Empathy Over Efficiency: Rethinking Communication in Modern Medical Systems for Improved Patient Outcomes

Vignette:
At age fifty, a woman schedules a routine colonoscopy following standard preventive care recommendations. She is asymptomatic and expects reassurance or, at most, follow-up guidance. After the procedure, she hears nothing for over two months. When the call finally comes, it is not from a physician, but from an administrative staff member who informs her that she must schedule an appointment to receive her results. A telehealth visit is offered.
When the appointment begins, the nurse practitioner appears to be accessing the medical record in real time. Within the first moments of the call, the provider states, "I see here that you have colorectal cancer." Without pause, context, or assessment of the patient's understanding, the provider continues: "You'll need to write down this number to call a surgeon. You're going to need part of your colon removed."
Less than two minutes into the encounter, the call has moved from routine check-in to a life-altering diagnosis and surgical referral. The patient, stunned, asks, "What do I have?" There is no discussion of the findings, no explanation of staging, no opportunity for questions, no acknowledgement of shock or fear, and no plan for emotional or informational support. The visit concludes with a phone number and a directive.

This interaction - brief, transactional, and devoid of relational engagement - illustrates a profound failure in patient-centered communication. This type of communication is a predictable outcome of systems that prioritize efficiency, throughput, and task completion over human connection, understanding, and care.

Communication failures of this kind certainly cause distress but the realities for patients also have the potential to produce actual harm. How information is conveyed—particularly life-altering diagnoses—shapes patient comprehension, trust, engagement with care, and long-term psychological outcomes. For patients navigating serious illness, the clinical encounter is not only a site of diagnosis and treatment but a moment of profound vulnerability. When communication is abrupt, impersonal, or poorly timed, it can exacerbate trauma, undermine informed decision-making, and widen existing inequities in health outcomes.

Despite decades of attention to patient-centered care, medical training and health care systems continue to treat communication as a secondary skill rather than a core clinical and ethical competency (Epstein & Street, 2011). This gap has significant implications not only for individual patients, but for health systems, professional accountability, and social welfare more broadly.

Introduction: Framing the Problem

Effective communication is foundational to quality health care. It influences patient understanding, adherence to treatment, satisfaction, trust in medical institutions, and health outcomes. Yet, in contemporary medical practice, communication is often constrained by time

Comment [A1]: Abstract was not provided.

Comment [A2]: This seems unusual that a nurse practitioner who is unfamiliar with the case would casually provide the diagnosis of colorectal cancer.

Definitive diagnoses are not typically given via telehealth. Instead, the diagnosis is provided during face to face visits.

As a reader, the vignette makes me immediately skeptical. I would recommend either revising the vignette or offering a peer-reviewed source with statistic related to lack of empathy or providers offering diagnoses when they are unfamiliar with the case.

Comment [A3]: Provide a citation that supports the assertion the medical system prioritizes efficiency over patient-centered care.

Comment [A4]: The paragraph requires further develop of the idea and reference support.

Comment [A5]: Provide a citation that verifies the statement. Without the citation, the reader cannot judge the veracity of the claim.

Comment [A6]: A citation is required for the statement.

Comment [A7]: A citation is required for the statement.

Comment [A8]: The statement is presented without a citation. The lack of reference citations weaken the argument.

Comment [A9]: The offered citation is 15 years. The citation is too old to use to support current practices. Locate a reference published in the last three to five years.

Comment [A10]: Expand the discussion. Avoid use of one to two sentence paragraphs. Instead, elaborate on the ideas and build an argument which is supported by published, current literature in the discipline.

Comment [A11]: Although this is an accurate statement, a citation which verifies the statement is required.

Comment [A12]: What's the citation for this statement?

pressures, productivity demands, and hierarchical systems that prioritize biomedical tasks over relational processes. As a result, even technically competent care can be experienced as harmful when delivered without empathy, clarity, or respect for the patient's emotional and informational needs. Failure for clinicians to identify and meet the unique needs and goals of patients and understand that those aspects can evolve and change throughout treatment can be detrimental to patient outcomes.

This article argues that current approaches to medical communication are insufficient because they are inadequately grounded in relational, trauma-informed, and structural understandings of care. Drawing on the framework of Relationship-Centered Care, we contend that communication should be understood not as an ancillary skill, but as a core component of clinical practice and a matter of social welfare and health policy. Using an integrative review of existing literature, we examine how failures in communication reflect broader systemic shortcomings in medical education, institutional priorities, and policy design—and propose directions for reform.

To address these limitations, a framework is needed that centers relationships—not merely information exchange—as the foundation of clinical care.

