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From Information Exchange to Human Connection: Reimagining Health Communication as a Process of Interpretation, Emotion, and Empowerment

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Abstract

Health communication is often evaluated as though its principal task were accurate transmission: clinicians provide information, patients receive it, and success is inferred from recall, satisfaction, or adherence. This article argues that such a model is too narrow for encounters in which patients must interpret uncertainty, express emotion, negotiate authority, disclose concerns, and determine whether they can meaningfully participate. Drawing on contemporary evidence from patient–clinician communication, shared decision-making, health literacy, empathy, language access, trust, and empowerment research, the article develops a non-empirical conceptual account of communication as a relational process. The central contribution is a proposed Interpretation–Emotion–Empowerment model in which information becomes clinically usable only through processes of meaning construction, emotional recognition, and communicative agency. These processes are treated as distinct but interacting, and their operation is conditioned by health literacy, language, culture, time, care setting, institutional trust, digital modality, and power asymmetry. The framework also separates patient-reported experience from clinical outcome and communication-process improvement from downstream effectiveness. Rather than claiming that better communication universally produces better outcomes, the model specifies where communication may enable participation, where it can fail despite technically accurate information, and which relationships require prospective validation. This reconstruction positions human connection not as an optional interpersonal addition to information exchange, but as part of the process through which information becomes interpretable, discussable, and actionable.

Keywords: Patient–clinician communication, Health literacy, Shared decision-making, Relational trust, Patient empowerment, Therapeutic empathy

Introduction

Healthcare communication is commonly described in terms of information delivery, comprehension, and response. That framing is necessary but incomplete. Patients do not encounter clinical information as neutral recipients. They interpret it through prior experience, illness meaning, perceived credibility, emotional state, role expectations, linguistic resources, and judgments about whether questioning or disagreement is safe. Evidence from cancer care illustrates this distinction: patient-centred communication was associated with trust through patient participation, whereas a direct communication–trust relationship was not supported after participation was considered [1]. Communication has also been linked to cancer-information avoidance through trust- and literacy-related pathways, suggesting that receiving information and being able or willing to engage with it are analytically different events [2].

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The relational field itself also requires conceptual precision. Patient-centred care, shared decision-making, and the working alliance overlap, but they are not interchangeable constructs [3]. Treating them as synonyms can obscure whether a study concerns an organizational orientation, a dyadic relationship, or a decision process. This article therefore reframes health communication around three interacting functions: interpretation, emotion, and empowerment. The proposed account does not assume that these functions form a universally causal sequence. Instead, it asks how information becomes meaningful, how emotional responses are recognized or missed, and how communicative conditions expand or restrict a patient's capacity to participate. The argument is explicitly bounded by setting, language, health literacy, culture, power, digital modality, illness context, and organizational conditions.

The limits of information-transmission models

An information-transmission model assumes that the principal communication problem is insufficient, unclear, or inaccurate content. Yet clinical interaction shows that communication failure can persist even when information is technically available. Conversation analysis of primary-care encounters found that patients can resist diagnostic closure while simultaneously softening that resistance in ways that preserve physicians' diagnostic authority [4]. The communicative issue is therefore not only whether a patient has been informed, but whether the interaction affords practical room to contest, reinterpret, or extend what has been said. Medication discussions provide a related example. In heart-failure care, nurse–patient conversations could be heavily fact focused and clinician initiated even while patients voiced concerns relevant to medication use and health-literacy needs [5]. More information does not automatically create greater understanding if the communicative structure privileges professional explanation over the patient's own problem definition. Likewise, clinicians describing difficult differences of opinion reported that educational emphasis alone could intensify disagreement, whereas eliciting values, validating emotions, and protecting the relationship could be more useful for navigating conflict [6]. These findings do not prove that validation is superior in every disagreement; they show that transmission alone is an inadequate explanatory model.

Experimental evidence further constrains strong claims. In a randomized trial, communication training improved some observable empathic behaviors but did not reduce low-value spinal imaging or improve patient-experience ratings [7]. Communication quality and downstream behavior therefore cannot be assumed to move together. A more useful conceptual distinction is between transmission adequacy—the accuracy and accessibility of information—and relational uptake—the extent to which information can be interpreted, questioned, emotionally processed, and incorporated into participation. The second state is proposed here as a conceptual synthesis rather than an empirically validated construct.

Because the limitations of transmission are multidirectional rather than sequential, the following figure represents them as interacting constraints and feedback relationships rather than as a linear communication pipeline **(Figure 1)**.

