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# Self-Reported Communication Practices among Surgical Ward Nurses: A Cross-Sectional Study in Iraq

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## ABSTRACT

**Objective:** This study aimed to describe nurses' self-reported communication practices across ten domains in the surgical wards of Al-Hilla Teaching Hospital, Iraq.

**Methods and Materials:** This single-center cross-sectional descriptive study was conducted among nurses working in surgical wards at Al-Hilla Teaching Hospital, Babylon Province, Iraq, from May 22 to September 1, 2025. A convenience sample of 104 nurses completed a modified 45-item self-report communication questionnaire covering verbal communication, nonverbal communication, active listening, written communication, presentation, patient education, personal connections, trust, cultural awareness, and compassion. The instrument was reviewed by 18 experts, and the total Cronbach's alpha was reported as .70. Data were analyzed descriptively using frequencies, percentages, means, and standard deviations.

**Findings:** Overall, 36 nurses (34.6%) were classified as poor, 47 (45.2%) as fair, and 21 (20.2%) as good in total communication ratings. Poor classifications were most frequent for making personal connections (78.8%), nonverbal communication (76.0%), presentation skills (68.3%), patient education (61.5%), and active listening (56.7%). In contrast, good classifications were most frequent for written communication (74.0%) and trust (65.4%). Cultural awareness and compassion were rated as good by 45.2% and 43.3% of participants, respectively. The reported mean for personal connections was internally inconsistent and should not be interpreted without item-level verification.

**Conclusion:** Nurses' self-reported communication ratings indicated several areas requiring further assessment, especially rapport, nonverbal communication, presentation, patient education, and listening. Stronger conclusions require validated instruments, behavioral observation, and patient-based evaluation.

**Keywords:** Self-Reported Communication, Surgical Nursing, Nurse–Patient Communication, Patient Education, Interpersonal Communication.

## Introduction

Nurse–patient communication is a relational clinical practice through which clinicians exchange information, respond to uncertainty, and recognize patients' emotional and social needs. In perioperative care, clear explanations, listening, confirmation of understanding, and coordination across professionals are important, but communication competence should be distinguished from nurses' confidence in their own communication. Previous research has related communication skills to nurses' perceived self-efficacy, without establishing that self-ratings alone predict safe performance (Henly, 2016; Leal-Costa et al., 2020).

Communication in surgical care is multidimensional. Instrumental tasks include accurate documentation and transfer of instructions; interpersonal tasks include respectful language, active listening, rapport, culturally responsive interaction, and compassion. Psychological concepts such as empathy, perceived trust, patient autonomy, and interpersonal self-efficacy offer a framework for understanding these tasks, but they were not independently measured as mechanisms in the present study (Dinç & Gastmans, 2013; Kirca & Bademli, 2019; Seyed Alitabar, 2025).

The perioperative context heightens the value of timely and understandable communication because patients may be unfamiliar with procedures, uncertain about recovery, or concerned about pain. Published surgical-nursing studies describe variable approaches to preoperative education and postoperative patient interaction. Importantly, evidence from studies that directly sampled patients must not be attributed to this nurse-only survey (Lee & Lee, 2013; Ascari et al., 2013; Lotfi et al., 2019).

Organizational demands and the social setting may shape communication opportunities. Time pressure, complicated patient needs, educational resources, and linguistic or cultural differences can influence the conditions under which nurses work. Research has documented barriers to communication and patient education; these factors are plausible interpretive contexts rather than tested explanatory variables in the present dataset (Hemsley et al., 2012; McElroy et al., 2016; Wang et al., 2024). Moreover, validated scales generally require item-level documentation and structural psychometric analyses beyond expert appraisal and one reliability coefficient (Granados-Gámez et al., 2022).

Evidence from Babylon Province is useful for describing where staff themselves perceive greater and lesser communication ability. Accordingly, the study aimed to describe the distribution of self-reported communication ratings across ten domains among 104 nurses employed in surgical wards at Al-Hilla Teaching Hospital. It did not test associations with age or clinical experience, objectively observe nurse–patient encounters, or measure patient-level outcomes. The contribution is therefore a localized, exploratory profile, not validation of a communication instrument or an account of causal psychological mechanisms.