Relationship-Centered Care as a Conceptual Framework

Relationship-Centered Care (RCC) is a well-established framework in health care scholarship that emphasizes the centrality of relationships in the delivery of effective, ethical, and humane medical care. The framework dates back to the mid-1990s and did not originate exclusively in medicine. It emerged at the intersection of medicine, social science, psychology, ethics, and education**.** Unlike models that focus narrowly on information exchange or patient satisfaction, RCC recognizes that health care occurs within a web of interpersonal relationships, each of which shapes clinical outcomes, decision-making, and patient experience (Tresolini & Pew-Fetzer Task Force, 1994; Beach & Inui, 2006; Suchman, 2006).

Building on this foundation, core principles of RCC include mutual respect between patients and providers; emotional presence and responsiveness as integral to care; recognition of power dynamics inherent in clinical encounters; and acknowledgment that providers are shaped by their relationships with patients, colleagues, institutions, and themselves. Importantly, RCC extends beyond the clinician–patient dyad to encompass clinician–family and clinician–clinician relationships (Tresolini & Pew–Fetzer Task Force, 1994; Beach & Inui, 2006; Suchman, 2006). This framework is particularly relevant to medical communication because it reframes communication not as a discrete skill or scripted behavior, but as a relational process embedded within broader social, institutional, and ethical contexts. From an RCC perspective, the failure illustrated in the vignette is not merely a lapse in empathy or bedside manner; it represents a breakdown in relational accountability, preparation, and shared meaning-making at a moment of profound patient vulnerability.

While patient-centered care has long emphasized respect for patient preferences and autonomy, RCC deepens this orientation by explicitly addressing the relational conditions necessary for those principles to be realized in practice. Without relational attention to timing, emotional

Comment [A13]: Provide a citation.

Comment [A14]: What published research supports the statement? Elaborate and provide evidence which supports the discussion.

Comment [A15]: Cite and describe a study which supports this claim.

Comment [A16]: This is a run-on sentence. Revise the statement for clarity.

Comment [A17]: The framework of relationship-centered care has not been defined or supported by a published reference in the discussion. The reviewer suggests revision. Relationship-centered care should be introduced, described and supported by references.

Comment [A18]: Do not capitalize relationship-centered care.

Comment [A19]: As a reader, I find the statement unclear. Development of the idea would be helpful.

Comment [A20]: A citation is required.

Comment [A21]: Please provide a reference citation for the statement.

Comment [A22]: Citation?

Comment [A23]: To what models do you refer?

Comment [A24]: A citation is required for this statement.

Comment [A25]: Discussion lacks proper citations.

readiness, trust, and power asymmetries, information—however accurate—can become harmful rather than supportive. (Epstein & Street, 2011; Mead & Bower, 2000)

By situating communication within a relationship-centered framework, this article conceptualizes medical communication as a clinical intervention in its own right, one with direct implications for patient well-being, equity, and system performance. This lens provides a foundation for examining how communication failures arise, how they disproportionately affect vulnerable populations, and why policy and training reforms are necessary to address them.

Patient-centered care (PCC) emerged as an important corrective to early paternalistic models of medicine, emphasizing respect for patient autonomy, preferences, and shared decision-making. PCC has contributed significantly to improvements in patient satisfaction, informed consent practices, and attention to patient values within clinical encounters.

Comment [A26]: Provide a citation when first introducing a paradigm or theory.

A branch of patient-center care, patient-centered culturally sensitive health care (PC-CSHC), more specifically aims to address the widening health disparities seen in the medical field. PC-CSHC emphasizes the need for clinicians to provide care tailored to the cultural, racial, spiritual, and socioeconomic preferences of their patients. Through implementing this, providers can better create realistic treatment plans that patients are more likely to follow while promoting patient satisfaction and better healthcare outcomes in minority and underserved populations. Patient engagement and satisfaction are goals of PC-CSHC and can be accomplished by making shared medical decisions. The patient's interest and adherence to symptom management and health-promoting behaviors can help providers gauge if the right treatment plans are being implemented. Barriers to patient care such as low income, inadequate health insurance and access to healthcare, lack of education, etc. are linked to poor patient outcomes, medical mistrust, and low patient engagement and self-efficacy (Garcia et al., 2025).

However, PCC has often been operationalized in ways that emphasize information exchange and patient choice without adequately addressing the relational conditions necessary for patients to process, integrate, and act on that information—particularly in moments of vulnerability, crisis, or trauma. In practice, patient-centered care can become transactional, checklist-driven, or reduced to communication scripts that fail to account for power dynamics, emotional readiness, and the broader relational context of care.

As health care systems have become increasingly time-constrained, technologically mediated, and fragmented, these limitations have become more pronounced, particularly in encounters involving serious diagnoses, uncertainty, or life-altering decisions.

Comment [A27]: The reviewer recommends revision. Statements lack the required reference citations. The ideas are not fully developed and brief two sentence paragraphs should be avoided.

