

A Common Ground Theory Analysis of Doctor–patient Interactions in the Emergency Units of Selected Private Hospitals in Asaba, Nigeria

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Abstract

Emergency settings are characterized by time pressure, emotional distress, uncertainty, and rapid decision-making, all of which may hinder mutual understanding between healthcare providers and patients. This study examines doctor–patient communication in the emergency units of selected private hospitals in Asaba, Delta State, Nigeria, through the lens of Common Ground Theory. Adopting a qualitative discourse-analytic research design, the study analyzed ten naturally occurring interactions involving doctors, patients, and relatives. Data were collected through observation and recorded conversations, transcribed verbatim, and subjected to thematic analysis. Findings reveal that communication breakdowns frequently arise from medical jargon, power asymmetry, emotional distress, language barriers, and assumptions of patient understanding. The study further demonstrates that grounding strategies such as clarification, lexical simplification, repetition, reassurance, and the teach-back method significantly enhance shared understanding. The findings confirm the relevance of Common Ground Theory in explaining communication successes and failures in emergency medical discourse. The study concludes that effective emergency care depends not only on clinical expertise but also on the ability of healthcare professionals to establish, negotiate, and maintain common ground with patients. It recommends integrating communication and grounding strategies into emergency medicine training and healthcare policy.

Keywords:Emergency unit, Common Ground Theory, doctor–patient interaction, healthcare discourse, grounding strategies.

Introduction

Communication is a fundamental component of healthcare delivery. Beyond diagnosis and treatment, healthcare professionals rely on communication to obtain information, explain procedures, provide emotional support, and facilitate collaborative decision-making. Effective

communication is particularly important in emergency units where decisions often involve life-threatening situations and require immediate action. In such settings, misunderstandings can have serious consequences, including delayed treatment, medication errors, patient dissatisfaction, and adverse clinical outcomes.

Emergency units represent one of the most communication-intensive environments in healthcare institutions. They involve interactions among doctors, nurses, patients, relatives, ambulance personnel, laboratory scientists, pharmacists, and other healthcare professionals. Unlike routine clinical consultations, emergency encounters are characterized by urgency, uncertainty, emotional distress, and limited time for extended discussion. Consequently, healthcare providers must balance efficiency with the need to ensure patient understanding.

Communication in emergency settings extends beyond the mere transmission of information. It involves the collaborative construction of meaning between participants who often possess unequal knowledge and authority. Doctors typically possess specialized medical knowledge, while patients may lack familiarity with medical terminology, diagnostic procedures, and treatment protocols. This imbalance can create barriers to understanding and reduce patient participation in clinical encounters.

One of the major challenges in emergency healthcare communication is the assumption of understanding. Healthcare professionals frequently interpret patients' nods, silence, or brief responses as evidence of comprehension. However, such responses may conceal confusion, anxiety, or reluctance to seek clarification. The resulting communication gaps can undermine informed consent, treatment compliance, and patient safety. As patient populations become increasingly diverse in terms of Language, education, and socioeconomic background, the challenge of establishing shared understanding between healthcare professionals and patients becomes more pronounced. Private hospitals in Asaba, Delta State, provide a useful context for examining emergency healthcare communication. These institutions complement public healthcare facilities by offering emergency services, specialist consultations, diagnostic investigations, and inpatient care.

Research has consistently demonstrated a strong relationship between communication quality and healthcare outcomes. Street et al. (2009) argue that effective clinician–patient communication contributes to improved diagnosis, treatment adherence, patient satisfaction, and

health outcomes. Similarly, Odebunmi (2006, 2011, 2021) has shown that communicative strategies could be employed to improve patient understanding and treatment adherence. Ha and Longnecker (2010) observe that communication failures remain among the leading causes of preventable medical errors globally. Within emergency departments, these challenges are intensified by overcrowding, noise, interruptions, and the emotional state of patients and their families hence this study seeks to contribute to the growing body of scholarship on healthcare communication by investigating communication practices in the emergency units of selected private hospitals in Asaba through the theoretical framework of Common Ground. Applying this framework to emergency medical discourse enables a deeper understanding of how communication breakdowns occur and how they are repaired during clinical encounters.

