

Original Article

Assessment of Barriers of Nurse-Patient Effective Communication in Emergency Department of Lahore General Hospital, Lahore

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ABSTRACT

Background: Nurse-patient communication in emergency departments may be constrained by clinical demands and interpersonal difficulties. Local assessment can identify perceived barriers. **Objective:** To identify nurse-perceived barriers to effective communication in the Emergency Department of Lahore General Hospital, Lahore, Pakistan. **Methods:** A descriptive cross-sectional study included 124 registered nurses recruited through convenience sampling. Participants completed the self-administered 27-item Barriers in Communication Questionnaire, covering demographic, knowledge-related, environmental, social, economic, and psychological domains using five-point response scales. Frequencies, percentages, means, and standard deviations were calculated using IBM SPSS Statistics version 26.0. **Results:** All participants were female. Barriers most frequently rated to a large or very great extent were lack of time (n = 108; 87.1%), overworking (n = 104; 83.9%), and nursing shortages (n = 99; 79.8%). Multiple simultaneous duties were endorsed by 95 nurses (76.6%), inadequate psychological support for patients by 89 (71.8%), and inadequate knowledge of communication skills by 88 (71.0%). **Conclusion:** Nurses perceived environmental and workload-related difficulties as the leading barriers, alongside communication-knowledge and psychological-support concerns. These findings identify priorities for local assessment without establishing actual communication failure or effects on patient outcomes. **Keywords:** Nurse-patient communication; Communication barriers; Emergency department; Registered nurses; Cross-sectional study; Pakistan.

INTRODUCTION

Effective nurse-patient communication involves the purposeful exchange of clinical information, explanations, concerns, and emotional support to facilitate understanding and participation in care (1). Communication is also an important patient-safety consideration because the information exchanged between healthcare professionals and patients contributes to assessment and care planning (2). In the emergency department (ED), these interactions occur alongside urgent clinical assessments, rapidly changing patient needs, and competing demands on

healthcare professionals' attention. Research on emergency-care delivery and nurse-patient communication has identified the clinical environment and the conditions under which care is provided as important considerations when examining communication difficulties (3,4). Understanding these difficulties therefore requires attention to both individual communication skills and the circumstances surrounding nurse-patient interactions.

Emergency nursing research has examined communication barriers as a multidimensional phenomenon encompassing demographic, knowledge-related, environmental, social, economic, and psychological factors (4). In a survey of 199 emergency nurses across nine hospitals in Palestine, environmental factors were the highest-rated barriers, followed by knowledge-related and psychological factors (4). Similarly, a study involving 184 nurses across five teaching hospitals in Iran identified occupational characteristics as the most prominent category, with excessive workload emerging as the leading individual barrier (5). Although these studies used different domain structures, both emphasized the importance of working conditions in nurses' perceptions of communication difficulties. Their findings support an assessment that considers organizational pressures alongside nurses' knowledge and the interpersonal circumstances of care, rather than treating communication barriers solely as deficiencies in individual practice (4,5).

Linguistic, sensory, and psychological factors introduce further dimensions to communication in emergency settings. A survey of physicians working in six hospitals in Makkah examined language and communication difficulties during emergency care, illustrating the relevance of linguistic barriers from the clinician's perspective (6). Research involving deaf and hard-of-hearing patients and healthcare workers has also examined communication barriers affecting access to emergency services, highlighting the importance of considering patients with differing communication needs (7). In an Indonesian emergency setting, research on nurse-family communication identified psychological barriers as a prominent concern (8). These studies address different participants and communication relationships but collectively indicate that an account of emergency communication cannot be restricted to information transmission alone; it must also consider the circumstances in which patients, families, and professionals attempt to understand one another (6-8).

The wider organization of emergency care provides an additional context for nurse-patient interaction. A scoping review of 37 studies on nurse-provider communication identified interruptions, high workloads, and professional power imbalances as barriers, while shared workspaces, electronic tools, and structured communication practices were described as potential facilitators (9). A separate study in Saudi Arabia examined nurses' perceptions of the quality of nurse-physician communication in EDs (10). These sources concern communication between clinicians rather than communication between nurses and patients, and their findings should not be treated as direct measurements of the latter. Nevertheless, they provide relevant organizational context for examining the environment in which patient-facing nursing communication takes place (9,10).