Dimension	**Patient-Centered Care**	**Relationship-Centered Care**
Primary focus	Patient preferences and	Relationships as the foundation of care

Dimension	Patient-Centered Care	Relationship-Centered Care
	autonomy	
Orientation	Information exchange and shared decision-making	Mutual respect, presence, and meaning-making
Scope	Primarily clinician–patient dyad	Clinician–patient, clinician–family, clinician–clinician, and clinician–self
View of communication	Skill or technique	Relational process and clinical intervention
Power dynamics	Often implicit	Explicitly acknowledged and addressed
Emotional context	Secondary or optional	Central to effective care
Response to vulnerability	Variable	Foundational consideration
Risk in practice	Can become transactional or scripted	Emphasizes relational accountability and continuity

Comment [A28]: What's the citation for the table?

This distinction helps explain why patient-centered frameworks alone may fail to prevent the type of communication breakdown illustrated in the vignette. While patient-centered care emphasizes respect for patient preferences, it does not necessarily require providers or systems to attend to timing, emotional readiness, relational continuity, or the impact of power asymmetries at moments of crisis. Relationship-centered care explicitly includes these elements, making it better suited to address communication failures that carry profound psychological, ethical, and social consequences (Epstein & Street, 2011; Mead & Bower, 2000).

While Relationship-Centered Care clarifies what is missing from prevailing models, it does not fully specify how communication should unfold in moments of acute vulnerability—an omission addressed by trauma-informed approaches.

Comment [A29]: Expand discussion.

Trauma-Informed Communication as a Foundation for Relationship-Centered Care

Relationship-Centered Care (RCC) provides a compelling conceptual framework for understanding medical communication as a relational process rather than a transactional exchange. However, RCC alone does not fully specify how providers and systems should communicate in contexts of vulnerability, fear, and physiological threat—conditions that are common in medical environments and nearly universal when serious diagnoses are delivered. For this reason, we argue that RCC should be explicitly underpinned by trauma-informed communication.

Trauma-informed approaches recognize that many patients carry prior experiences of trauma and that medical encounters themselves can be experienced as threatening, disempowering, or destabilizing—particularly when communication is abrupt, confusing, or delivered without relational containment. A trauma-informed approach emphasizes practical, organization-spanning principles that can be translated into clinical communication behaviors. SAMHSA identifies six guiding principles—safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment, voice, and choice; and attention to cultural,

Comment [A30]: Citation is missing.

historical, and gender factors—that can be continuously assessed and embedded across systems of care (Substance Abuse and Mental Health Services Administration, 2014).

Comment [A31]: Statements do not sufficiently define or describe trauma-informed approaches.

Why trauma-informed communication is necessary in modern medical care

The vignette illustrates an interaction that can be clinically "efficient" while psychologically destabilizing: delayed results, limited preparation, and an abrupt disclosure of cancer followed by immediate instruction toward surgery. Such delivery shapes patient comprehension, informed consent, and ongoing engagement with care—particularly when individuals are in shock or emotionally overwhelmed. (Ong et al., 1995)

While this interaction aligns with what is often described in the clinical literature as the delivery of "serious" or "life-altering" information, recent scholarship cautions against reducing these encounters to procedural models of "breaking bad news." Studies increasingly emphasize that narrow endpoints such as patient satisfaction fail to capture the complexity of patient experience, including meaning-making, emotional processing, trust formation, and perceived safety (Back et al., 2019).

Comment [A32]: Only one citation was provided. However, the statement refers to "studies". Revision is suggested. Elaborate on Back et al findings and compare the findings with other studies.

Trauma-informed care can significantly improve the mental, physical, and emotional outcomes for patients. For this care to be effective, clinicians must first recognize the signs and symptoms of trauma which may not be the same for all patients. Screening is a tool used to help rule in the presence of trauma and can improve outcomes for many patients and can ensure the right care is provided. Offering emotional security and utilization of active listening can help clinicians promote resilience and help minimize patient suffering. The pervasive nature of trauma and the psychological toll that patients may face signifies the importance of creating a secure and supportive environment during appointments as well as building trust with the patient. Through empowering and providing patients with the opportunity to make decisions regarding care and treatment, clinicians can better meet the needs of those who have experienced trauma. Training and education are crucial aspects of providing trauma-informed care to patients (Menschner & Maul 2023).

Comment [A33]: Every statement in this paragraph required a citation. It is insufficient to present a single citation at the end of the paragraph. Multiple reference sources should be offered to add creditability to the discussion. Revision is recommended.