## Methods and Materials

### *Study design, recruitment, and clinical setting*

This single-center descriptive cross-sectional survey was conducted among nurses working in surgical wards at Al-Hilla Teaching Hospital, Babylon Province, Iraq, from 22 May to 1 September 2025. A non-probability convenience sample of 104 nurses provided self-reports. The available study record refers both to surgical wards and operating rooms; it does not identify the number of units, their specialties, or the exact distribution of respondents across wards and operating theatres. The sampling frame is therefore described conservatively as surgical-ward nursing staff in one hospital, without extending the results to operating-room personnel as a separate population. There was no intervention, longitudinal follow-up, or independent patient sample.

### *Instrument characteristics and psychometric limitations*

The research used an adopted and modified 45-item self-report communication questionnaire covering verbal communication, nonverbal communication, active listening, written communication, presentation, patient education, making personal connections, trust, cultural awareness, and compassion. Respondents required approximately 15–20 minutes. Eighteen experts reportedly reviewed its content, and the overall Cronbach alpha coefficient was reported as .70. However, the exact parent instrument, item wording and allocation by domain, response options, translation or modification procedures, and item-level scoring key were not supplied. No content-validity index, factor analysis, test–


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retest coefficient, or separate subscale reliability estimates were reported. Consequently, content review and alpha = .70 should be regarded as preliminary information, not sufficient evidence of established construct validity (Granados-Gámez et al., 2022).

*Scoring and statistical analysis*

Only descriptive analyses were documented: frequency, percentage, mean, and standard deviation. The source report classifies total scores as poor (45–75), fair (76–105), and good (106–135); these cutoffs were retained to describe the reported distribution, but no validated external criterion or empirical calibration was available to justify the labels. The instrument-specific thresholds for the ten domains were not provided. Therefore, domain-level categories are presented strictly as previously assigned self-report ratings and should not be read as calibrated clinical proficiency. No correlation, group-comparison test, regression, adjustment for confounding, or patient-outcome model was available for verification.

## Findings and Results

All 104 participating nurses were included in the reported descriptive summaries. As shown in Table 1, 68 (65.4%) were aged 21–29 years, 55 (52.9%) were female, 57 (54.8%) were graduates of a nursing institute, and 51 (49.0%) reported less than five years of nursing experience. Fifty-two (50.0%) reported receiving no training sessions. These are marginal distributions; the data supplied do not establish how individual demographic characteristics relate to questionnaire scores.

Table 2 displays the ten questionnaire domains as originally categorized. Nonverbal communication (79/104, 76.0%), making personal connections (82/104, 78.8%), presentation (71/104, 68.3%), patient education (64/104, 61.5%), and active listening (59/104, 56.7%) most frequently received the label "poor." By contrast, written communication (77/104, 74.0%) and trust (68/104, 65.4%) most frequently received the label "good." Because domain-specific cutoffs and validity data are unavailable, these contrasts are descriptive, not proof of observed performance differences. The overall communication categories presented in Table 3.

**Table 1.**

Sociodemographic characteristics of participating nurses (N = 104)

| Characteristic | Category | n | % |
|---|---|---|---|
| Age (years) | 21-29 | 68 | 65.4 |
| Age (years) | 30-39 | 27 | 26.0 |
| Age (years) | 40-49 | 4 | 3.8 |
| Age (years) | ≥50 | 5 | 4.8 |
| Sex | Male | 49 | 47.1 |
| Sex | Female | 55 | 52.9 |
| Education level | Secondary School Nursing | 21 | 20.2 |
| Education level | Nursing Institute graduate | 57 | 54.8 |
| Education level | College of Nursing | 26 | 25.0 |
| Marital status | Single | 40 | 38.5 |
| Marital status | Married | 62 | 59.6 |
| Marital status | Divorced | 2 | 1.9 |
| Overall experience (years) | <5 | 51 | 49.0 |
| Overall experience (years) | 5-10 | 38 | 36.5 |
| Overall experience (years) | >10 | 15 | 14.4 |
| Surgical-ward experience (years) | <5 | 85 | 81.7 |
| Surgical-ward experience (years) | 5-10 | 9 | 8.7 |
| Surgical-ward experience (years) | >10 | 10 | 9.6 |
| Communication-training sessions | No | 52 | 50.0 |
| Communication-training sessions | 1-2 Sessions | 37 | 35.6 |
| Communication-training sessions | >2 Sessions | 15 | 14.4 |

Note. Percentages are based on the full sample (N = 104) and may not sum exactly to 100 because of rounding. Categories describe the respondents rather than implying representativeness of all nurses in the province.