Within Pakistan, the literature included in the present review addresses related but distinct aspects of emergency communication. Research in a public-sector hospital examined patients' attendants' perceptions and attitudes toward nurses in the ED (11). Another study investigated communication barriers and customer satisfaction in private tertiary care hospitals in Karachi (12). These perspectives contribute to understanding emergency-care experiences, but neither directly establishes how registered nurses at Lahore General Hospital perceive barriers during their interactions with patients. Differences in respondents, institutional settings, and the aspects of communication examined also limit the extent to which findings from these studies can answer a nurse-focused, institution-specific research question (11,12).

The resulting knowledge gap concerns the nature and relative prominence of communication barriers as perceived by nurses working in the ED of Lahore General Hospital, rather than whether communication difficulties occur in emergency care generally. An assessment spanning the six questionnaire domains can provide a structured account of these perceptions without assuming that the pattern reported elsewhere applies to this institution. Such evidence may help nursing administrators identify areas warranting closer review and guide the development of locally appropriate improvement initiatives. Importantly, nurses' reports can identify perceived obstacles and priorities for further investigation, but they should not be interpreted as direct measurements of communication performance, patient harm, or the effectiveness of a proposed intervention.

Accordingly, this descriptive cross-sectional study aimed to identify and describe the barriers to effective nurse-patient communication perceived by registered nurses working in the Emergency Department of Lahore General

Hospital, Lahore, across the demographic, knowledge-related, environmental, social, economic, and psychological domains of the 27-item Barriers in Communication Questionnaire.

MATERIAL AND METHODS

A quantitative, descriptive cross-sectional study was conducted in the Emergency Department of Lahore General Hospital, Lahore, Pakistan, to describe registered nurses' perceptions of barriers to effective nurse-patient communication. The design enabled the assessment of perceived barriers across demographic, knowledge-related, environmental, social, economic, and psychological domains without evaluating an intervention or establishing causal relationships. The study was completed over six months following approval of the research synopsis. The target population comprised registered nurses working in the emergency department, with a population size of 180 nurses used for the sample-size calculation.

Registered nurses were eligible if they worked in the emergency department, provided direct patient care, had at least six months of clinical experience, and provided written informed consent. Nurses who were ill or receiving medical treatment at the time of data collection were excluded. Additional exclusion criteria included diagnosed medical conditions, cognitive impairment, or psychological or psychiatric disorders that could affect the ability to complete the questionnaire accurately. Nursing students, interns, nursing managers, and nurses working in administrative roles were also excluded.

Participants were selected using nonprobability convenience sampling. The sample-size calculation used Slovin's formula, $n = N / (1 + Ne^2)$, where n represented the sample size, N the population size, and e the specified error parameter. Substituting a population of 180 nurses and an error parameter of 0.05 gave approximately 124 nurses. The study included 124 participants. This calculation provided the numerical basis for the sample size, while participant selection remained nonprobability-based.

Following institutional permission, the study purpose and objectives were explained to potential participants. Eligible nurses who agreed to participate provided written informed consent before receiving the questionnaire. Participants were given the opportunity to ask questions and were informed that participation was voluntary, that they could refuse to provide information, and that they could withdraw consent without penalty. Questionnaires were self-administered and collected upon completion. Data collection comprised a questionnaire-based assessment of nurses' characteristics and perceptions of communication barriers.

The structured questionnaire contained two sections. The first recorded age, gender, marital status, educational qualification, and clinical experience. Age was recorded in years. Marital status was categorized as married, single, or widowed/divorced. Educational qualifications comprised a General Nursing Diploma, Bachelor of Science in Nursing, Post-RN Bachelor of Science in Nursing, and Master of Science in Nursing. Clinical experience was recorded using the questionnaire categories of 1–3, 4–6, 7–10, and more than 10 years. These variables characterized the participating nurses and were distinct from the demographic-barrier items concerning differences between nurses and patients.

