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A modified framework for understanding provider–patient communication in healthcare

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ABSTRACT

Effective communication between healthcare providers and patients is vital for delivering safe, high-quality, and culturally sensitive care. Despite the availability of various communication models, there remains a lack of an integrated framework that supports practice across diverse clinical settings. This study develops a modified framework by synthesizing Peplau's Interpersonal Relations Theory, the Patient-Centered Care (PCC) framework, and Cultural Competence models. Using a theoretical synthesis approach, each theory was critically reviewed for its key concepts, communication principles, and clinical relevance, and thematic mapping was applied to identify overlaps in communication stages, relational dynamics, cultural awareness, and patient autonomy. These findings were combined into a unified framework that aligns theoretical rigor with practical application, providing healthcare professionals with guidance to strengthen therapeutic relationships, address cultural diversity, and improve communication outcomes, particularly in complex or high-stakes care situations. The proposed model offers a structured approach to enhance patient engagement, satisfaction, and safety in contemporary healthcare systems.

1. Introduction

Understanding communication among healthcare providers and patients is crucial for several factors, such as enhancing patient satisfaction, improving health outcomes, facilitating shared decision-making, building trust and confidence, addressing emotional and psychosocial needs, and reducing healthcare disparities. Given this, patient- healthcare providers communication is integral to the overall healthcare system worldwide (Gao et al., 2024).

Over the years, several theoretical frameworks and models, including interpersonal relations theory, patient-centered communication, and cultural competence theory, have been developed to measure patient-healthcare providers' communication. However, research tends to use each model or theoretical framework independently to measure patient-healthcare providers' communication. Because patient-healthcare providers' communication is noted to be complex, applying each of the frameworks independently does not offer a comprehensive understanding of patient-healthcare providers' communication in healthcare settings (Rey Velasco et al., 2022).

A modified framework integrating interpersonal relations theory, patient-centered communication, and cultural competence theory is needed to strengthen patient-healthcare providers' communication experiences. This study proposes a modified framework to measure patient-healthcare providers' communication in a healthcare environment. This study is expected to promote quality healthcare delivery, which will, in effect, contribute to achieving universal health coverage.

There is a lack of integrative frameworks that bring together multiple theoretical perspectives to guide nursing practice. Existing models, such as Peplau's Interpersonal Relations Theory, Patient-Centered Care (PCC), and Cultural Competence frameworks, have typically been applied in isolation. This fragmented approach limits their practical applicability in real-world, diverse healthcare settings. The present study addresses this gap by developing a novel integrated communication framework that synthesizes core elements from these theories. This is the first attempt, to our knowledge, to combine these three perspectives into

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a unified model designed to guide nurses in establishing culturally sensitive, relationship-based, and patient-centered communication. The framework aims to support nurses in navigating complex interpersonal interactions, particularly in culturally diverse environments such as those found in Gulf and global healthcare systems.

2. Methods

This study employed a theoretical synthesis approach to construct a modified communication framework for healthcare provider–patient interaction. The process involved an in-depth conceptual analysis of three foundational theories: Peplau's Interpersonal Relations Theory, the PCC framework, and established models of Cultural Competence. Rather than conducting a formal systematic review, this study focused on the critical examination and comparison of these theories to identify points of conceptual overlap, complementarity, and theoretical gaps.

Each theory was reviewed for its core constructs, communication principles, and clinical relevance. Thematic mapping was used to highlight intersections across the models, particularly in relation to communication phases, relational dynamics, cultural awareness, and patient autonomy. These insights were then synthesized to develop an integrated framework that aligns theoretical rigor with practical applicability in diverse healthcare settings.

To support relevance and contextual validity, the emergent framework was further reviewed by senior nurse educators and clinical practitioners familiar with intercultural communication and therapeutic care. Their informal feedback guided refinements to ensure the framework's clarity, usability, and relevance in real-world nursing practice.

2.1. The interpersonal relations theory

The interpersonal relations theory has been used widely in the nursing world. The concept, the history and the components of the interpersonal relations theory will be discussed below.