Patient perspectives, rather than clinician convenience or institutional efficiency, must meaningfully inform how these conversations are conducted, evaluated, and taught.
These risks are further amplified in technology-mediated contexts. Telehealth remains a common mode of care delivery in oncology and across the cancer care continuum, yet multiple studies note that the delivery of serious diagnoses via telemedicine introduces unique relational challenges, including reduced nonverbal cues, diminished opportunities for emotional attunement, and increased risk of perceived abruptness or detachment (Heyer, A., et al 2021)

Aligning trauma-informed principles with RCC

Comment [A34]: What are the citations that support this section?

Trauma-informed communication operationalizes RCC by translating relational values into observable practices:

- **Safety (psychological as well as physical):** Providers prepare the patient for what is coming ("I have difficult results to discuss"), assess whether the patient is in a private/supportive space, and pace information to avoid overwhelming cognitive load.
- **Trustworthiness and transparency:** Clear explanation of the process (why there was a delay; what the report shows; what is known vs. uncertain) reduces the patient's sense of being managed or rushed.
- **Collaboration and mutuality:** The encounter is framed as a shared plan ("Let's go through the findings together and decide next steps") rather than a directive.
- **Empowerment, voice, and choice:** Patients are offered structured choices (timing of follow-up, inclusion of family, written summary, option for second opinion, and time to ask questions) to counteract helplessness during threatening news. Providers must also educate patients and ask patients about their goals of care to make sure patients are making informed decisions tailored to their unique preferences and needs.
- **Cultural, historical, and gender considerations:** Communication explicitly recognizes differential trust in institutions and varied preferences for information and decision-making, rather than assuming a single "ideal" patient response.

Importantly, these trauma-informed principles extend beyond the clinician–patient dyad. They depend on workflows, staffing models, and institutional norms—precisely the relational ecology emphasized by RCC. When systems delegate serious diagnosis disclosure without safeguards, compress visits into productivity-driven time slots, or rely on telehealth without structured protocols for delivering bad news, they inadvertently create conditions that increase patient distress and erode trust.

Trauma-informed communication in digital and telehealth settings

The literature on trauma-informed care in digital health underscores that technology design and deployment can either support or undermine core trauma-informed principles, particularly safety, choice, and trustworthiness (Gerber et al., 2020). In telehealth contexts, trauma-informed communication is not simply "being nice on video." It requires intentional design: ensuring adequate visit length for serious results, proactive patient preparation, explicit consent to proceed with difficult information, structured pauses for emotion, and a clear follow-up plan that includes both informational and supportive resources. Guidance specific to breaking bad news by video has emphasized the need for preparation, clear signaling, empathic presence, and deliberate pacing—practices that are consistent with both RCC and trauma-informed principles.

Implications for training and systems

A trauma-informed, relationship-centered approach also highlights why one-off communication workshops often fail: providers require longitudinal training, coached practice, and system reinforcement. Recent work continues to document gaps in training on delivering difficult news and the need for stronger curricular approaches that match the clinical reality providers will face.

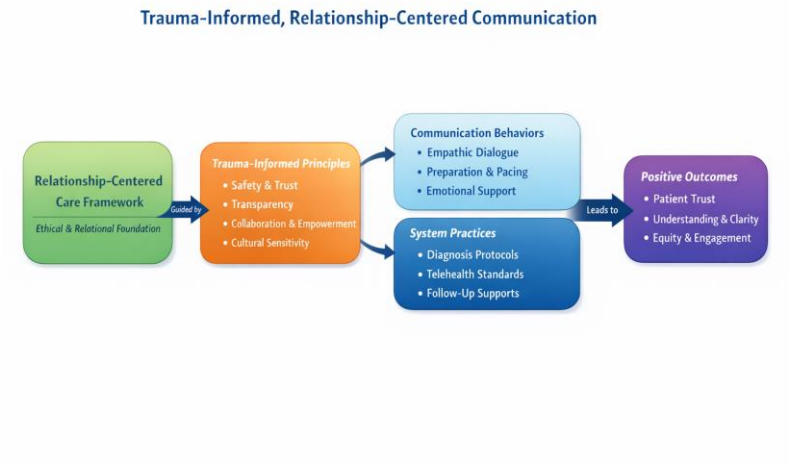
Comment [A35]: What work?

Taken together, trauma-informed communication offers a necessary underpinning for RCC—one that operationalizes relational accountability in moments of vulnerability and provides a bridge from values to practice. In the sections that follow, we examine the structural and institutional conditions that produce predictable communication failures and identify training and policy levers that can embed trauma-informed, relationship-centered communication as a standard of care.

A Conceptual Model for Trauma-Informed, Relationship-Centered Communication

Comment [A36]: What are the citations that support this section?