Literature Review

Numerous studies have examined effective communication in healthcare setting but not so much attention has been devoted to the interactional construction of common ground in emergency-unit settings within Nigeria. According to Street, Makoul, Arora, and Epstein (2009), clinician–patient communication influences health outcomes through improved access to information, enhanced therapeutic relationships, increased treatment adherence, and greater patient satisfaction. This supports Ha and Longnecker (2010) argument that effective doctor–patient communication improves diagnostic accuracy, facilitates informed decision-making, and reduces the likelihood of medical errors. Conversely, ineffective communication may result in misunderstanding, patient dissatisfaction, reduced compliance with treatment recommendations, and adverse health outcomes.

The World Health Organization (2021) identifies communication failure as a major contributor to patient-safety incidents globally. Healthcare systems increasingly recognize that communication competence is as important as technical competence in ensuring quality patient care. Consequently, communication training has become an essential component of medical and nursing education in many countries. O'Hagan et al. (2014) contend that communication effectiveness in healthcare should not be measured solely by speed but also by the extent to which mutual understanding is achieved.

Emergency units are among the most communication-intensive settings within healthcare institutions. They are characterized by urgency, unpredictability, emotional distress, and rapid clinical decision-making. Healthcare professionals operating in emergency environments often face multiple communication challenges, including overcrowding, interruptions, environmental noise, staff shortages, and limited consultation time. Pun et al. (2015) observe that emergency departments require healthcare workers to process large amounts of information within short periods while simultaneously responding to patient needs. These conditions increase the likelihood of communication breakdowns and misunderstandings. Unlike routine clinical consultations, emergency encounters often involve patients experiencing pain, anxiety, confusion, or reduced consciousness, thereby limiting their ability to provide accurate information.

Heritage and Maynard (2006) argue that medical consultations frequently reflect unequal distributions of knowledge and authority. Doctors generally control the structure of consultations by asking questions, providing diagnoses, and determining treatment options. Patients, in contrast, are expected to respond to questions and comply with recommendations. Odebunmi (2024) reiterates: “doctors are generally believed to be assuming and cold; they are thus placed on a power pedestal and approached with caution and differences”. Such asymmetry may discourage patients from seeking clarification even when they do not fully understand medical information.

Silverman, Kurtz, and Draper (2016) note that patients often struggle to understand specialized medical vocabulary, abbreviations, and diagnostic terminology. Misunderstanding may affect informed consent, medication adherence, and treatment outcomes. The use of jargon becomes particularly problematic in emergency units where patients are expected to process information under stressful conditions. Clark and Brennan (1991) emphasize that successful communication requires grounding processes through which participants establish and confirm understanding. These processes include clarification requests, repetition, paraphrasing, acknowledgment, and feedback. When misunderstandings occur, participants engage in repair strategies designed to restore shared understanding. Pun et al. (2015) found that time pressure and environmental distractions frequently contribute to communication breakdowns in emergency departments. Similarly, O'Hagan et al. (2014) observed that healthcare professionals often prioritize clinical efficiency

at the expense of patient understanding. Street et al. (2009) demonstrated that patient-centered communication significantly improves health outcomes, treatment adherence, and patient satisfaction. Heritage and Maynard (2006) further reported that communication effectiveness is closely related to clinicians' ability to recognize and address patients' informational needs.

Much of the Nigerian work on doctor–patient communication has been led by Odebunmi and colleagues. Prominent among these studies are: Adegbite and Odebunmi (2006; 2010), Odebunmi and Adeoti (2024), and Odebunmi (2005, 2010, 2025) all examine how doctors and patients create, maintain, or fail to achieve shared understanding during consultations. These studies provide useful foundations for discussing common ground, even when the term itself is not the primary theoretical framework.

Odebunmi (2005) observe that interaction between doctor and client in orthodox medical practice in Nigeria lean on Leech's tact, generosity, approbation, sympathy and Pollyanna maxims and Brown and Levinson's bald on record, positive politeness and negative politeness. Adegbite and Odebunmi (2010) analyse the deployment of face strategies in orthodox medical practice in Southwestern, Nigeria. They compare the deployment of bald on record acts, positive politeness, negative politeness and off record politeness in the orthodox and traditional medical setting. Adegbite and Odebunm (2006) investigates doctors' and patients' mutual contextual beliefs and pragmatic strategies during diagnosis, a concept that strongly overlaps with common ground. The duo observes that doctor–patient communication has traditionally been characterized by asymmetrical power relations. Doctors possess institutional authority, specialized knowledge, and decision-making power, whereas patients often occupy dependent communicative positions. This imbalance influences how information is exchanged and interpreted during clinical encounters.