Several studies have highlighted the concept regarding Peplau's interpersonal relations theory. Generally, the theory of interpersonal relations is a middle-range theory that describes the therapeutic relationship between the healthcare providers and consumers of health services (Bello, 2017; Brandenburg, 2017; Hagerty, 2015; Hagerty et al., 2017; Senn, 2013; Sheldon, 2009; Washington, 2013). In particular, the therapeutic relationship helps healthcare providers to apply intelligent, sensitive, and collaborative approaches to communicate with consumers of the services (Bello, 2017; Senn, 2013; Sheldon, 2009; Washington, 2013). Consequently, whilst therapeutic communication encourages consumers of services, it also provides mutual respect between healthcare providers and consumers. Communication serves as a medium for both stakeholders to learn from each other (Bello, 2017). Indeed, this communication process seems to be affected by several factors, which include environment, attitudes, beliefs, and culture.

The theory of interpersonal relations was originally developed by Peplau (1952) to facilitate the therapeutic relationship between nurses and consumers for services within the psychiatric setting (Brandenburg, 2017; Deane and Fain, 2016; Hagerty, 2015; Senn, 2013; Sheldon, 2009). Historically, the original theory was referred as theory as "talking to patients" (Senn, 2013). This theory evolved through educational endeavors and aimed to achieve better health outcomes for consumers of services (Senn, 2013). In fact, interpersonal relations theory has transformed into being used not only in psychiatric but also in other specialties, which include clinical practice, research, nursing administration, and nursing education (Deane and Fain, 2016; Senn, 2013). Similarly, Senn (2013) showed that the theory of interpersonal relations is widely taught as an integral component of the nursing curriculum.

Several studies have highlighted the various dimensions of interpersonal relations theory (Bello, 2017; Brandenburg, 2017; Deane and Fain, 2016; Hagerty, 2015; Hagerty et al., 2017; Senn, 2013; Sheldon, 2009; Washington, 2013). Broadly, the theory has three interlocking and overlapping dimensions, which include the orientation phase, working phase, and termination phase (Deane and Fain, 2016; Hagerty, 2015; Hagerty et al., 2017; Senn, 2013).

However, some studies have expanded the working and termination phases into two sub-dimensions (Bello, 2017; Brandenburg, 2017; Sheldon, 2009; Washington, 2013). For instance, the working phase is divided into identification and exploitation, whilst the termination phase is divided into resolution and termination (Fig. 1).

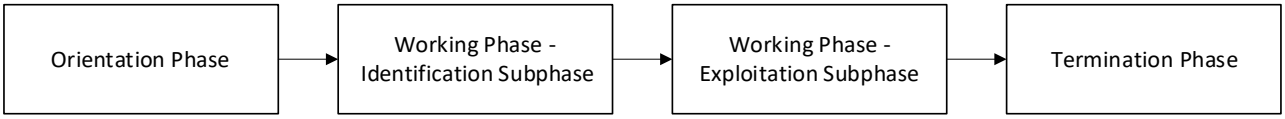

Fig. 1: Peplau's theory of interpersonal relations

The orientation phase is the time when the healthcare provider and health service consumer begin to develop a therapeutic relationship when they get to know and trust each other (Brandenburg, 2017; Washington, 2013). In fact, this phase, where data collection during the initial assessment is placed as the patient is seeking help and the healthcare provider is assisting the patient to

identify the problem (Bello, 2017; Senn, 2013; Sheldon, 2009). During provider-patient interaction, the healthcare provider maximizes verbal communication and minimizes non-verbal communication to ask questions and have a comprehensive understanding of the patient (Brandenburg, 2017; Deane and Fain, 2016). Thus, the exchange of information enables patients to develop a trusting relationship with the healthcare providers (Brandenburg, 2017).

Several studies have conceptualized the working phase as the actual assessment process where most of the therapeutic relationship is accomplished (Deane and Fain, 2016; Hagerty, 2015; Hagerty et al., 2017; Senn, 2013). Subsequently, whilst the working phase describes patients' reaction to illness (Deane and Fain, 2016; Senn, 2013), it seems to consume most of the healthcare providers' working time (Hagerty et al., 2017). This is ascribed to the fact that most of the actual consultation and medication takes place at this stage. For example, healthcare providers may perform additional tasks as surrogate parents if the patient is in a developmental stage of infancy or adolescence (Senn, 2013).

Consumers of health services perceive healthcare providers as providers of unconditional care, exhibiting empathy, health educators, resource persons, and counsellors (Hagerty et al., 2017; Senn, 2013). In addition, the working phase highlights the consumers' perception of healthcare providers' communication, management of the physical environment, pain management, and control (Hagerty, 2015). Also, the healthcare providers use their professional knowledge, skills, and education to solve a particular health issue (Senn, 2013).

