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Communicative Competence of Nurses in the Lens of Patients

Rose Ann Erlie A. Davila[1]

Master of Science in Nursing, Samar State University, Catbalogan City, Philippines[1]

Corresponding author:
Name: Rose Ann Erlie A. Davila
Address: Samar State University, Arteche Blvd, Catbalogan City, Samar, Philippines
E-mail: roseannerlie.davila@ssu.edu.ph

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Abstract

Introduction: Communication is central to effective nursing care and patient outcomes. Objective: This study aimed to assess nurses' communicative competence as perceived by patients, focusing on the following domains, namely; interest in the patient as a person, understanding patient's experience of illness, attention to context, and participation in care. Methods: Using a descriptive correlational design, the study surveyed 626 admitted patients from both public and private hospitals in Borongan City, adapting the validated 18-item Rochester Communication Rating Scale. Descriptive statistics summarized the patient respondents' socio-demographic profiles, and Spearman's rank correlation examined relationships between these variables and perceived communicative competence of nurses. Results: Showed that nurses demonstrated satisfactory communicative competence overall, with the highest ratings in understanding patient's experience of illness (M=3.72, SD=0.939) and participation in care (M=3.71, SD=0.918), and comparatively lower scores in interest in the patient as a person (M=3.63, SD=0.900), and attention to context (M=3.28, SD=1.343). Correlational analysis revealed no significant relationships between socio-demographic profiles and perceived communicative competence of nurses, with correlation coefficients ranging from r = –0.063 to r = 0.067 and all p-values >0.05. These findings suggest that patients evaluate nurses' communicative competence independently of their socio-demographic profiles. Conclusion: The study concludes that nurses demonstrate satisfactory communicative competence, yet gaps in contextual awareness remain. The study provides preliminary evidence supporting the universality of patient expectations for empathetic, participatory, and culturally sensitive communication. Findings emphasize the need for targeted professional development and institutional strategies to enhance consistent, patient-centered communication in similar healthcare settings.

Keywords:
Communication, Hospital Care, Nurse-Patient Relations, Patient Perception

INTRODUCTION

Nurses play a pivotal role in the complex structure of the healthcare system, skillfully interweaving compassion, expertise, and effective communication to provide holistic care to patients. Among the myriad skills indispensable to nursing practice, effective communication holds a paramount position. Nurses, as frontline providers in the healthcare system, are expected not only to deliver clinical care but also to engage in meaningful, empathetic, and culturally sensitive communication that supports patients' physical, emotional, and psychological needs (Afriyie, 2020; Hardie et al., 2021). Communicative competence in nursing goes beyond basic information exchange, it requires active listening, clarity in explaining medical information, sensitivity to patient concerns, and the ability to manage emotionally charged or culturally complex interactions.

Research has consistently shown that effective nurse-patient communication leads to improved treatment adherence, enhanced chronic disease management, higher patient satisfaction, and better clinical outcomes (Kwame & Petrucka, 2021; Sharkiya, 2023). Conversely, poor communication has been associated with patient dissatisfaction, increased anxiety, and even medical errors (McCabe & Healey, 2018; Tiwary et al., 2019). In fast-paced hospital environments, nurses often face challenges such as time constraints, high patient loads, and emotional demands, which can limit their ability to communicate effectively (Jenstad et al., 2024; Danaher et al., 2023).

In the Philippine context, these issues are further complicated by cultural diversity, limited training opportunities, and varying patient expectations. Corpuz (2023) highlights that, Filipino nurses, particularly in primary and hospital settings, often encounter communication barriers arising from systemic constraints and sociocultural dynamics.

Moreover, existing literature shows a significant gap in evaluating nurses' communication skills from the patients' perspective, especially within provincial healthcare institutions. Few studies have explored how nurses' communication is experienced by patients or whether patients' socio-demographic profiles influence their perceptions.

This study was conducted to address these gaps by determining the communicative competence of nurses from the perspective of patients, determining the socio-demographic profile of patient-respondents, and determining the correlation between the socio-demographic profile of patients and their perceived communicative competence of nurses.

METHODS

1. Design

This study employed descriptive correlational design to examine the relationship between nurses' communicative competence, as perceived by patients, and patients' socio-demographic profiles in hospital settings.