Taken together, Relationship-Centered Care and trauma-informed communication can be understood as complementary and mutually reinforcing components of effective medical communication. In this conceptual model, Relationship-Centered Care serves as the overarching framework, establishing relationships as the ethical and clinical foundation of care. Trauma-informed communication functions as the operational mechanism through which relational values are enacted in practice—particularly in moments of vulnerability, uncertainty, or threat. When trauma-informed principles such as safety, transparency, collaboration, and empowerment are embedded within relationship-centered systems, they shape both individual clinician behaviors (e.g., pacing, preparation, empathic presence) and institutional practices (e.g., workflows for delivering serious diagnoses, telehealth protocols, follow-up supports). Together, these elements form a pathway from values to action, resulting in improved patient comprehension, trust, engagement, and equity, while reducing the risk of psychological harm and erosion of institutional trust.



This model highlights that communication failures are rarely the result of individual clinician shortcomings alone, but rather reflect misalignment between relational values, trauma-informed practices, and the systems in which care is delivered.
Despite the clarity of this model, its implementation is routinely undermined by the structural and institutional realities of contemporary health care.

Structural and Institutional Barriers to Trauma-Informed, Relationship-Centered Communication

Comment [A37]: The reviewer beliefs this section has insufficient reference supports to verify the argument presented.

While Relationship-Centered Care and trauma-informed communication provide clear guidance for ethical and effective clinical interactions, their implementation is often constrained by structural and institutional conditions that shape how care is delivered. Communication failures such as those illustrated in the vignette are rarely the result of individual clinician disregard or incompetence. Rather, they are the predictable outcomes of systems designed around efficiency, throughput, and risk management rather than relational continuity, psychological safety, and patient understanding (Shanafelt et al., 2017).

Contemporary health care environments place increasing pressure on providers to deliver complex information within compressed timeframes. Productivity metrics, relative value unit (RVU) requirements, and scheduling models frequently limit the duration and flexibility of clinical encounters, even when patients are receiving life-altering diagnoses. In such contexts, communication becomes task-oriented—focused on conveying results and initiating referrals—rather than relational, reflective, or responsive to patient emotional states. These pressures undermine providers' ability to pace conversations, assess understanding, and provide the emotional containment required for trauma-informed care. Because of the uniqueness of each patient encounter, it is difficult for healthcare providers to predict and allot sufficient time from patient to patient.

Hierarchical structures within medical institutions further complicate communication practices. Decisions about who delivers serious diagnoses are often driven by availability, workflow logistics, or delegation norms rather than by relational continuity or clinical appropriateness. As a result, patients may receive devastating news from providers with whom they have no established relationship, in settings that do not allow for follow-up questions or emotional support. This leaves patients with unanswered questions and uncertainty with the progression of their care. Often times, patients with chronic illnesses and complex diagnoses will have multiple healthcare providers involved in various aspects of their treatment, thus contributing to discontinuity in care and increasing the likelihood of gaps in communication between providers. This not only can further the distress and confusion patients may experience but can also jeopardize patient safety and quality of care received (Noest, et al., 2014). These gaps erode trust and can leave patients feeling abandoned when relational stability is most needed. Communication and continuity within healthcare teams is vital for improving patient outcomes and satisfaction, but many common healthcare practices and policies can further create impersonal relationships.

Psychological principles suggest that dressing in uniforms or hospital gowns, wearing masks, and assigning patients with wristbands all contribute to deindividuation. Deindividuating

practices in healthcare institutions can benefit providers through identifying them as part of a team, but roles often overlap, thus leaving members of the group individually unidentifiable which may reduce personal accountability for decision-making and patient outcomes. Additionally, dressing patients similarly and the use of patient labels can make providers feel less personally connected to their patients and may decrease empathetic care. Focusing on standardized procedures set by private practices and corporate hospitals combined with de-individuating practices weakens the recognition of patients as unique individuals and may take away from a patient's personal experiences and specific needs (Haque, O. S., & Waytz, A. 2012). For healthcare providers to better support and care for patients, they must view patients as individuals, personalize treatment plans and have conversations aimed at better understanding unique circumstances–all of which are complicated by the growing use of technology in healthcare systems.

Technology-mediated care introduces additional institutional challenges and further diminishes personal relationships between patients and healthcare providers. While telehealth and the use of patient portals have expanded access and convenience, it has also been integrated rapidly, often without parallel investment in communication standards or training specific to high-stakes conversations. Delivering serious diagnoses via telehealth or patient portals without clear protocols for preparation, privacy assessment, emotional support, and follow-up reflects a system-level failure to align technological innovation with trauma-informed, relationship-centered principles. In these settings, efficiency gains may come at the cost of increased patient distress and disengagement.

Importantly, these structural barriers disproportionately affect patients who are already vulnerable, including those with limited health literacy, prior trauma exposure, mistrust of medical institutions, or fewer social supports. When communication is rushed, opaque, or directive, patients with fewer resources are less able to seek clarification, advocate for themselves, or pursue second opinions. Thus, communication failures function not only as clinical shortcomings but as mechanisms through which health inequities are reproduced. From a social welfare and policy perspective, these patterns underscore the need to move beyond individual-level solutions. Training providers to communicate more empathically and empower patients to be involved in decision making are necessary but insufficient if institutional conditions consistently undermine trauma-informed, relationship-centered practice. Without structural alignment—through policy, reimbursement models, accreditation standards, and organizational accountability—communication failures will remain a predictable feature of modern health care delivery.