Moreover, some studies have categorized the working phase into two sub-components, which include the identification and exploitation phases (Deane and Fain, 2016; Hagerty, 2015; Hagerty et al., 2017; Senn, 2013). Subsequently, the identification phase is the stage where the health problem is identified and a suitable healthcare provider intervention is built for the problem (Bello, 2017; Brandenburg, 2017; Sheldon, 2009). During this stage, both verbal and non-verbal communication are practically applied. Indeed, healthcare providers provide several supports to consumers, which include exploring their feelings and possible fears, anxiety and helplessness, and possible coping strategies to their health conditions (Bello, 2017).

Furthermore, the exploitation phase describes the stage where the consumer uses the existing resources to solve the condition. These resources constitute healthcare providers, support services, and the capacity of the health system (Bello, 2017; Brandenburg, 2017; Sheldon, 2009; Washington, 2013). In particular, consumers use the existing therapeutic relationships and resources to collaborate with healthcare providers. This helps them to participate fully in the delivery of health services. The termination phase is the phase where the evaluation of healthcare providers' intervention progress towards their goals, reviewing their time together, and the end of the provider-patient professional relationship occurred (Bello, 2017; Hagerty et al., 2017; Senn, 2013). It is the stage when providers help the patient to be independent in leading a productive, healthier life (Deane and Fain, 2016; Hagerty, 2015; Hagerty et al., 2017; Senn, 2013). Moreover, at this stage, healthcare providers are preparing patients to get back to a normal, productive life by fulfilling relationships and social activities (Deane and Fain, 2016).

In short, interpersonal relations between patients and healthcare providers are fundamental to delivering a high quality of care (Hagerty, 2015). The interpersonal relationship between providers and patients goes through three stages. All these stages are strongly connected to each other, and none of these stages can be overlooked. Therefore, the success of the termination phase depends on how well healthcare providers and patients navigate both the orientation and working phases. Furthermore, a successful termination phase will contribute to high-quality care and patient satisfaction.

2.2. Patient-centered communication model

Patient-centered communication (PCC) can be defined in terms of the process and outcome of interaction between patient and healthcare providers in understanding the patient's perspectives, understanding the patient psychologically as well as their social context, having a shared understanding with the healthcare providers about problem and treatment and helping the patient to share power and involve them in their health decisions (Epstein and Street, 2007; Treiman et al., 2018). In fact, high-quality PCC would build a strong patient-provider relationship and trust, which may contribute to decreasing anxiety levels which enabling patients to end up with improving their satisfaction (Epstein and Street, 2007).

Several studies have highlighted that there are six overlapping core functions or domains of PCC to produce effective communication that can influence health outcomes (Blanch-Hartigan et al., 2015; Epstein and Street, 2007; McCormack et al., 2011; Treiman et al., 2017; Treiman et al., 2018). These six overlapping core domains are exchanging information, fostering healing relationships, making decisions, responding to emotions, managing uncertainty, and enabling patient self-management (Fig. 2) (Blanch-Hartigan et al., 2016; Epstein and Street, 2007; Treiman et al., 2018).

Exchanging information is very important for patients and their families who are seeking information about their illness, diagnosis, and treatment. Providing this information seems to decrease anxiety as well as uncertainty and improve their satisfaction. Healthcare providers ought to emphasize the significance of assessing or understanding patients' and families' information needs to provide them with this information (Blanch-Hartigan et al., 2016; Epstein and Street, 2007).