2. Sample Size and Sampling Technique

The study targeted admitted patients from both public and private hospitals in Borongan City as respondents, aiming to assess their perceptions of nurses' communicative competence. A total of 626 patients participated, 310 from private hospital and 316 from public hospital.

The sample size was determined using Slovin's formula. The population size was calculated by multiplying the number of staff nurses per hospital by 27, based on Lurie at al. (2008), who recommend 27 RCRS evaluations per nurse for reliable assessment. With 51 nurses in the private hospital and 56 in the public hospital, the total population was 2,889 (1,377 from the private and 1,512 from the public hospital).

A non-probability convenience sampling technique was employed due to the practical constraints of the hospital setting, such as patient availability, medical condition, and time limitations. Participants were selected based on availability and willingness to participate during their hospital admission. In consideration of the inherent potential bias of the sampling procedure, as well as to enhance sample representativeness, patients were recruited from different wards (private and general) across both hospital types.

Inclusion criteria included patients who are 18 years old and above, conscious and oriented individuals capable of giving informed consent, and patients admitted for at least 48 hours to ensure adequate interaction with nursing staff. Exclusion criteria included patients with cognitive impairment or communication difficulties, critically ill patients or those in intensive care units, and minor patients who required guardians' approval to sign informed consent forms.

3. Instruments

Two structured questionnaires were used to collect quantitative data. The first instrument captured the socio-demographic profile of patient respondents, including age, sex, gender, area of admission, and highest educational attainment. Responses were analyzed using frequency distributions and descriptive statistics.

The second instrument was the Rochester Communication Rating Scale (RCRS), an 18-item tool adapted from Epstein et al. (2004), originally developed to assess communication skills in medical students. The RCRS measures four core domains of nurse-patient communication: (1) interest in the patient as a person, (2) understanding patient's

experience of illness, (3) attention to context, and (4) participation in care. Responses were rated using a five-point Likert scale (1= strongly disagree to 5 = strongly agree), with corresponding interpretive scores reflecting the frequency of communicative behaviors observed.

To ensure cultural and contextual relevance, the RCRS was translated and back-translated by bilingual experts. A panel of Filipino healthcare and communication professionals reviewed the translated items for content validity and clarity. A pilot test was conducted on a comparable hospital to evaluate the tool's feasibility and refine item wording.

The instrument demonstrated high internal consistency, with a Cronbach's alpha of 0.91, affirming its reliability in measuring communicative competence among nurses. Interrater reliability for RCRS was 0.59 and showed item means from 0.45 to 0.83, with standard deviations of 0.03 to 0.10. The RCRS has previously shown strong construct validity aligned with patient-centered care frameworks (Stalburg, 2015).

4. Data Collection Process

Data collection commenced following ethical clearance from the Samar State University Ethics Committee. The researcher visited public and private hospitals and directly approached admitted patients after securing approval from the hospitals. The study's purpose, procedures, benefits, and voluntary nature were clearly explained, and informed consent was obtained from willing respondents. Patients were given time to review the consent form, ask questions, and choose whether to complete the questionnaire independently or with assistance. Each participant completed two forms: the socio-demographic questionnaire and the RCRS.

Completed questionnaires were collected directly by the researcher and securely stored. Each was assigned a unique code to ensure anonymity. All information was handled with strict confidentiality. After study completion, data were de-identified and retained in line with ethical and institutional policies.

5. Data Analysis

Descriptive statistics, including frequency counts and percentages, were used to summarize the socio-demographic profile variables such as age, sex, gender, area of admission, and highest educational attainment of respondents.

To assess nurses' communicative competence, mean scores and standard deviations were computed from the RCRS responses. The mean reflected the average perception across patients, while the standard deviation measured response variability.

Normality of the RCRS data was tested using Shapiro-Wilk test ($W=0.985$, $p < 0.001$), indicating non-normal distribution. As a result, Spearman's rank correlation was used to analyze the relationship between socio-demographic profile and communicative competence scores. These analyses allowed for determining whether there were any significant correlations between the patients' socio-demographic profile and nurses' communicative competence as perceived by patients.