The second section comprised the 27-item Barriers in Communication Questionnaire previously used by Al-Kalaldeh and colleagues (4). The instrument covered six domains: demographic factors, comprising four items; knowledge-related factors, four items; environmental factors, five items; social factors, five items; economic factors, two items; and psychological factors, seven items. Demographic items addressed age, gender, cultural, and religious differences between nurses and patients. Knowledge-related items concerned patients' educational background, nurses' knowledge of communication skills and patients' illnesses, and patients' awareness of nursing duties. Environmental items addressed nursing shortages, overworking, time constraints, the presence of multiple critically ill patients, and work-related violence. Social items concerned accompanying family members, familiarity with the hospital environment, participation in treatment planning, relationships between nurses and other healthcare providers, and nurses' reluctance to listen to patients' feelings. Economic items addressed multiple duties and inadequate monthly income. Psychological items concerned patients' pain or physical symptoms, disease stage, nurses' self-esteem and attitudes, despair or apathy toward work, previous negative experiences of patient care, and psychological support provided to patients.

Participants rated each questionnaire statement using the same five response categories: 1, very small extent; 2, small extent; 3, moderate extent; 4, large extent; and 5, very great extent. The questionnaire instructed respondents to select the response that best represented how true each statement was for them. Communication barriers were operationalized through individual item ratings, domain scores, and an overall questionnaire score, with higher scores interpreted as greater perceived barriers.

Under the five-point scoring structure, the theoretical summed-score ranges were 4–20 for each of the demographic and knowledge-related domains, 5–25 for each of the environmental and social domains, 2–10 for the economic domain, and 7–35 for the psychological domain. The theoretical overall score ranged from 27 to 135. Domain and overall findings were also expressed as percentage scores. The study-defined overall categories were low barriers at scores of $\leq 40\%$, moderate barriers at 41–70%, and high barriers at $>70\%$. These categories represented nurses' perceptions rather than direct observations of communication performance or patient outcomes.

Data were analyzed using IBM SPSS Statistics version 26.0. The analysis was descriptive and summarized the characteristics and questionnaire responses of the 124 participating nurses. Categorical characteristics and individual item responses were presented as frequencies and percentages; tabulated outputs also included valid and cumulative percentages. Age and questionnaire scores were summarized using means, standard deviations, and minimum and maximum values.

Clinical experience was described according to its recorded categories. For individual barrier items, the numbers and percentages of respondents selecting "large extent" or "very great extent" were combined to describe the most frequently endorsed barriers. Domain findings were compared descriptively using percentage scores to accommodate differences in the number of items across domains. Skewness and kurtosis were examined to characterize score distributions, and internal consistency of the 27-item questionnaire was assessed using Cronbach's alpha.

Ethical approval was obtained from the Ethical Review Committee of Lahore General Hospital, Lahore, before data collection, and written administrative permission was secured from the hospital's Medical Superintendent. The study followed the ethical principles of the 2008 Declaration of Helsinki. Written informed consent was obtained from every participant. Confidentiality and anonymity were maintained during data collection, analysis, and reporting, and participants were assured that their identities would not be disclosed in publications arising from the study. Participation did not provide a financial benefit.

RESULTS

The study included 124 registered nurses, all of whom were female. Their mean age was 31.4 ± 6.2 years, with a range of 22–52 years. The largest age group was 26–30 years, comprising 45 participants (36.3%). Most participants were married ($n = 79$, 63.7%). A General Nursing Diploma was the most common educational qualification ($n = 56$, 45.2%), followed by post-RN BSN ($n = 48$, 38.7%). The largest clinical-experience category was 1–3 years ($n = 38$, 30.6%) (Table 1).