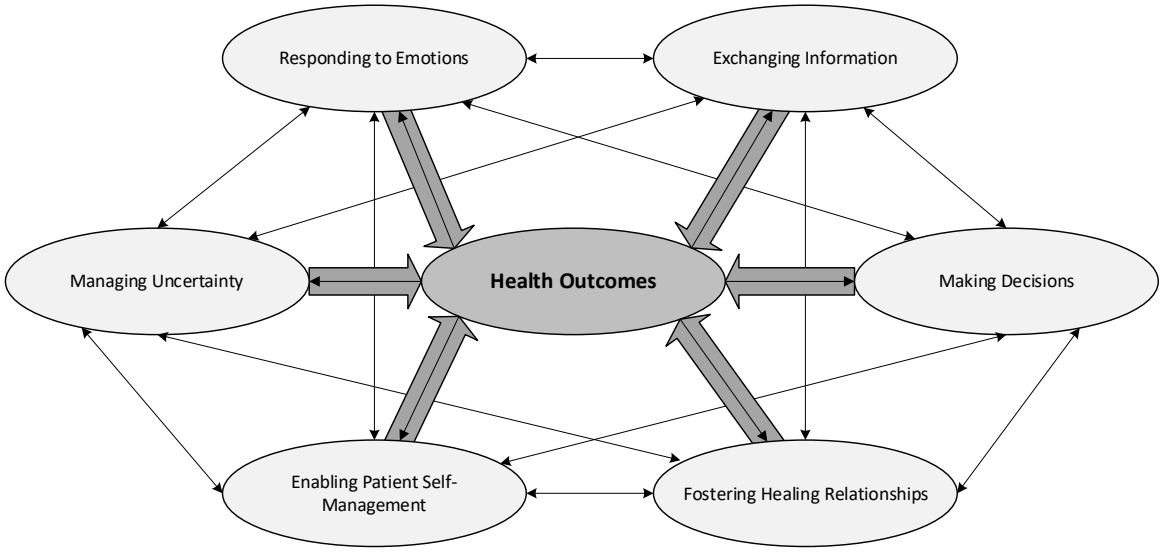

Fig. 2: National Cancer Institute conceptual framework of patient-centered communication

Epstein and Street (2007) stated that fostering a healing relationship emphasizes the significance of building rapport, mutual trust, commitment, and mutual understanding about patients' and healthcare providers' roles and expectations (Epstein and Street, 2007; Treiman et al., 2018). Patients and their families require a good relationship with a healthcare provider that is characterized by trust and rapport. This relationship can be strong when the providers are delivering high-quality information as well as encouraging patients and their families to actively participate in discussing their health (Blanch-Hartigan et al., 2016).

The decision-making process requires a high quality of information exchanged among patients and healthcare providers. During care, the decision is important in every step of the disease (Blanch-Hartigan et al., 2016; Treiman et al., 2018). This dimension considers the involvement of both patients and their families in their health as well as identifying the person in the family who is responsible for the final health decision (Epstein and Street, 2007).

Patients with certain diseases may be distressed regarding their illness. The responsibility of healthcare providers here is to evolve or elicit this distress by having a good rapport with patients, communicating professionally, and understanding patients' emotions and then responding to these emotions (Blanch-Hartigan et al., 2016; Epstein and Street, 2007).

Uncertainty is often difficult to reduce, but it can be managed by providing all necessary information and support that is required by the patient. This will enable patients and their families to better deal with anxiety regarding their illness (Epstein and Street, 2007).

According to Epstein and Street (2007), enabling patient self-management considers navigating patients through the healthcare system, supporting patient autonomy, as well as providing guidance to the patient to help them access the resources.

2.3. Cultural competence theory

Cultural competence theory is a main theory that has been employed in healthcare. The concept, history, and components of the theory are discussed below.

Several studies have outlined that cultural competence is the ability of healthcare providers to achieve effective work within a culturally diverse environment (Albougami et al., 2016; Cai et al., 2017; Campinha-Bacote, 2002a; 2002b; 2009; Campinha-Bacote, 2001; Suh, 2004). More specifically, cultural competence is an ongoing process in which the health professional endeavors to attain greater efficiency and the ability to work in different cultural backgrounds while caring for patients, whether individuals, families, or groups (Albougami et al., 2016; Campinha-Bacote, 2002b; 2009; Campinha-Bacote, 2001). Consequently, culturally competent healthcare providers ought to have a set of congruent knowledge, attitudes, and behaviors that help them to work proficiently in a transcultural environment of the client (individuals, family, community), while demonstrating respect for these different cultures (Cai et al., 2017; Suh, 2004).

In fact, the cultural competence model is believed to be an important element for healthcare providers to provide safe and high-quality care to different cultural populations (Cai et al., 2017). In short, this theory is appropriately comprehensive to guide the development of educational interaction as well as empirical research (Albougami et al., 2016).

Historically, the origin of cultural competence appeared first in 1969 with Campinha-Bacote (Cai et al., 2017; Campinha-Bacote, 2002b). She was pursuing her undergraduate degree, and during that time, there was a conflict in race relations. She found herself not fitting into another ethnic group. When she completed her doctoral degree, she extended her interest into transcultural nursing and medical anthropology (Campinha-Bacote, 2002b; Campinha-Bacote, 2001). The works of Leininger (1999) and Pedersen (1988) in both areas, transcultural nursing

and multicultural development, were merged to develop the essential constructs of the theory of cultural competence (Campinha-Bacote, 2002b).