Odebunmi and Adeoti (2024) which is the closest to the present study examine the role of common ground in the management of patients' disagreement with doctors' recommendations in Nigerian hospital visits. Drawing on common ground theory, activity type theory, and conversation analysis, the authors demonstrate that doctor–patient interactions are shaped by both pre-existing shared knowledge and emergent understandings developed during consultations. Their findings reveal that participatory communicative practices, which allow for the

negotiation of common ground, enhance patient satisfaction and therapeutic cooperation, whereas non-participatory approaches often reinforce institutional power asymmetries. The study therefore establishes common ground as a crucial pragmatic resource for achieving effective healthcare communication and resolving interactional conflicts in clinical encounters. Of all Nigerian work on doctor-patient interactions this is the closest to the present study which focus is on emergency unit.

From the literature review we observe that studies has shown that strategies could be employed to improve patient understanding and treatment adherence. By analyzing naturally occurring doctor-patient interactions in selected private hospitals in Asaba, Delta State, this study contributes to further enhance our understanding of communication processes in emergency healthcare environments and provides practical insights for improving patient safety and healthcare quality.

Theoretical Framework

The theoretical underpinning for this study is Common Ground Theory by Herbert H. Clark. Clark's major work, *Using Language* (1996), established the foundation of the Theory of Common Ground. According to Clark (1996), communication is not simply the transmission of information from one person to another; rather, it is a joint activity in which speakers and listeners coordinate meaning together. He defined common ground as the shared knowledge, beliefs, and assumptions that participants rely upon during interaction. The historical development of the theory can be linked to earlier works in pragmatics and discourse studies. Paul Grice influenced the theory through his Cooperative Principle, which explains that participants in communication generally cooperate to make conversations meaningful (Grice, 1975). Clark extended these ideas by emphasizing that communication involves continuous negotiation of understanding between participants. During the late twentieth century, scholars in linguistics, psychology, and communication studies increasingly focused on interactive communication processes, thereby contributing to the popularity of common ground theory.

The theory identifies shared understanding as the basis of successful communication. Clark (1996) distinguishes between communal common ground and personal common ground. Communal common ground refers to knowledge shared because individuals belong to the same social or cultural community. For example, doctors and

patients may share certain cultural beliefs about illness and treatment. Personal common ground, however, develops from previous interactions and shared experiences between specific individuals. A doctor who has treated a patient repeatedly over time develops personal common ground that facilitates effective communication and trust.

In doctor–patient interactions, the theory is particularly useful because healthcare communication often involves differences in knowledge and authority. Doctors possess professional medical knowledge, while patients may have little understanding of medical concepts. Consequently, misunderstandings may occur when doctors use technical Language unfamiliar to patients. The Theory of Common Ground suggests that doctors should adapt their communication styles to patients’ levels of understanding in order to create mutual comprehension. This may involve explaining medical terms in simpler Language, encouraging questions, and confirming patients’ understanding of diagnoses and treatment procedures.

The theory also emphasizes the role of feedback in communication. Effective communication depends on the ability of participants to confirm understanding during interaction. In healthcare settings, patients may ask questions, repeat instructions, or use nonverbal responses to indicate comprehension. Similarly, doctors observe patients’ verbal and nonverbal cues to determine whether communication has been successful. According to Clark and Brennan (1991), grounding processes such as clarification and acknowledgment are essential for maintaining effective interaction. In medical consultations, such processes reduce communication breakdown and improve treatment compliance.

Another important application of the theory is in promoting patient-centered healthcare. Modern healthcare systems increasingly emphasize collaboration between doctors and patients. Through common ground, doctors can establish empathy, trust, and emotional connection with patients. When patients feel understood and respected, they are more likely to disclose sensitive health concerns and follow medical advice. Effective common ground therefore contributes to patient satisfaction and positive health outcomes. The theory is equally relevant in multicultural healthcare environments where linguistic and cultural differences may hinder communication. Patients and doctors from different cultural backgrounds may interpret illness, symptoms, and treatment differently. In such situations, achieving common ground becomes essential for preventing misunderstanding and ensuring quality

healthcare delivery. Healthcare practitioners may use translators, culturally sensitive explanations, and visual aids to bridge communication gaps and improve shared understanding.