Implications for Medical Education and Professional Training

Comment [A38]: No reference supports were presented in this section. Without the reference supports, the scholarly tone is compromised.

The structural barriers described above are reinforced—and often normalized—through medical education and professional socialization. Although communication is widely acknowledged as important, it is frequently treated as an ancillary competency rather than as a core clinical skill requiring the same rigor, supervision, and assessment as diagnostic or procedural expertise. As a result, providers may enter practice technically proficient yet underprepared to navigate high-stakes, emotionally charged conversations in trauma-informed, relationship-centered ways.

Many medical curricula rely on brief workshops, simulated patient encounters, or checklists that emphasize technique over relational presence. While these approaches may improve discrete behaviors, they are insufficient for preparing providers to manage real-world complexity and emotion—particularly in moments involving serious diagnoses, uncertainty, or patient distress. Simulated encounters often also fail to recognize the importance of patient education and are rather focused on practicing physical skills and practicing thinking about differential diagnoses.

Without longitudinal reinforcement and reflective supervision, communication skills risk becoming scripted performances rather than integrated clinical capacities.
This type of adjunct curriculum within medicine further undermines relationship-centered communication. When on clinical rotations, students learn implicitly which behaviors are valued through observation of senior providers, time pressures on clinical services, and institutional reward structures. If learners observe rushed disclosure of serious diagnoses, delegation of difficult conversations without relational continuity, or prioritization of efficiency over patient understanding, these practices become normalized—even when they conflict with formal teaching on empathy and patient-centered care.

A trauma-informed, relationship-centered approach to communication requires a shift in how communication is taught, practiced, and evaluated across the continuum of medical education. Rather than treating communication as a discrete skill, training programs and patient encounters should conceptualize it as a form of clinical judgment—one that requires situational awareness, emotional attunement, ethical reasoning, and adaptability. This includes preparing providers to recognize patient vulnerability, anticipate emotional responses, and intentionally structure conversations to support safety, comprehension, and agency.
Several educational implications follow from this reframing. First, communication training should be longitudinal, extending across undergraduate medical education, graduate medical education, and continuing professional development. Second, training must include supervised practice in real clinical contexts, particularly for delivering serious or life-altering information. Third, reflective spaces—such as facilitated debriefings or mentorship are essential for helping providers process the emotional labor of these encounters and integrate trauma-informed principles into their professional identity.

Importantly, education alone cannot carry the full burden of change. Even well-trained providers will struggle to practice trauma-informed, relationship-centered communication if institutional conditions consistently undermine these values. Nevertheless, medical education plays a critical role in shaping professional norms, expectations, and accountability. By explicitly aligning communication training with relationship-centered and trauma-informed frameworks, medical education can help interrupt cycles in which systemic pressures are reproduced through professional practice.

Policy and System-Level Implications

If trauma-informed, relationship-centered communication is to become a standard of care rather than an aspirational ideal, it must be supported through policy, regulation, and institutional

accountability. Communication failures such as those illustrated in the vignette persist because health care systems have not consistently aligned incentives, standards, and oversight with relational and psychological dimensions of care. Addressing these gaps requires attention to multiple policy domains.

Accreditation and Professional Standards

Accrediting bodies play a critical role in shaping professional priorities. While communication competencies are often referenced in accreditation standards, they are rarely operationalized with specificity or evaluated with the same rigor as technical skills. Accrediting organizations for undergraduate and graduate medical education could strengthen expectations by explicitly requiring demonstrated competence in trauma-informed, relationship-centered communication, particularly for high-stakes encounters such as serious diagnoses, end-of-life discussions, and major treatment decisions. Importantly, such standards should emphasize observed practice and reflective supervision rather than reliance on self-report or isolated simulations.

Reimbursement and Time Structures

Payment models strongly influence how clinical time is allocated. Fee-for-service structures and productivity metrics often disincentivize the extended, flexible encounters necessary for trauma-informed communication. Policy reforms that recognize time spent on complex communication—through billing codes, bundled payments, or value-based models—would signal that relational work is legitimate clinical labor rather than an optional add-on. Without such alignment, providers may be forced to choose between meeting institutional expectations and meeting patient needs.