Subsequently, the cultural competence model has been widely used in the healthcare field (Campinha-Bacote, 2002a; Campinha-Bacote, 2001). In particular, cultural competence theory has been applied in different settings, including psychiatric, rehabilitation, case management, community services, and home care (Campinha-Bacote, 2002a; Campinha-Bacote, 2001). The cultural competence model has been suggested as a framework for health policy development (Campinha-Bacote, 2002a). Nowadays, the term cultural competence has become universal in the healthcare field.

Several theoretical frameworks have been proposed to guide healthcare providers in considering the various cultural competence dimensions (Albougami et al., 2016; Cai et al., 2017; Campinha-Bacote, 2002a; 2002b; 2009; Campinha-Bacote, 2001). These cultural competence dimensions are five, which include cultural awareness, cultural knowledge, cultural skills, cultural encounters, and cultural desire (Fig. 3) (Albougami et al., 2016; Cai et al., 2017; Campinha-Bacote, 2009; Campinha-Bacote, 2001). The dimensions of the cultural competence theory overlap. During care, providers ought to fully understand each dimension to provide efficient patient care.

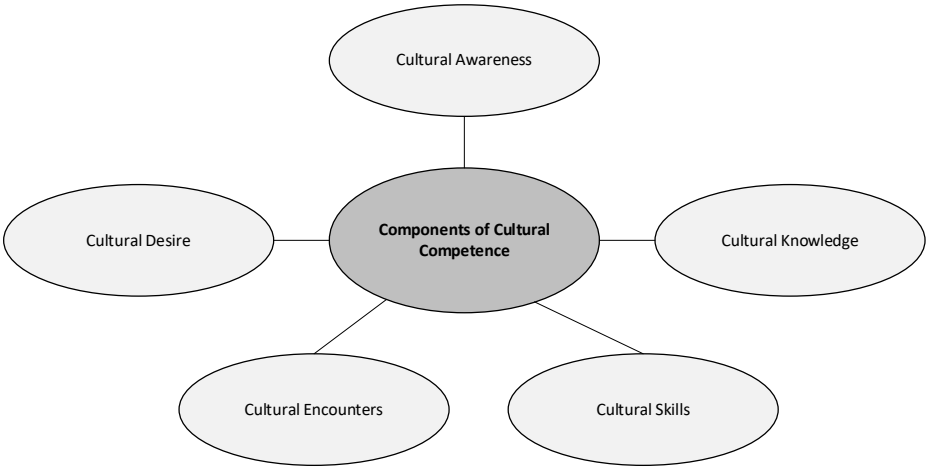

Fig. 3: The process of cultural competence in the delivery of healthcare services

Cultural awareness is the process by which healthcare providers become sensitive, respectful, and appreciative of the values, beliefs, problem-solving strategies, and practices of patients' culture (Albougami et al., 2016; Campinha-Bacote, 2002a; 2002b; 2009; Campinha-Bacote, 2001). Consequently, this process involves a continuous assessment of cultural background. Moreover, the cultural awareness process includes an in-depth exploration of one's own prejudge and biases against other cultures (Campinha-Bacote, 2002a; 2002b; 2009; Campinha-Bacote, 2001). Continuous assessment of cultural background as well as exploration of one's own prejudge and biases of client culture would enable healthcare providers to avoid bias during patient care (Albougami et al., 2016).

Cultural knowledge is the process of seeking and gaining information regarding different ethnic groups and cultures (Campinha-Bacote, 2002a; 2009). Obtaining cultural knowledge of different ethnic groups or cultures, such as client beliefs and values, would significantly involve an in-depth understanding of the patient's worldview (Albougami et al., 2016; Campinha-Bacote, 2009; Campinha-Bacote, 2001). It is noteworthy that cultural knowledge is one of the most important requirements whilst providing care to patients with diverse cultures to understand patient behavior as well as patient worldview (Campinha-Bacote, 2001).

Cultural skills are the ability of the healthcare providers to collect necessary data or information from the patient (Albougami et al., 2016; Campinha-Bacote, 2002a; 2002b; 2009; Campinha-Bacote, 2001). Cultural skills enable healthcare professionals to consider culturally specific assessments whilst gathering relevant information regarding a patient's history during the patient's physical assessment or patients' health problem (Campinha-Bacote, 2002b; Campinha-Bacote, 2001).