6. Research Ethics

This study received ethical approval from the Institutional Human Research Ethics Committee (IHREC) of Samar State University, ensuring compliance with ethical standards and the protection of respondents' rights. The research followed the data privacy Act of 2012 (R.A. 10173), safeguarding anonymity and confidentiality by collecting no personally identifiable information.

Prior to participation, all respondents received informed consent form explaining the study's purpose, procedures, potential risks and benefits, and their rights, including voluntary participation and the option to withdraw at any time without consequence. The researcher ensured transparency, fairness, and respect for autonomy throughout the process. Ethical conduct was maintained in all stages of data collection, analysis, and reporting.

RESULTS

Socio-Demographic Profile of Patient-Respondents

The majority of respondents (59.1%) belonged to the prime working age group (25-54 years old), while the smallest proportion (9.9%) came from the mature working age group (55-64 years old). Females made up the majority at 70.1%, with males comprising 29.9%. Nearly all respondents (94.4%) identified as straight, with a small portion identifying as part of the LGBTQ+ community. Most were admitted to general wards (86.1%), and only 13.9% were admitted in private rooms. Educational background varied: 21.6% had high school education without completing it, while only 0.3% had earned a doctorate degree.

Table 1. Socio-Demographic Profile of Patient-Respondents (N = 626)

Variables	n	%
Age		
15 – 24 (early working age)	118	18.8%
25 – 54 (prime working age)	370	59.1%
55 – 64 (mature working age)	62	9.9%

Variables	n	%
65 years and older (elderly)	76	12.2%
Sex		
Male	187	29.9%
Female	439	70.1%
Gender		
Straight	591	94.4%
Lesbian	17	2.7%
Gay	7	1.1%
Bisexual	6	1.0%
Transgender	1	0.2%
Asexual	4	0.6%
Area of Admission		
Private	87	13.9%
General Ward	539	86.1%
Highest Educational Attainment		
No schooling	10	1.6%
Elem Level	60	9.6%
Elem Grad	61	9.7%
High School Level	135	21.6%
High School Grad	114	18.2%
Junior High Level	10	1.6%
Senior High Level	19	3.0%
Senior High Grad	21	3.4%
College Level	94	15.0%
College Grad	74	11.8%
Master's Degree	26	4.2%
Doctorate Degree	2	0.3%

Table 2. Summary Table on Level of Communicative Competence of Nurses

Indicator	Mean	SD	Interpretation
Interest in patient as a person	3.63	0.900	Satisfactory
Understanding patient's experience of illness	3.72	0.939	Satisfactory
Attention to context	3.28	1.343	Good
Participation in care	3.71	0.918	Satisfactory
Grand Mean	3.585	0.863	Satisfactory

Legend: (00–1.49 = poor), (50–2.49 = fair), (50–3.49 = Good), (50–4.49 = Satisfactory), (50–5.00 = Very satisfactory)

Table 3. Scoring of the Communicative Competence Scale

Mean Score	Descriptive Rating	Interpretation
4.50-5.00	Very Satisfactory level of Communicative Competence	Able to accomplish communicative goals 75-100% of the time
3.50-4.49	Satisfactory level of Communicative Competence	Able to accomplish communicative goals 55-74% of the time
2.50-3.49	Good level of Communicative Competence	Able to accomplish communicative goals 45-54% of the time
1.50-2.49	Fair level of Communicative Competence	Able to accomplish communicative goals 26-44% of the time
1.00-1.49	Poor level of Communicative Competence	Able to accomplish communicative goals at most 25%of the time

Table 4. Test of Significant Relationship Between the Socio-Demographic Profile of Patient-Respondents and Their Perceived Communicative Competence of Nurses

Profile	Communicative competence	r-value	p-value	Decision	Interpretation
Age	Interest in	0.067	0.094	Fail to reject H0	Not significant
Sex	patient as a	-0.025	0.530	Fail to reject H0	Not significant
Gender	person	-0.035	0.376	Fail to reject H0	Not significant