Telehealth Governance and Protocols

As telehealth becomes a growing component of health care delivery, policy frameworks must distinguish between routine care and encounters that require heightened relational safeguards. Delivering serious diagnoses via telehealth should not default to the most convenient modality or available clinician, and patient portals should not be an alternative to personal communication. Clear institutional protocols—supported by regulatory guidance—are needed to ensure appropriate preparation, consent, privacy, visit length, and follow-up when telehealth is used for high-stakes communication. Absent such standards, telehealth risks amplifying rather than mitigating communication-related harm.

Organizational Accountability and Quality Measurement

Current quality metrics rarely capture the relational and psychological dimensions of care. Patient satisfaction surveys and complaint-based systems provide limited insight into whether communication supported understanding, trust, and emotional safety. Policymakers and health

systems should consider developing and validating measures that assess communication quality in ways that reflect patient experience and equity, particularly for populations at higher risk of trauma or marginalization. Incorporating such measures into quality improvement and reporting structures would elevate communication from an individual skill to an organizational responsibility.

Equity and Social Welfare Considerations

From a social welfare perspective, communication failures function as a structural determinant of health (Bowen et al., 2016). Patients with fewer resources, lower health literacy, language barriers, or prior experiences of trauma are disproportionately harmed when communication is rushed, opaque, or directive. Policies that strengthen communication standards therefore serve as equity interventions, reducing the likelihood that vulnerability is compounded by system design. Framing communication as a matter of social welfare underscores the ethical obligation of institutions to protect patients from avoidable psychological harm.

Taken together, these policy levers highlight that improving medical communication is not solely a matter of clinician education or individual intention. It is a systems-level challenge that requires coordinated action across education, reimbursement, technology governance, and accountability mechanisms. Without such alignment, trauma-informed, relationship-centered communication will remain unevenly practiced and inequitably distributed.

Comment [A39]: The discussion in these sub-sections needs further development of the ideas and support from existing literature.

Discussion and Conclusion

The clinical encounter described at the outset of this article is striking and familiar. A serious diagnosis is delivered efficiently, accurately, and without malice—yet in a manner that leaves the patient disoriented, frightened, and unsupported. This vignette illustrates how harm can occur even in the absence of technical error, and how communication itself functions as a determinant of patient well-being.

By situating medical communication within a relationship-centered and trauma-informed framework, this article argues that communication failures are best understood as systemic rather than individual shortcomings. Relationship-Centered Care provides a necessary conceptual foundation by recognizing that clinical care is inherently relational and that outcomes are shaped not only by what is said, but by how, when, and within what relational context information is conveyed. Trauma-informed communication operationalizes these relational commitments, translating values such as safety, transparency, collaboration, and empowerment into observable practices—particularly in moments of vulnerability.

The analysis highlights how contemporary health care systems frequently undermine these principles. Time pressures, productivity metrics, hierarchical delegation, and rapid adoption of technology without corresponding communication safeguards create predictable conditions in which relational care deteriorates. These conditions do not affect all patients equally. Individuals with prior trauma exposure, limited health literacy, fewer social supports, lower socioeconomic statuses, or historical mistrust of medical institutions are disproportionately harmed when these

conditions exist. In this way, communication failures function as mechanisms through which inequities are reproduced, making medical communication a matter of social welfare as well as clinical quality.

Importantly, this article does not argue that providers lack compassion or awareness. Rather, it demonstrates how professional training and institutional design shape what is possible in practice and how standardization in healthcare systems inevitably takes away from the uniqueness of patients and individualization within healthcare teams. When communication is treated as a secondary skill—taught episodically, assessed superficially, and unsupported by system-level incentives—providers are left to navigate ethically complex encounters within structures that reward efficiency over presence. Education reforms, while essential, cannot succeed in isolation without parallel policy alignment.
The policy implications outlined here underscore that trauma-informed, relationship-centered communication is achievable using existing levers: accreditation standards that emphasize observed practice, reimbursement models that recognize relational labor, telehealth governance that differentiates routine care from high-stakes communication, and quality measures that reflect patient experience and equity. Together, these approaches shift responsibility from individual providers to the systems that shape care delivery.

Reframing communication as infrastructure for care has practical and ethical significance. Just as health systems invest in technologies, protocols, and procedures to reduce physical harm, they bear responsibility for designing environments that minimize avoidable psychological harm. Communication is not ancillary to care; it is care. When delivered without preparation, relational continuity, or attention to patient vulnerability, even accurate information can destabilize, disempower, and disengage a patient. When delivered within trauma-informed, relationship-centered systems, communication can foster understanding, trust, and agency—outcomes essential to both health and social welfare.

As healthcare continues to evolve amid technological advancement and increasing complexity, a key challenge is how to communicate differently. Aligning values, training, and policy around trauma-informed, relationship-centered communication offers a path forward—one that honors the humanity of patients and providers alike, and recognizes that what is said to patients in moments of vulnerability matters as much as any intervention provided.