Cultural encounters can be defined as the process of encouraging the healthcare providers to directly participate in cross-cultural communication or interaction with different cultures (Campinha-Bacote, 2002b; 2009; Campinha-Bacote, 2001). This domain of the cultural competence theory requires obtaining cultural knowledge (Campinha-Bacote, 2002a). For instance, providers may find themselves knowledgeable about certain cultural or ethnic groups. This knowledge is based on reading information regarding these specific groups or communicating with a few members of these groups (Albougami et al., 2016).

Cultural desire is the "driving force" or the motivation of the healthcare professional to "want to" be involved in the cultural competence process rather than "have to" (Campinha-Bacote, 2001). For instance, healthcare providers may have cultural awareness, cultural knowledge, cultural skills, and cultural encounters, but they also must have the

motivation to work in a culturally diverse environment (Campinha-Bacote, 2002b; 2009).

3. Discussion

3.1. Integrating theoretical frameworks: Overlaps and synergies

The integration of cultural competence, interpersonal relations theory, and patient-centered communication presents a comprehensive strategy to enhance nurse-patient communication. Cultural competence provides foundational principles—awareness, knowledge, skills, desire, and encounter—that support healthcare professionals in fostering respectful, bias-free interactions. These elements are essential in building trust, promoting understanding, and ultimately improving patient satisfaction.

The orientation phase of Peplau's Interpersonal Relations Theory aligns closely with the exchange of information domain in the patient-centered communication framework. Both emphasize initial verbal engagement during patient assessment, with less reliance on non-verbal cues. At this stage, culturally competent practices are particularly important. Awareness of a patient's cultural values, beliefs, and expectations helps prevent miscommunication and lays the groundwork for a trusting relationship. Incorporating cultural sensitivity into this phase ensures that information exchange is meaningful and respectful, enabling clinicians to understand the patient's worldview and avoid causing unintentional harm.

Moving into the working phase, there is significant overlap with five patient-centered communication dimensions: exchanging information, fostering healing relationships, making decisions, responding to emotions, and managing uncertainty. This phase encompasses most of the nurse's clinical engagement, where therapeutic relationships are solidified. Effective communication during this phase involves detailed information sharing, which enhances trust and allows patients to participate meaningfully in decision-making. As a result, nurses are better equipped to identify and respond to patient emotions, fears, and coping mechanisms—thus helping to mitigate uncertainty and strengthen the emotional bond.

Furthermore, this phase is where empathy, patient education, and psychological support are most deeply embedded. Culturally competent behavior, through active reflection and adaptation to the patient's cultural and emotional context, enables nurses to connect patients' cultural beliefs with their illness experience. This enhances both the emotional and informational quality of communication, leading to more personalized care.

Finally, the termination phase aligns with the self-management domain of patient-centered communication. Here, the nurse facilitates the patient's transition to autonomy by using established rapport to encourage independent navigation of the healthcare system. Guided by mutual respect and trust, patients draw upon the therapeutic relationship and available resources to regain a sense of control and return to their social and personal lives. Cultural competence in this phase ensures that discharge planning and follow-up care respect patients' preferences and community contexts, further supporting continuity of care.

In summary, the intersection of these frameworks creates a dynamic, patient-focused approach that strengthens communication, encourages therapeutic engagement, and improves care outcomes in culturally diverse clinical environments.

3.2. Critical engagement with theories and rationale for integration

Peplau's Interpersonal Relations Theory emphasizes the therapeutic nurse-patient relationship and the phases of interaction required to establish trust and mutual understanding. While this model offers valuable insight into emotional and relational dynamics, it assumes a basic level of verbal communication, which may not be feasible for patients with language barriers or speech impairments such as aphasia. This limits its standalone applicability in diverse or complex clinical contexts.

PCC model complements Peplau's framework by prioritizing the patient's preferences, autonomy, and involvement in decision-making. However, PCC often lacks structured guidance for how to effectively communicate when patients face cognitive, linguistic, or cultural challenges. Similarly, Cultural Competence Models fill this gap by providing strategies to recognize and adapt to cultural values, beliefs, and practices—but they can risk becoming prescriptive or superficial if not grounded in authentic relational dynamics.