Lack of time received the highest item rating, with a mean score of 4.27 ± 0.80 ; 108 nurses rated it to a large or very great extent (87.1%; 95% CI, 80.1–91.9%). Nurses overworking and nursing shortage were the next most frequently endorsed items, reported by 104 (83.9%; 95% CI, 76.4–89.3%) and 99 participants (79.8%; 95% CI, 71.9–86.0%), respectively (Table 2). Outside the environmental domain, multiple simultaneous duties were rated to a large or very great extent by 95 nurses (76.6%). Lack of psychological support for patients and inadequate knowledge of communication skills received corresponding ratings from 89 (71.8%) and 88 nurses (71.0%), respectively. Religious differences had the lowest combined proportion ($n = 47$, 37.9%), followed by nurses' reluctance to hear patients' feelings ($n = 48$, 38.7%).

Table 1. Characteristics of participating nurses (N = 124)

A. Continuous age summary

Characteristic	n	Mean $\pm$ SD	Minimum–maximum
Age, years	124	31.4 ± 6.2	22–52

B. Sociodemographic and professional characteristics

Characteristic	Category	n (%)
Gender	Female	124 (100.0)
Gender	Male	0 (0.0)
Age, years	22–25	25 (20.2)
Age, years	26–30	45 (36.3)
Age, years	31–35	37 (29.8)
Age, years	36–40	12 (9.7)
Age, years	>40	5 (4.0)
Marital status	Married	79 (63.7)
Marital status	Single	40 (32.3)
Marital status	Widowed/divorced	5 (4.0)
Educational qualification	General Nursing Diploma	56 (45.2)
Educational qualification	Post-RN BSN	48 (38.7)
Educational qualification	BSN	20 (16.1)
Educational qualification	MSN	0 (0.0)
Clinical experience, years	1–3	38 (30.6)
Clinical experience, years	4–6	36 (29.0)
Clinical experience, years	7–10	32 (25.8)
Clinical experience, years	>10	18 (14.5)

Abbreviations: BSN, Bachelor of Science in Nursing; MSN, Master of Science in Nursing; RN, registered nurse; SD, standard deviation.

Table 2. Individual communication-barrier ratings and proportions selecting “large extent” or “very great extent” (N = 124)

Item means sample SDs, combined percentages, and confidence intervals were calculated from the reported response frequencies. Questionnaire item numbers and domain membership are retained.

Domain	Questionnaire item	Item score (1–5), mean ± SD	Large/very great extent, n (%)	95% Wilson CI for proportion, %
Demographic	1. Age differences between nurses and patients	3.38 ± 1.06	60 (48.4)	39.8–57.1
Demographic	2. Gender differences between nurses and patients	3.55 ± 1.01	69 (55.6)	46.9–64.1
Demographic	3. Cultural differences between nurses and patients	3.66 ± 1.00	75 (60.5)	51.7–68.6
Demographic	4. Religious differences between nurses and patients	3.12 ± 1.10	47 (37.9)	29.8–46.7
Knowledge-related	5. Patient's educational background	3.75 ± 1.00	81 (65.3)	56.6–73.1
Knowledge-related	6. Nurse's inadequate knowledge of communication skills	3.89 ± 0.96	88 (71.0)	62.4–78.2
Knowledge-related	7. Nurse's inadequate knowledge of patient's illness	3.61 ± 1.03	73 (58.9)	50.1–67.1
Knowledge-related	8. Patient's awareness of nursing duties	3.44 ± 1.07	63 (50.8)	42.1–59.4
Environmental	9. Nursing shortage	4.07 ± 0.89	99 (79.8)	71.9–86.0
Environmental	10. Nurses overworking	4.19 ± 0.83	104 (83.9)	76.4–89.3
Environmental	11. Lack of time	4.27 ± 0.80	108 (87.1)	80.1–91.9
Environmental	12. Presence of multiple critical cases in the unit	3.94 ± 0.91	93 (75.0)	66.7–81.8
Environmental	13. Presence of work-related violence	3.68 ± 1.03	77 (62.1)	53.3–70.2
Social	14. Absence of family members accompanying the patient	3.25 ± 1.07	51 (41.1)	32.9–49.9
Social	15. Unfamiliar hospital environment for the patient	3.44 ± 1.02	62 (50.0)	41.3–58.7
Social	16. Patient's participation in treatment plan	3.36 ± 1.04	58 (46.8)	38.2–55.5
Social	17. Relationship of nurses with other healthcare providers	3.57 ± 1.01	70 (56.5)	47.7–64.9
Social	18. Nurse's reluctance to hear patients' feelings	3.16 ± 1.07	48 (38.7)	30.6–47.5
Economic	19. Nurses holding multiple duties simultaneously	4.02 ± 0.96	95 (76.6)	68.4–83.2
Economic	20. Nurse's inadequate monthly income	3.40 ± 1.10	62 (50.0)	41.3–58.7
Psychological	21. Patients' complaints of pain or physical symptoms	3.87 ± 0.98	87 (70.2)	61.6–77.5
Psychological	22. Stage of the patient's disease	3.63 ± 1.02	74 (59.7)	50.9–67.9
Psychological	23. Nurse's low self-esteem	3.40 ± 1.07	62 (50.0)	41.3–58.7
Psychological	24. Negative attitude of the nurse toward the patient	3.23 ± 1.08	53 (42.7)	34.4–51.5