Researchers have widely applied the Theory of Common Ground in studies of healthcare communication, counseling, education, and organizational discourse. In doctor–patient interaction studies, the theory helps scholars analyze communication barriers, patient participation, informed consent, and shared decision-making. It is particularly valuable in qualitative research because it provides insight into how meaning is negotiated during conversations and interviews. Despite its strengths, the theory has certain limitations. Achieving complete common ground may be difficult because individuals often interpret experiences differently. In healthcare interactions, power imbalance between doctors and patients may also hinder open communication. Patients may hesitate to ask questions or express disagreement because doctors occupy positions of authority. Nevertheless, the theory remains important because it highlights the need for cooperation, empathy, and mutual understanding in communication.

In sum, the Theory of Common Ground, developed mainly by Herbert H. Clark, explains communication as a collaborative process based on shared understanding. Rooted in pragmatics and discourse theory, the theory has become highly relevant in healthcare communication studies. In doctor–patient interaction, it explains how mutual understanding, feedback, empathy, and cultural sensitivity contribute to effective communication and better healthcare outcomes. The theory is therefore appropriate for studies examining communication processes and relationships between doctors and patients.

In medical contexts, common ground includes shared understanding of symptoms, procedures, risks, and expectations. Failure to establish common ground can result in misunderstandings with serious clinical implications. The grounding criterion for common ground is that understanding is sufficient when participants believe it is sufficient for current purposes nevertheless, in emergency settings most cases, this criterion is often lowered due to urgency.

Methodology

The study was conducted in selected private hospitals in Asaba, Delta State, Nigeria. Asaba serves as the administrative capital of Delta State and hosts several private healthcare institutions that provide emergency

medical services to diverse populations. These hospitals receive patients with varying educational, linguistic, and socio-economic backgrounds, making them suitable contexts for investigating communication practices in emergency healthcare settings. The population comprised doctors, patients, and patient relatives involved in emergency-unit interactions.

This study adopts a qualitative discourse-analytic research design. Qualitative discourse analysis is appropriate because the study seeks to examine how meaning is negotiated during naturally occurring interactions between healthcare professionals and patients in emergency units. The design enables an in-depth exploration of communicative practices, shared understanding, and communication breakdowns within emergency medical discourse. Also, purposive sampling was employed to select interactions that demonstrated significant communicative exchanges relevant to the objectives of the study. Ten interactions were selected because they contained instances of information seeking, clarification, explanation, misunderstanding, negotiation of meaning, and communication repair. Data were collected through non-participant observation and recording of naturally occurring emergency-unit interactions. Permission was obtained from hospital authorities, while ethical principles of confidentiality, anonymity, and informed consent were strictly observed. Participants' identities were protected through the use of interaction numbers. The recorded interactions were transcribed verbatim to preserve the linguistic features necessary for discourse analysis. The data were analyzed thematically using Common Ground Theory (Clark, 1996) as the analytical framework. Particular attention was paid to:

- Establishment of common ground.
- Communication breakdowns.
- Grounding strategies.
- Clarification and repair mechanisms.
- Power relations in interaction.
- Patient understanding and participation.
- Patterns emerging across the interactions were grouped into themes and interpreted within the broader context of healthcare communication scholarship.

Data Presentation and Analysis

Interaction 1:

Medical Terminology and Limited Understanding

Doctor: What brings you in today?

Patient: My chest is tight.

Doctor: Any history of hypertension?

Patient: I don't know.

Doctor: Have you been on BP medication before?

Patient: I take drugs sometimes.

The interaction reveals a communication gap resulting from specialized medical terminology. The patient's response suggests unfamiliarity with the terms "hypertension" and "BP medication." The doctor assumes the existence of shared medical knowledge that the patient does not possess. Consequently, common ground remains weak, leading to ambiguity and incomplete information exchange.

Interaction 2: Assumed Understanding

Doctor: We need to run some tests to rule out anything serious.

Patient: Okay.

Doctor: You'll be prepared for ECG and laboratory investigations.

Patient: Alright.

The patient's brief responses are interpreted as evidence of understanding. However, no verification occurs. The grounding process remains incomplete because understanding is assumed rather than confirmed.