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**Table 2.**

Reported domain classifications and mean scores (N = 104)

| Communication domain | Poor n (%) | Fair n (%) | Good n (%) | M ± SD |
|---|---|---|---|---|
| Verbal Communication | 29 (27.9%) | 49 (47.1%) | 26 (25.0%) | 11.35 ± 3.780 |
| Non-Verbal Communication | 79 (76.0%) | 9 (8.7%) | 16 (15.4%) | 6.836 ± 3.283 |
| Active Listening | 59 (56.7%) | 24 (23.1%) | 21 (20.2%) | 7.95 ± 3.501 |
| Written Communication | 5 (4.8%) | 22 (21.2%) | 77 (74.0%) | 8.14 ± 1.417 |
| Presentation skills | 71 (68.3%) | 18 (17.3%) | 15 (14.4%) | 5.70 ± 2.591 |
| Patient Education | 64 (61.5%) | 23 (22.1%) | 17 (16.3%) | 7.61 ± 3.088 |
| Making Personal Connections | 82 (78.8%) | 6 (5.8%) | 16 (15.4%) | Not reported* |
| Trust | 4 (3.8%) | 32 (30.8%) | 68 (65.4%) | 12.08 ± 1.895 |
| Cultural Awareness | 18 (17.3%) | 39 (37.5%) | 47 (45.2%) | 8.04 ± 1.824 |
| Compassion | 20 (19.2%) | 39 (37.5%) | 45 (43.3%) | 11.08 ± 3.202 |

Note. Domain categories reflect the study's original unvalidated self-report classifications; domain-specific item counts and cutoff derivation were not supplied. The original report listed 50.30 ± 2.290 for "Making Personal Connections," a value incompatible with straightforward interpretation against the overall score (84.13 ± 19.318). That domain mean has therefore been withheld pending verification of the item-level scoring and raw dataset; all other displayed means are unverified reported values and should not be summed without the documented scoring algorithm.

**Table 3.**

Reported overall communication categories (N = 104)

| Rating | n | % |
|---|---|---|
| Poor | 36 | 34.6 |
| Fair | 47 | 45.2 |
| Good | 21 | 20.2 |
| Total | 104 | 100.0 |

Note. The reported total score was 84.13 ± 19.318. Original total-score categories were poor = 45–75, fair = 76–105, and good = 106–135; their psychometric basis was not documented. Classification does not establish clinical performance standards.

## Discussion and Conclusion

This study provides a single-hospital profile of nurses' self-assessed communication. About four in five respondents were assigned either fair (45.2%) or poor (34.6%) overall ratings, but these labels depend on cutoff rules without reported criterion validation. The most frequently unfavorable domain ratings concerned rapport, nonverbal interaction, patient education, presentation, and listening, whereas written communication and trust were described more favorably. Rather than establishing psychological or cultural causes, these distributions identify specific domains for future verification with validated and behavior-based assessment (Granados-Gámez et al., 2022; Kirca & Bademli, 2019).

*Interpretive framework: relational, psychological, and cultural dimensions*

Communication is better understood as an interaction between the nurse, patient, task, and institutional setting than as a stable personal trait. A relational lens considers trust, compassion, and rapport; a psychological lens considers perceived self-efficacy and sensitivity to distress; and a cultural lens considers patient expectations, language, and respectful interpretation of nonverbal behavior. These constructs are useful to frame questions about the findings, but the study did not measure mediation, cultural competence mechanisms, psychological distress, or patient perspectives. Their explanatory role therefore remains hypothetical (Leal-Costa et al., 2020; McElroy et al., 2016; Seyed Alitabar, 2025).

*Listening and nonverbal communication*

The high proportions of unfavorable ratings for nonverbal communication (76.0%) and active listening (56.7%) suggest topics worth examining in a prospective quality-improvement assessment. Nonverbal behavior is context dependent: a gesture, eye contact, pause, or supportive touch may be helpful in one interaction and inappropriate in another. Objective evaluation would need observed patient encounters with defined behavioral indicators, rather than only a nurse's retrospective self-appraisal (de Rezende et al., 2015; Hemsley et al., 2012).



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Listening and nonverbal behavior also interact with workload and time constraints. The finding should not be attributed to staff workload, education, or years of experience because those relationships were not analyzed. Future research can record unit staffing, patient acuity, observed interruptions, and linguistic needs and examine their association with independent communication ratings (Hemsley et al., 2012; Yazew et al., 2021).