Domain	Questionnaire item	Item score (1–5), mean $\pm$ SD	Large/very great extent, n (%)	95% Wilson CI for proportion, %
Psychological	25. Nurse's feelings of despair and apathy toward the job	3.55 $\pm$ 1.05	70 (56.5)	47.7–64.9
Psychological	26. Nurse's previous negative experiences with patient care	3.48 $\pm$ 1.07	66 (53.2)	44.5–61.8
Psychological	27. Lack of psychological support provided for patients by nurses	3.91 $\pm$ 0.97	89 (71.8)	63.3–78.9

Abbreviations: CI, confidence interval; SD, standard deviation.

Table 3. Unweighted domain and overall score mean reconstructed from the reported item frequencies (N = 124)

Questionnaire domain	Number of items	Mean summed item score	Mean item score (1–5)	Mean percentage of maximum possible score, %
Demographic	4	13.71	3.43	68.5
Knowledge-related	4	14.69	3.67	73.5
Environmental	5	20.15	4.03	80.6
Social	5	16.79	3.36	67.2
Economic	2	7.42	3.71	74.2
Psychological	7	25.07	3.58	71.6
Overall	27	97.84	3.62	72.5

Table 4. Distribution of participants across the study-defined overall barrier categories (N = 124)

Category counts and percentage-score bands are retained from the manuscript; percentages and confidence intervals are calculated from those counts.

Barrier category	Percentage-score band, %	n (%)	95% Wilson CI for proportion, %
Low barriers	≤ 40	4 (3.2)	1.3–8.0
Moderate barriers	41–70	71 (57.3)	48.5–65.6
High barriers	> 70	49 (39.5)	31.4–48.3

Abbreviation: CI, confidence interval.

Environmental factors had the highest mean item score at 4.03, equivalent to 80.6% of the maximum possible score. Economic and knowledge-related factors followed, with mean item scores of 3.71 and 3.67, corresponding to 74.2% and 73.5%, respectively. Psychological factors accounted for 71.6% of the maximum possible score, followed by demographic factors at 68.5% and social factors at 67.2%. Across all 27 items, the mean summed rating was 97.84, corresponding to a mean item score of 3.62 and 72.5% of the maximum possible score (Table 3).

The study-defined overall categories comprised 71 nurses with moderate barriers (57.3%; 95% CI, 48.5–65.6%), 49 with high barriers (39.5%; 95% CI, 31.4–48.3%), and four with low barriers (3.2%; 95% CI, 1.3–8.0%) (Table 4).

DISCUSSION

This study identified environmental and workload-related factors as the most prominent barriers to nurse–patient communication perceived by nurses in the Emergency Department of Lahore General Hospital. Time constraints, overworking, and nursing shortages were the leading individual concerns, alongside inadequate knowledge of communication skills, multiple simultaneous duties, and difficulties involving patients' physical distress and psychological support. The findings therefore indicate that respondents perceived communication difficulties across both the conditions of care delivery and the interpersonal aspects of nursing practice, rather than as a problem attributable to a single factor.