Profile	Communicative competence	r-value	p-value	Decision	Interpretation
Area of admission		-0.031	0.440	Fail to reject H0	Not significant
Educational Attainment		0.017	0.680	Fail to reject H0	Not significant
Age		0.061	0.129	Fail to reject H0	Not significant
Sex	Understanding	-0.046	0.255	Fail to reject H0	Not significant
Gender	patient's	0.055	0.168	Fail to reject H0	Not significant
Area of admission	experience of	-0.063	0.116	Fail to reject H0	Not significant
Educational Attainment	illness	0.019	0.632	Fail to reject H0	Not significant
Age		0.005	0.909	Fail to reject H0	Not significant
Sex		-0.016	0.704	Fail to reject H0	Not significant
Gender	Attention to	-0.042	0.319	Fail to reject H0	Not significant
Area of admission	context	0.011	0.798	Fail to reject H0	Not significant
Educational Attainment		0.009	0.838	Fail to reject H0	Not significant
Age		0.055	0.897	Fail to reject H0	Not significant
Sex		-0.019	0.638	Fail to reject H0	Not significant
Gender	Participation in	-0.044	0.277	Fail to reject H0	Not significant
Area of admission	care	0.020	0.617	Fail to reject H0	Not significant
Educational Attainment		0.026	0.511	Fail to reject H0	Not significant

Level of significance is set at 0.05

Level of Communicative Competence of Nurses

Interest in the patient as a person. Nurses scored a satisfactory mean rating of 3.63 in showing interest in the patient as a person, or were able to accomplish communicative goals 55-74% of the time.

Understanding patient's experience of illness. Nurses scored the highest satisfactory mean rating of 3.72 in understanding patient's experience of illness, or were able to accomplish communicative goals 55-74% of the time.

Attention to context. Nurses scored lowest in attention to context at 3.28, corresponding to a good level of communicative competence, or were able to accomplish communicative goals 45-54% of the time.

Participation in care. Nurses scored a satisfactory mean rating of 3.71 in participation in care, or were able to accomplish communicative goals 55-74% of the time.

Correlation of Respondents' Socio-Demographic Profile and Communicative Competence of Nurses

Results of the correlation analysis revealed no statistically significant relationships between patients' socio-demographic profiles and their perceptions of nurses' communicative competence across all four domains. The correlation coefficients were consistently low, ranging approximately from r = –0.063 to r = 0.067**,** with all p-values exceeding 0.05**,** indicating the absence of meaningful associations. These findings suggest that these factors do not significantly influence how patients perceive nurses' communication skills.

DISCUSSION

The age distribution of respondents appears broadly consistent with national demographics (PSA, 2021) and is aligned with literature suggesting that individuals in this age group tend to demonstrate higher healthcare engagement and productivity (Majaski, 2024). However, the underrepresentation of older adults highlights a limitation, as their unique healthcare needs are not fully captured, a gap commonly noted in age-focused health research.

The predominance of female respondents aligns with evidence indicating that women are more likely to engage in health communication and rate interpersonal aspects of care more critically (Long et al., 2021). This sex imbalance, common in health surveys (Burra at al., 2022), raises concerns about generalizability of findings, particularly regarding male patients whose communication preferences and expectations may differ.

Sexual orientation data suggest that samples dominated by heterosexual respondents do not fully capture the healthcare experiences of LGBTQ+ populations. Prior studies (Molina-Mula & Gallo-Estrada, 2020; Norris & Borneskog, 2022) emphasized inclusive sampling as crucial for understanding stigma, discrimination, and gaps in culturally competent care, indicating that greater diversity could enhance insights into patient experiences and inform more inclusive communication practices.

Most participants were from general wards, which, according to prior studies are characterized by higher nurse-patient ratios and limited opportunities for personalized care (Wang et al., 2020; Atsavapranee et al., 2023). Such settings are

associated with lower patient satisfaction and outcomes, suggesting that the care environment is an important factor influencing patient perceptions and communication.

Educational attainment among patient respondents varied, with notable proportion having incomplete high school education. Study of Zajacova and Lawrence (2019) indicates that health literacy significantly shapes patient-provider communication. Patients with higher education often interact more proactively (Krist et al., 2017), whereas those with limited formal education may encounter barriers to comprehension and participation (Griese et al., 2020), emphasizing the importance of tailored communication strategies.