These frameworks, while individually robust, each hold partial strengths. Their overlap lies in the shared emphasis on empathy, respect, and individualized care. Yet contradictions emerge when one model assumes verbal reciprocity (Peplau), another emphasizes autonomy (PCC), and a third focuses on sociocultural context (Cultural Competence). By integrating them, this framework addresses such limitations: It brings together relational depth, patient-centered structure, and cultural adaptability. The result is a more comprehensive, flexible guide for nurses navigating communication in real-world clinical settings, particularly with patients who have complex communication needs (Table 1).

These theoretical elements are synthesized into a unified model that illustrates their interconnections and practical application (Fig. 4).

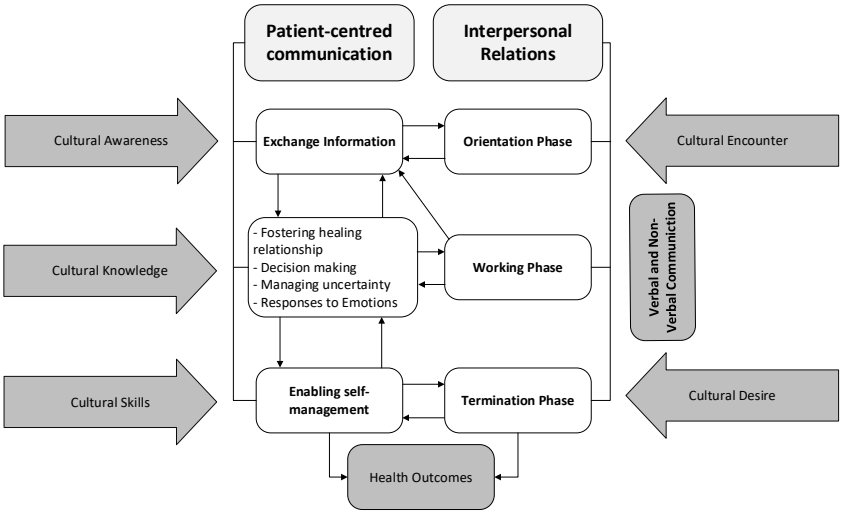

Fig. 4: A modified framework for understanding nurse-patient communication

Table 1: Integrated communication framework: Theoretical components

Theory	Core concept	Communication contribution	Role in integrated framework
Peplau's Interpersonal Relations Theory	Therapeutic relationship building over time	Focuses on nurse-patient trust and communication phases (orientation, working, termination).	Establishes a relational foundation, particularly for building trust with non-verbal or vulnerable patients.
PCC	Respect for autonomy, values, and participation in care decisions	Encourages individualized communication and shared decision-making.	Ensure communication strategies are tailored to the patient's preferences and involvement.
Cultural Competence Models	Awareness, sensitivity, and adaptation to cultural contexts	Enhancing communication effectiveness across linguistic and cultural boundaries.	Supports equitable care and addresses language/cultural barriers in communication.

3.3. Practical application of the framework

The integrated communication framework can be practically applied by guiding nurses in their daily interactions with patients who have communication challenges, particularly those from culturally diverse backgrounds. For example, a nurse caring for a non-verbal patient with aphasia can initiate trust-building through consistent presence and empathetic engagement, as outlined in Peplau's Interpersonal Relations Theory. Person-centered care principles can be applied by adapting communication techniques to meet the patient's individual needs—such as using visual aids or simplified language, while ensuring the patient remains at the center of decision-making. Cultural competence is reflected through awareness and respect for the patient's cultural background, including involving family members appropriately and adapting care practices to align with cultural values.

Together, these approaches enable the nurse to deliver care that is not only clinically effective but also emotionally supportive and culturally sensitive. The framework thus serves as a practical guide that enhances therapeutic relationships, improves communication outcomes, and supports the delivery of safe, individualized care across diverse healthcare settings.

4. Conclusion and implications for practice

A good understanding of effective communication among patients and healthcare providers is important to improve healthcare delivery and quality. Limited research has focused on merging these concepts together. The proposed framework can help healthcare providers to deeply understand communication between providers and patients, and to improve communication and service delivery between patients and healthcare providers. However, some of these theories were failures to consider some of the important features of patient-centered care. First, the interpersonal relations theory and cultural competence theory were failures to consider the family of the patient as a part of communication to provide holistic care. Second, both theories consider the language of patients, which is the most important element of building conversation, relationship, as well as patient satisfaction. Therefore, healthcare providers who work in multicultural settings can face many challenges due to either different languages or cultures or religions or all of them together (Alshammari et al., 2019).

Compliance with ethical standards

Conflict of interest

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

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