The prominence of environmental barriers is consistent with the Palestinian emergency-nursing study by Al-Kalalkeh and colleagues, in which environmental factors were the highest-rated domain, followed by knowledge-related and psychological factors (4). Kordkolaee and colleagues similarly identified occupational characteristics, particularly excessive workload, as prominent barriers among emergency nurses in Iranian teaching hospitals (5). These findings converge on the importance of working conditions in nurses' perceptions of communication difficulties. Nevertheless, the comparisons are not numerically interchangeable. The studies differed in their settings, participant composition, and domain structures, with occupational and environmental characteristics grouped differently across instruments. The present findings consequently support agreement in the relative

prominence of work-related concerns, rather than equivalence in barrier severity or evidence of a common causal mechanism across institutions (4,5).

A plausible explanation for this pattern is that competing clinical responsibilities reduce the opportunities available for sustained explanation, listening, and clarification. Nurses managing several urgent demands may perceive a conflict between completing immediate clinical tasks and attending to patients' informational and emotional needs. This interpretation is compatible with the interruptions and workload pressures identified in the scoping review by Borawski and colleagues, although that review concerned nurse-provider rather than nurse-patient communication (9). Such pressures could affect both forms of interaction, but this possibility should not be mistaken for a demonstrated pathway in the present study. Staffing ratios, time spent communicating, and observed interruptions were not measured; the results establish the prominence of these concerns in respondents' perceptions, not their objective frequency or effects on care.

Knowledge-related findings add a complementary dimension to the environmental pattern. Inadequate knowledge of communication skills was the most frequently endorsed item within this domain, consistent with the importance of knowledge-related barriers in the Palestinian study (4). This suggests that local assessment of communication support should consider both the opportunity to communicate and nurses' perceived preparedness to do so. However, endorsing a questionnaire item about inadequate knowledge is not equivalent to demonstrating a competency deficit through observation or formal assessment. The educational qualifications of participants also cannot explain these ratings because communication-training exposure was not measured and no association between qualification and barrier scores was established. The findings identify a potential area for educational assessment without attributing communication difficulties to any particular qualification group.

The economic-domain responses require similarly careful interpretation. Multiple simultaneous duties were more prominently endorsed than inadequate monthly income, suggesting that this domain captured concerns that may overlap with workload and competing responsibilities. It would therefore be inappropriate to interpret the economic-domain pattern as evidence that inadequate remuneration caused communication difficulties or compelled nurses to undertake secondary employment. The questionnaire did not record actual salaries, additional employers, or the duration and distribution of duties. The multiple-duty finding is more appropriately considered alongside the occupational pressures identified in previous emergency-nursing research than treated as confirmation of a separate salary-driven mechanism (5). This overlap also illustrates why questionnaire domains should be understood as organizational categories for describing perceptions rather than independent causal explanations.

Psychological findings emphasized patients' pain or physical symptoms and the perceived lack of psychological support provided to patients. One possible interpretation is that physical distress increases the need for reassurance while also making participation in clinical conversations more difficult. This interpretation is compatible with the inclusion of patients' clinical condition among the communication-barrier dimensions examined by Kordkolae and colleagues (5). The prominence of psychological concerns also broadly accords with the Indonesian study by Aisyah and colleagues, although that research examined nurse-family communication rather than the same nurse-patient relationship assessed here (8). Differences in the participants and communication partners could help explain why psychological barriers were more prominent in that setting. In the present study, ratings concerning despair, apathy, or previous negative experiences indicate perceived communication concerns; they do not establish the prevalence of burnout, psychiatric disorders, or impaired professional performance.

The comparatively lower prominence of demographic and social domains does not make their constituent concerns unimportant. Cultural differences were more frequently endorsed than religious differences, while unfamiliarity with the hospital environment was also identified as a concern. These responses suggest that nurses perceived variation in the circumstances surrounding patient interactions, but they do not establish the language proficiency, health literacy, or cultural preferences of the patients involved. Bakhsh and colleagues examined language barriers from physicians' perspectives in Makkah, while Tannenbaum-Baruchi and colleagues investigated communication access among deaf and hard-of-hearing patients and healthcare workers (6,7). These studies provide complementary perspectives on differing communication needs, but their findings cannot be used to equate cultural differences in the present questionnaire with language or sensory barriers that were not directly assessed.