Nurses demonstrated generally satisfactory communicative competence across domains, with notable variation. The comparatively lower score in interest in the patient as a person may suggest that nurses' expressions of empathy and personal engagement are not uniformly applied. Study of Babaii et al. (2021) highlights that genuine personal interest is essential for building rapport and fostering trust. Moreover, Mcharo et al., (2022) argue that such interest should extend beyond physical symptoms to encompass patients' values and social contexts, indicating that enhancing nurses' capacity to engage holistically remains an important area for professional development.

The relatively high score in understanding patient's experience of illness may suggest that nurses are generally able to demonstrate empathy, a key component of trust in patient-provider relationships (Pratt et al., 2020; Torres-Vigil et al., 20221). However, variability in engagement indicates that some nurses may still face challenges in consistently applying patient-centered approaches. Furthermore, prior research emphasizes that cultural sensitivity is not always systematically integrated into practice (Anton-Solanas et al., 2022), implying that opportunities remain to enhance communication strategies that effectively address the diverse backgrounds and needs of patients.

Lower scores in attention to context may reflect challenges in integrating patients' social, economic, and environmental realities into care. Consistent with previous findings, nurses often overlook social determinants of health, which can affect patient outcomes and satisfaction (Phillips et al., 2020). Nowaskie and Najam (2022) argued that addressing context is crucial for equitable care and contributed additional data showing that inconsistency remains a challenge.

Scores in participation in care suggest that nurses generally engage patients in decision-making, although the level of involvement may vary. Evidence indicates that patient participation improves health outcomes and satisfaction, but achieving this require deliberate and structured communication strategies (Guttman et al., 2021; McAllister-Williams et al., 2020). Variability in practice implies that reinforcing consistent participatory approaches could enhance patient empowerment and shared decision-making.

The overall communicative competence score (3.585) suggest that nurses demonstrate satisfactory communication skills, but gaps remain. As Querstret et al. (2020) observed, performance is uneven across staff, likely due to differences in training, workload, and individual skills.

The p-values obtained through correlation analysis between socio-demographic profile and patients' perception of the nurses, communicative competence showed that there was no significant relationship between the two aforementioned variables. This suggests that patients generally assess communication quality based on their experience rather than their age, sex, education, etc. These results contrast with some prior studies that identified demographic influences on healthcare perception (Tolotti et al., 2022), indicating that communicative competence is more universally experienced when baseline standards of care are met.

The findings support the theoretical stance that patient-centered communication should be consistent and inclusive, regardless of patient background (Lee et al., 2020). However, findings also suggest questions about whether subtle biases or contextual factors not captured in this analysis may still shape patient perceptions. This points to a potential limitation of the sample size and scope, which have been insufficient to detect weaker or indirect associations.

Importantly, while there is the absence of statistical significance and the observations are inferenced from related literature, it does not negate the need for culturally competent and bias-aware communication. As Abirami and Chitra (2020) argue, inclusive strategies and equitable policies remain essential for ensuring that all patients feel valued and understood. These findings contribute to current knowledge by reinforcing that communication quality should not depend on patient demographics, and suggest that future studies should explore these relationships with larger, more diverse populations as well as factors that precipitated the absence of quantitative significant relationship like sample homogeneity or the prevailing cultural norms which may influence participants' perceptions.

CONCLUSION

The study's findings suggest that nurses generally demonstrate satisfactory communicative competence across the domains of interest in patient as a person, understanding patient's experience of illness, and participation in care. However, variability in performance indicates that expressions of contextual awareness are not consistently applied. While these observations align with existing literature on patient-centered communication, the study's limited geographical scope and sample characteristics warrant caution in generalizing the

results. Moreover, the study reinforces existing communication theories while contributing preliminary evidence that demographic factors like age, sex, gender, highest educational attainment, and area of admission do not significantly influence patient perceptions, suggesting a broader, more universal expectation of care.

Ultimately, the study highlights the ongoing need for targeted professional development, institutional support, and tailored strategies to enhance empathy, contextual awareness, and inclusive communication, which may improve patient trust, engagement, and participation in care across similar clinical settings, particularly in rural and underserved areas.

Conflict of Interest

The author has no conflict of interest to disclose.

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