Interaction 3: Verification of Understanding

Doctor: I'm going to explain everything step by step. Do you understand so far?

Patient: Yes, doctor.

Doctor: Can you tell me what you understood?

Patient: You want to check my heart.

The doctor actively seeks confirmation of understanding. The patient's ability to restate the explanation demonstrates successful grounding. Common ground is strengthened through feedback and verification.

Interaction 4: Differing Interpretations of Symptoms

Doctor: Can you tell me where the pain is?

Patient: My chest. It feels heavy.

Doctor: When did it start?

Patient: This morning. I thought it would pass.

The patient interprets the symptom as manageable, while the doctor treats it as potentially life-threatening. The differing interpretations indicate weak common ground regarding symptom severity.

Interaction 5: Triage Conflict

Relative: Doctor, please attend to him first. He is the breadwinner.

Doctor: We attend to patients based on medical urgency.

Relative: But he looks worse than others.

The interaction demonstrates competing frameworks of interpretation. The relative evaluates urgency socially, while the doctor evaluates urgency clinically. The absence of shared assumptions produces tension and disagreement.

Interaction 6: Clarification of Meaning

Doctor: When you say dizzy, do you mean lightheaded or spinning?

Patient: Like the room is turning.

Doctor: That helps. Thank you.

The doctor employs clarification to identify the patient's intended meaning. Through questioning and elaboration, common ground is successfully established.

Interaction 7: Emergency Consent

Doctor: We need to run tests immediately.

Patient: Will I be okay?

Doctor: Our goal is to stabilize you first. We will explain more

shortly.

Time constraints limit detailed explanation. Nevertheless, the doctor's reassurance helps maintain relational common ground and reduces patient anxiety.

Interaction 8: Medication History

Doctor: Are you currently taking any medication?

Patient: Just the white tablets.

Doctor: What are they called?

Patient: I don't know.

The patient lacks the vocabulary required to identify the medication. Shared knowledge is insufficient for effective information exchange, demonstrating a breakdown in common ground.

Interaction 9: Discharge Instructions

Doctor: Take this medication twice daily after meals.

Patient: Okay.

Doctor: Can you repeat how you will take it?

Patient: I will take it after breakfast and dinner every day.

The doctor employs the teach-back technique to confirm understanding. The successful repetition indicates that common ground has been established.

Interaction 10: Language Simplification

Doctor: Have you experienced palpitations?

Patient: Sorry?

Doctor: Has your heart been beating unusually fast?

Patient: Yes, especially since yesterday.

The initial use of medical terminology creates a communication barrier. The doctor repairs the breakdown through lexical simplification, thereby restoring mutual understanding.

In summary, the analysis of the ten interactions produced four major themes:

- Medical jargon as a barrier to understanding.
- Assumed rather than verified understanding.
- Clarification and teach-back as effective grounding strategies.
- Power asymmetry and institutional constraints in emergency communication.

These themes collectively demonstrate that communication in emergency units is a dynamic process of negotiating understanding under conditions of urgency, uncertainty, and unequal knowledge.

Discussion of Findings

The findings of this study show that communication in hospital emergency units is a complex process shaped by institutional demands, linguistic choices, interpersonal relationships, and contextual constraints. Through the analytical lens of Common Ground Theory, the study demonstrates that successful emergency healthcare communication depends largely on the ability of healthcare professionals and patients to establish, maintain, and repair shared understanding during interaction. One of the most significant findings is the prevalence of communication barriers arising from medical terminology. Interactions 1, 8, and 10 demonstrate that patients frequently encounter difficulties understanding specialized medical vocabulary. Terms such as "hypertension," "palpitations," and references to medication categories created obstacles to effective communication because they were not part of the patients' communicative repertoire. These findings support the observations of Silverman, Kurtz, and Draper (2016), who argue that excessive reliance on technical medical Language often limits patient participation and understanding. The findings also align with Street et al. (2009), who maintain that effective healthcare communication requires clinicians to adapt their Language to patients' levels of comprehension.

The study further reveals that emergency-unit communication is frequently characterized by assumed understanding rather than verified understanding. In Interaction 2, the patient repeatedly responded with brief expressions such as "okay" and "alright," which the doctor interpreted as evidence of comprehension. However, no attempt was made to verify whether the patient actually understood the proposed procedures. This finding illustrates one of the central concerns of Common Ground Theory: participants often assume that sufficient common ground exists when, in reality, understanding remains

incomplete. Clark (1996) emphasizes that successful communication requires continuous verification rather than mere assumptions of understanding.