*Patient education, presentation, and written information*

A majority of respondents were placed in the good category for written communication (74.0%), whereas 61.5% were in the poor category for patient education and 68.3% for presentation skills. These self-reported contrasts may reflect perceived comfort with documentation versus face-to-face explanations, but that interpretation has not been tested. Indeed, perceived documentation ability cannot establish accuracy of records, and negative ratings for teaching do not demonstrate failures in patients' actual understanding (Abid et al., 2018; Che et al., 2016).

Existing studies emphasize the practical value of concise preoperative explanation, checking comprehension, and tailoring teaching to patients' readiness and needs. Programs using teach-back, simulated encounters, and feedback could be piloted locally, although the present survey provides no evidence that such a program would change outcomes. A recent synthesis identifies contextual barriers and facilitators to nurse-led patient education, which should be measured directly in future evaluation (Lee & Lee, 2013; Wang et al., 2024).

*Rapport, trust, compassion, and cultural responsiveness*

Self-ratings of personal connection appeared unfavorable for most respondents, while those of trust were largely favorable. The discrepancy is informative as a possible distinction between perceived dependability and interpersonal closeness, yet it may also reflect undocumented wording, item allocation, or classification rules. Most importantly, the published personal-connection mean (50.30) is not readily reconcilable with the reported total-score framework. That mean cannot be scientifically interpreted or replaced by an inferred value without the original questionnaire and participant-level dataset (Dinç & Gastmans, 2013; Ozaras & Abaan, 2018).

Fewer than half the respondents fell in the good categories for cultural awareness (45.2%) or compassion (43.3%). Cultural responsiveness depends on the interaction between clinical norms and patients' preferred language, values, decision-making roles, and perceptions of dignity. Compassion requires observable responsiveness to suffering, not simply positive self-description. These domains need patient-reported and observer-rated triangulation before stronger claims are possible (Lee & Seomun, 2016; McElroy et al., 2016).

The biopsychosocial perspective offers a rationale for including psychosocial and interpersonal dimensions in surgical care, but it should not be represented as a mechanism established by these data. Likewise, external studies reporting links between communication and care behaviors or patient satisfaction do not provide evidence of those relationships in this particular sample. Here, patient satisfaction, adherence, perioperative anxiety, safety events, or recovery were not assessed (Kirca & Bademli, 2019; Lotfi et al., 2019; Seyed Alitabar, 2025).

*Clinical interpretation, limitations, and future validation*

The most defensible application is an exploratory needs assessment: hospital educators could use the reported domains to prioritize what to evaluate more rigorously. A follow-up protocol should specify the 45 items and their sources, perform translation and cognitive interviewing if applicable, test content validity quantitatively, examine factor structure and subscale reliability, and prospectively compare nurse reports with patient evaluations or trained-observer ratings. A validated nurse–patient communication scale provides a methodological comparator, not evidence that the instrument in this study was validated (Granados-Gámez et al., 2022). Training efficacy would require a separate intervention design with predefined outcomes.

Limitations materially affect interpretation. The convenience sample (N = 104) from one hospital does not



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support regional prevalence estimates. Specific units within the surgical service were not identified, preventing separate claims about operating rooms. A 45-item modified questionnaire lacked traceable provenance, item-to-subscale assignments, cutoff rationales, and factor-analytic evidence; its overall alpha of .70 alone is insufficient. The personal-connection mean and the relationship of subscale means to the total score are unresolved. Self-report may be affected by recall and social-desirability biases, and no observed communication, patient assessments, or clinical outcomes were collected. No tests connected experience, training, or demographics to communication ratings; causality and temporal development cannot be inferred.

In this single-center cross-sectional survey, nurses most frequently assigned fair overall ratings to their communication, with relatively unfavorable self-reported classifications for nonverbal behavior, listening, patient education, presentation, and rapport. The instrument's incomplete validation and unresolved scoring inconsistency prevent treating these ratings as definitive measures of clinical competence. The findings can inform hypotheses and guide local measurement priorities, but they do not establish effects of nursing experience, communication training, patient safety, satisfaction, or recovery. Independent psychometric review and direct clinical and patient-based evaluation are prerequisites for stronger conclusions.

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## Declaration of Interest

The authors of this article declared no conflict of interest.

## Ethical Considerations

The study reported approval by the University of Babylon, College of Nursing Ethics Committee (decision dated 24 April 2025; decision no. 20). Permission was also obtained from Al-Hilla Teaching Hospital, and participants provided consent.

## Transparency of Data

In accordance with the principles of transparency and open research, we declare that all data and materials used in this study are available upon request.

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## Authors' Contributions

All authors equally contribute to this study.

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