References

Back, A. L., Fromme, E. K., & Meier, D. E. (2019). Training clinicians with communication skills needed to match medical treatments to patient values. *Journal of the American Geriatrics Society, 67*(S2), S435–S441. https://doi.org/10.1111/jgs.15709

Beach, M. C., & Inui, T. S. (2006). Relationship-centered care: A constructive reframing. *Journal of General Internal Medicine, 21*(S1), S3–S8. https://doi.org/10.1111/j.1525-1497.2006.00302.x

Bowen, E. A., Murshid, N. S., & Smith, J. C. (2016). Trauma-informed social policy: A conceptual framework for policy analysis and advocacy. *American Journal of Public Health, 106*(2), 223–229. https://doi.org/10.2105/AJPH.2015.302970

Chokshi, B., Walsh, K., & Dooley, D. (2020). Teaching trauma-informed care: A symposium for medical students. *MedEdPORTAL, 16*, 10941. https://doi.org/10.15766/mep_2374-8265.10941

Epstein, R. M., & Street, R. L., Jr. (2011). The values and value of patient-centered care. *Annals of Family Medicine, 9*(2), 100–103. https://doi.org/10.1370/afm.1239

Garcia, K. A., Wippold, G. M., Goodrum, N. M., Williams, M. M., & Kloos, B. (2025). Bridging health self-efficacy and patient engagement with patient-centered culturally sensitive health care for Black American adults. *Journal of Community Psychology 53*(1), e23147. https://doi.org/10.1002/jcop.23147.

Gerber, M. R., Elisseou, S., Sager, Z. S., & Keith, J. A. (2020). Trauma-informed telehealth in the COVID-19 era and beyond. *Federal Practitioner*, *37*(7), 302–308. PMC7473719.

Haque, O. S., & Waytz, A. (2012). Dehumanization in medicine: Causes, solutions, and functions. *Perspectives on Psychological Science*, *7*(2), 176–186. https://doi.org/10.1177/1745691611429706

Heyer, A., Granberg, R. E., Rising, K. L., Binder, A. F., Gentsch, A. T., & Handley, N. R. (2021). Medical oncology professionals' perceptions of telehealth video visits. *JAMA Network Open*, *4*(1), e2033967. https://doi.org/10.1001/jamanetworkopen.2020.33967

Hopper, E. K., Bassuk, E. L., & Olivet, J. (2010). Shelter from the storm: Trauma-informed care in homelessness services settings. *The Open Health Services and Policy Journal, 3*, 80–100. https://doi.org/10.2174/1874924001003010080

Mead, N., & Bower, P. (2000). Patient-centredness: A conceptual framework and review of the empirical literature. *Social Science & Medicine, 51*(7), 1087–1110. https://doi.org/10.1016/S0277-9536(00)00098-8

Menschner, C., & Maul, A. (2016). *Key ingredients for successful trauma-informed care implementation*. Center for Health Care Strategies. https://www.chcs.org/resource/key-ingredients-for-successful-trauma-informed-care-implementation/

Noest, S., Ludt, S., Klingenberg, A., Glassen, K., Heiss, F., Ose, D., Rochon, J., Bozorgmehr, K., Wensing, M., Szecsenyi, J., Involving patients in detecting quality gaps in a fragmented healthcare system: development of a questionnaire for Patients' Experiences Across Health Care Sectors (PEACS), *International Journal for Quality in Health Care*, Volume 26, Issue 3, June 2014, Pages 240–249, https://doi.org/10.1093/intqhc/mzu044

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Ong, L. M. L., de Haes, J. C. J. M., Hoos, A. M., & Lammes, F. B. (1995). Doctor–patient communication: A review of the literature. *Social Science & Medicine, 40*(7), 903–918. https://doi.org/10.1016/0277-9536(94)00155-M

Shanafelt, T. D., Dyrbye, L. N., & West, C. P. (2017). Addressing physician burnout: The way forward. *JAMA, 317*(9), 901–902. https://doi.org/10.1001/jama.2017.0076
Substance Abuse and Mental Health Services Administration. (2014). *SAMHSA's concept of trauma and guidance for a trauma-informed approach* (HHS Publication No. SMA 14-4884). U.S. Department of Health and Human Services.

Suchman, A. L. (2006). A new theoretical foundation for relationship-centered care: Complex responsive processes of relating. *Journal of General Internal Medicine, 21*(S1), S40–S44. https://doi.org/10.1111/j.1525-1497.2006.00338.x

Tresolini, C. P., & Pew–Fetzer Task Force on Advancing Psychosocial Health Education. (1994). *Health professions education and relationship-centered care*. Pew Health Professions Commission.

Comment [A42]: Is this the correct citation?

Health professions education and relationship-centered care : report of the Pew-Fetzer Task Force on Advancing Psychosocial Health Education. (1994). Pew Health Professions Commission.