress & burnout	Overwork, job dissatisfaction, emotional exhaustion	25%
Lack of basic amenities	No proper breaks, absence of relaxation, increased frustration	20%
Financial challenges	Low salaries, feeling undervalued, low morale	15%
Long working hours	Extended shifts, exhaustion, impact on communication skills	15%

Table 3: Participants pointed most often to time constraints (25%) and stress and burnout (25%), including overwork, job dissatisfaction, and emotional exhaustion. Lack of basic amenities, such as proper breaks and rest space, accounted for 20%; financial challenges accounted for 15%; and long working hours accounted for the remaining 15%.

Table 4. Clarity of nurses' explanations of treatment options

Theme	Representative codes	%
Patient education & health literacy	Lack of medical knowledge, unfamiliarity with medical terms	25%
Language & communication barriers	Difficulty with English explanations, no written materials	20%
Nurse job satisfaction & motivation	Undervalued work, lack of feedback, reduced passion	20%
Patient emotional & physical state	Pain, anxiety, frustration affecting clarity	20%
Lack of supervision & support for nurses	Overwhelmed nurses, low confidence, reduced motivation	15%

Table 4: Patient education and health literacy emerged as the leading theme (25%). Language and communication barriers, including difficulty understanding information delivered in English and a lack of written materials, accounted for 20%, as did nurse job satisfaction and motivation, and patients' own emotional and physical state at the time of the conversation. Lack of supervision and support for nurses accounted for the remaining 15%.

Table 5. Feeling heard during care decisions

Theme	Representative codes	%
Active listening & empathy	Listen without criticism, avoid defensiveness, acknowledge concerns	25%
False reassurance	Offering hope without basis, dismissing distress	20%
Communication barriers	Changing subject, lack of empathy, blocking communication	20%
Therapeutic communication skills	Appropriate responses, avoiding personal opinions	20%

Table 5: Active listening and empathy was the most valued and most frequently missing element (25%). False reassurance, general communication barriers, and gaps in therapeutic communication skill each accounted for 20%.

Table 6. Suggestions for improving comfort in raising questions

Theme	Representative codes	%
Clear & kind communication	Simple explanations, no jargon, listening to concerns	25%
Creating a comfortable environment	Blankets, tea, lighting, relaxation techniques	20%
Personalized patient interaction	Asking about feelings, managing medications, comfort	20%
Observational awareness	Recognizing behavioral or physical cues	20%

Table 6: Clear and kind communication led (25%), followed by creating a comfortable environment, personalized patient interaction, and observational awareness, each cited around 20%. Across all five sets of responses, a consistent pattern emerges: patients' ability to understand and participate in decisions about their care depends jointly on system-level pressures affecting nurses (time, staffing, stress, training) and on relational qualities in the moment of interaction (active listening, plain language, emotional atonement).

Discussion

The demographic profile of this sample predominantly aged 31–40, mostly female, and largely without a reported medical condition provides useful context but also signals limits on generalizability, since males, older or younger adults, and patients managing chronic illness may experience communication differently and were underrepresented here.

The core findings align closely with the wider literature on nurse-patient communication. Language difficulties and low health literacy have consistently been shown to impede patient comprehension, particularly around complex clinical decisions, and inadequate communication training among nurses has repeatedly been linked to worse outcomes and lower satisfaction (13). The emotional burden patients carry into these conversations, often underestimated by care teams, compounds the difficulty of processing treatment information (14). At the same time, other research offers a more favorable picture of nurses as approachable, empathetic communicators who often act as effective mediators between patients and physicians rather than sources of miscommunication suggesting that the barriers identified here may be more situational or institution-specific than universal, and should be interpreted with that caveat (15).

The prominence of time constraints, stress, and burnout in this study's findings mirrors research showing that heavy workloads push nurses toward rushed, superficial interactions, and that chronic stress linked to understaffing and long hours erodes the emotional resilience communication depends on (16). These pressures reduce not only the thoroughness of treatment discussions but also patient trust, reinforcing that institutional conditions not just individual skill shape communication quality (17). Even so, evidence from empowering work environments suggests that supportive leadership and peer collaboration can buffer these effects, maintaining communication quality even under strain; this implies that investment in nurse leadership and resilience training, alongside systemic reform, may meaningfully narrow the gaps this study identifies (18).

Findings on health literacy and language barriers likewise track a substantial evidence base showing that limited health literacy and non-native language status impede shared decision-making, and that nurse morale and wellbeing directly shape communication quality. At the same time, patient comprehension is not purely a function of nurse behavior: research on patient engagement and self-efficacy suggests patients' own active participation matters, and well-resourced settings often deploy visual aids, simplified language, and follow-up protocols that help offset literacy and language gaps pointing to concrete, low-cost interventions this study's participants also called for (19).

The findings on listening and false reassurance reinforce a well-established link between empathetic, attentive communication and patient trust, satisfaction, and engagement in care decisions, while confirming that well-intentioned but ungrounded reassurance can shut down open dialogue. It is also worth noting that communication breakdowns are frequently bidirectional: what a patient perceives as inattentiveness may sometimes reflect legitimate clinical prioritization under time pressure rather than a lack of empathy, and patients' own emotional state or communication style can contribute to the gap (20). This does not diminish the case for strengthening nurses' listening skills, but it does argue for viewing communication effectiveness as jointly produced rather than attributable to one party alone.

Finally, patients' recommendations around comfort, personalization, and observational awareness align with person-centered care principles and with evidence that calm, non-threatening environments and small comfort measures increase patients' willingness to ask questions. These strategies are valuable but not a complete solution: system-level constraints such as staffing and time, along with patient-side factors like cultural norms or mistrust of the healthcare system, mean that environmental and relational adjustments must be paired with broader institutional and policy change to fully close the communication gap (21).

Conclusion

The findings demonstrate that effective nurse-patient communication and shared decision-making are influenced by both interpersonal and social factors. Language barriers, low health literacy, inadequate communication skills, workload, stress, and limited time can restrict patients' understanding and participation in care decisions. At the interpersonal level, active listening, empathy, clear and simple explanations, and personalized communication were identified as essential for helping patients feel heard and comfortable asking questions. Strengthening nurses' communication training, reducing workplace pressures, improving patient education, and promoting supportive nurse-patient interactions may enhance communication and encourage greater patient involvement in shared decision-making.

Recommendations

- **Communication training:** Provide regular training for nurses on therapeutic communication, active listening, empathy, and shared decision-making.
- **Use simple language:** Encourage nurses to avoid medical jargon and provide clear explanations, particularly for patients with limited health literacy.
- **Address language barriers:** Provide culturally appropriate communication and translated or written educational materials where needed.
- **Reduce workload and stress:** Improve staffing, workload management, and opportunities for breaks to allow nurses adequate time for patient communication.
- **Promote patient participation:** Encourage patients to ask questions, express concerns, and actively participate in decisions about their care.
- **Create a supportive environment:** Healthcare institutions should promote respectful, patient-centered interactions and provide supportive supervision for nurses.
- **Further research:** Larger studies should be conducted to explore interpersonal and social factors affecting nurse-patient communication and shared decision-making.

Study Strengths

The study's thematic analysis provided an in-depth, multifaceted view of both patient experience and nurse-side challenges. Including both nurses and patients offered a balanced perspective on communication barriers, and the findings translate into practical, directly applicable recommendations for clinical settings.

Study Limitations

The small sample size ($n = 10$) limits generalizability to the broader population of nurses and patients, and the single-site design restricts the applicability of findings across different healthcare environments. Larger, multi-site studies would strengthen confidence in these conclusions.

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