The nurse-focused perspective of this study also complements, rather than replicates, the Pakistani literature on patients' attendants' attitudes and communication-related satisfaction in emergency care (11,12). Nurses, patients, and accompanying family members may emphasize different aspects of the same interaction because their responsibilities, expectations, and access to information differ. The present findings cannot determine whether patients would identify workload pressures as the leading concern or whether they would place greater emphasis on explanations, responsiveness, or involvement in care. This distinction is important when interpreting agreement across studies: different perspectives can illuminate related problems without measuring the same outcome. Combining these perspectives would provide a more balanced basis for understanding communication within the local emergency-care setting.

For clinical practice, the findings identify priorities for institutional assessment rather than interventions of demonstrated effectiveness. Reviewing task allocation and opportunities for patient interaction, assessing communication-learning needs, and examining the provision of psychological support would be consistent with the concerns raised by respondents and the work-related and interpersonal barriers described in previous studies (4,5,8). These areas should be considered together rather than assuming that training alone can resolve time-related difficulties. Likewise, structured communication approaches identified in nurse-provider research require evaluation for their intended purpose before being applied to nurse-patient interactions (9). The potential service-level value of this study lies in directing attention toward locally perceived obstacles; it does not establish that any proposed change would reduce adverse events, improve satisfaction, or enhance patient outcomes.

A strength of the study is its focus on nurses involved in direct patient care within a clearly defined emergency department. The use of a previously employed 27-item questionnaire enabled a structured assessment across six domains and facilitated comparison with related emergency-nursing research (4). Reporting individual response distributions also provided more specific information than an overall score alone, distinguishing concerns such as lack of time from those involving communication knowledge, income, or patient support. This detail is useful for identifying questions that warrant closer local investigation. It does not, however, substitute for evidence that the questionnaire's wording and scoring operate consistently in the population in which it was administered.

Several limitations constrain interpretation. Convenience sampling at a single institution limits transferability to other emergency departments, and the exclusively female sample does not establish how male nurses would perceive the same barriers. Participation may have been influenced by nurses' availability or interest in communication difficulties. Excluding nurses who were ill or receiving treatment could also have affected the representation of staff experiencing health-related difficulties, although the direction of any resulting bias cannot be determined. Self-administered responses are susceptible to recall and social-desirability effects, particularly for items addressing attitudes, reluctance to listen, or psychological experiences. Respondents may therefore have differed in their willingness to endorse personally sensitive concerns compared with environmental pressures.

The cross-sectional, descriptive design also prevents assessment of temporal relationships, independent determinants, or changes in perceptions over time. No adjusted analyses established whether participant characteristics explained the ratings, and descriptive differences between domains should not be interpreted as statistically tested differences. Measurement interpretation is additionally affected by items concerning patients' awareness, participation, and interprofessional relationships that do not explicitly state whether these characteristics are adequate or inadequate. Study-defined score categories should therefore not be equated with validated clinical thresholds for communication failure. Most importantly, the study did not include patients' accounts, direct observation of interactions, or patient outcomes. Its findings describe nurses' perceptions of potential barriers rather than the frequency of communication failures or their clinical consequences.

Future research should examine whether the same pattern is observed across emergency departments and whether nurse-reported barriers correspond with patients' experiences and directly assessed communication. Further evaluation of questionnaire comprehension and scoring would strengthen comparisons across settings. Longitudinal or intervention studies could then examine whether changes addressing the identified concerns are accompanied by improvements in communication, rather than assuming such benefits from the present descriptive findings.

CONCLUSION

Registered nurses participating in this study at Lahore General Hospital perceived time constraints, overworking, and nursing shortages as the leading barriers to effective nurse-patient communication. Concerns involving communication knowledge, multiple duties, patients' physical distress, and psychological support were also prominent. The findings provide an institution-specific account of perceived obstacles and a basis for prioritizing local assessment of communication support, without establishing actual communication failure, causal determinants, or effects on patient outcomes.

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