Another important finding concerns the effectiveness of grounding strategies in facilitating mutual understanding. This corroborates Odebunmi and Adeoti (2024) who observe that greater participatory communication tends to improve patient satisfaction. Interactions 3, 6, 9, and 10 demonstrate how clarification, simplification, repetition, and teach-back techniques contribute to successful communication. In these interactions, doctors actively sought evidence of patient comprehension rather than relying on passive indicators such as nodding or silence. The use of clarification questions and requests for patient restatement enabled healthcare professionals to identify and correct misunderstandings before they affected clinical decision-making. These findings support Clark and Brennan's (1991) proposition that grounding processes are essential for maintaining successful communication. The teach-back strategy observed in Interactions 3 and 9 emerged as one of the most effective communication practices identified in the study. By asking patients to repeat information in their own words, healthcare professionals were able to assess comprehension directly. This finding corroborates previous healthcare communication studies that identify teach-back as a valuable patient-safety tool capable of reducing misunderstandings and improving treatment adherence.

Again, the findings highlight the influence of power asymmetry on emergency healthcare communication. This aligns with Adegbite and Odebunmi (2010) observation that doctors are placed on power pedestal as they occupy positions of institutional authority and possess specialized knowledge, while patients often depend on them for information, diagnosis, and treatment decisions. This imbalance affects interactional dynamics and may discourage patients from seeking clarification when they do not understand medical information. Heritage and Maynard (2006) similarly argue that doctor-patient interactions are structured by unequal distributions of knowledge and authority. Power asymmetry was particularly evident in Interaction 5, where disagreement emerged between a patient's relative and the attending doctor regarding treatment prioritization. The relative evaluated urgency based on social and economic considerations, whereas the doctor relied on clinical triage principles. The resulting tension illustrates how different participants may operate with distinct interpretive frameworks that hinder the

establishment of common ground. The findings suggest that healthcare professionals must actively explain institutional procedures and decision-making processes in order to reduce conflict and facilitate understanding. Another notable finding concerns the role of emotional distress in shaping communication. Emergency units are environments characterized by anxiety, uncertainty, fear, and vulnerability. Patients often seek reassurance in addition to medical treatment. Interaction 7 demonstrates how the doctor's response focused not only on clinical information but also on emotional reassurance. Although time constraints limited detailed explanation, the doctor's acknowledgment of the patient's concerns helped maintain relational common ground. This finding supports patient-centered communication models that emphasize empathy and emotional support as integral components of healthcare interaction.

The study further reveals that emergency communication is constrained by institutional pressures such as urgency and limited consultation time. Emergency clinicians often face the challenge of balancing rapid decision-making with the need for patient understanding. While immediate clinical intervention may be necessary, insufficient explanation can contribute to confusion and dissatisfaction. This finding supports the observations of Pun et al. (2015), who identify time pressure as one of the primary communication challenges in emergency departments.

The findings confirm that effective emergency healthcare communication requires deliberate efforts to establish common ground through clarification, simplification, feedback, and empathy. Such practices enhance patient understanding, improve treatment compliance, strengthen trust, and contribute to better healthcare outcomes.

Conclusion

This study examined communication practices in emergency units of selected private hospitals in Asaba, Delta State, Nigeria using Common Ground Theory as its analytical framework. The findings demonstrate that emergency healthcare communication is a dynamic and collaborative process in which shared understanding cannot be assumed but must be actively negotiated. It further highlights the practical significance of grounding strategies in promoting patient safety, improving healthcare outcomes, and strengthening doctor-patient relationships in emergency environments. The study identified medical jargon, assumed

understanding, power asymmetry, emotional distress, and institutional pressures as major barriers to effective communication. At the same time, grounding strategies such as clarification, simplification, repetition, reassurance, and teach-back techniques were found to facilitate mutual understanding and reduce communication breakdowns.

Recommendations

Based on the findings, the study recommends as follows:

- Healthcare professionals should avoid unnecessary medical jargon when communicating with patients and relatives.
- Emergency clinicians should routinely employ teach-back techniques to verify patient understanding.
- Hospitals should develop communication protocols that encourage clarification and patient participation.

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