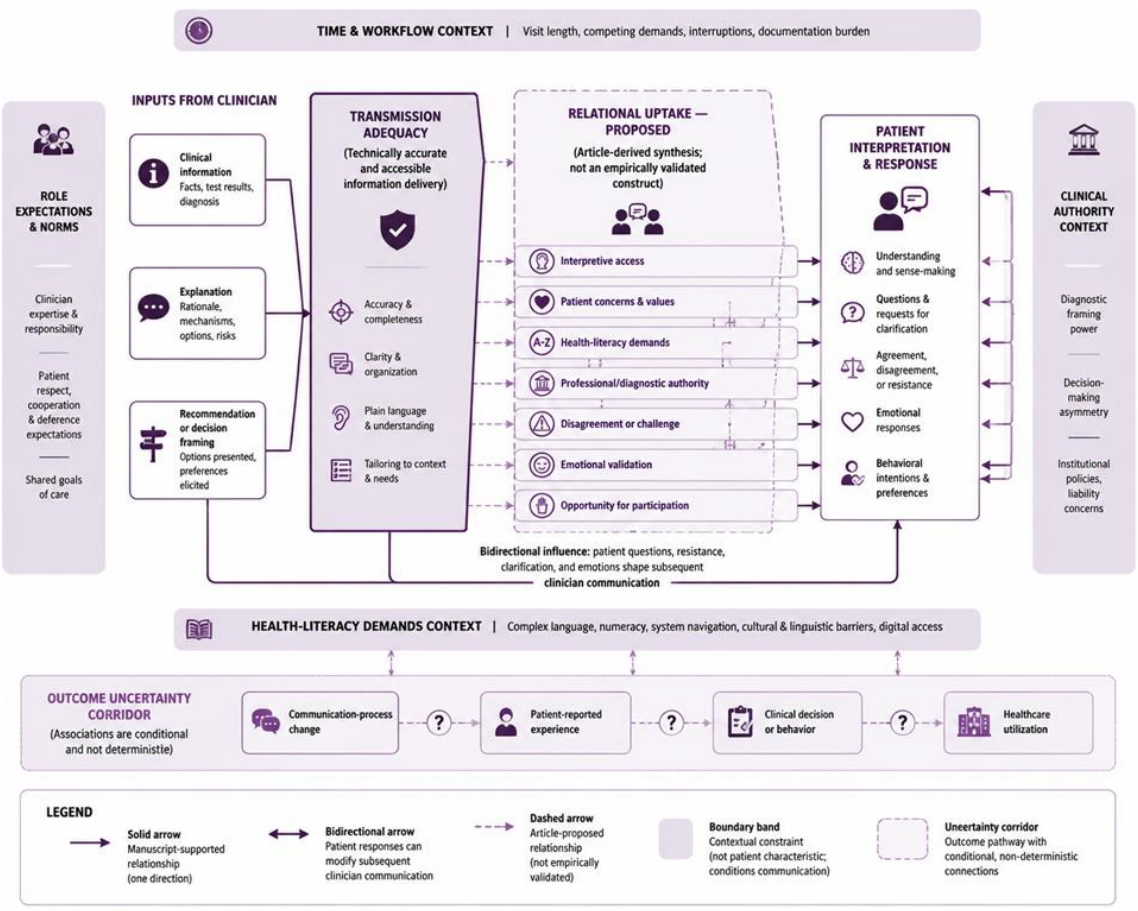

Figure 1. Where Information Transmission Stops Explaining the Clinical Encounter

Interpretation and the construction of meaning

Meaning is not identical to semantic accuracy. It is produced through the form, sequence, language, and social context in which information is exchanged. In interpreter-mediated pain communication with Hmong patients, summarization and omission could remove narrative detail and vocal-affective cues that carried information about pain severity and emotional meaning [8]. A message may therefore remain factually recognizable while losing clinically important context.

Language concordance is similarly conditional. Partial shared-language use in primary care could strengthen rapport, yet limited fluency also created opportunities for misunderstanding; interpreter support remained important when linguistic confidence exceeded actual precision [9]. Thus, relational closeness and semantic reliability may diverge. A broader synthesis of communication with communicatively vulnerable patients likewise found that effective communication often depends on adaptations involving language, culture, interpreters, and other communication supports, while the evidence base remains heterogeneous [10].

The article therefore treats interpretation as an active transformation layer between information and usable meaning. This proposed layer includes not only comprehension of words, but inference about relevance, credibility, intent, implications, and whether clarification is possible. Interpretation may fail because information is inaccessible, because context is lost, because institutional or professional language overrides the patient's framing, or because the patient and clinician assign different significance to the same facts. Meaning construction is consequently both cognitive and relational.

Emotion as a communication process

Emotion is often treated as a background influence on communication or as a state that the clinician should manage. A stronger formulation is that emotion is also communicative content. Fear, frustration, shame, hope, grief, or uncertainty can change what a patient asks, what remains undisclosed, and how clinical information is

interpreted. Clinician responses to emotional cues are not experienced equivalently: observational evidence indicates that more engaged responses can be associated with more positive communication experiences, while passive responses may be experienced less favorably [11].

Yet "empathy" should not be used as a catch-all explanation. A thematic analysis of therapeutic-empathy definitions identified distinguishable components involving exploration, understanding, shared understanding, feeling, action, and boundaries [12]. Methodological critique further shows that empathy research frequently overlaps with satisfaction, patient-centredness, and perceived care quality, complicating claims about what has actually been measured [13].

For this article, emotional communication therefore includes three separable functions: expression, recognition, and response. Expression concerns what emotional information becomes available; recognition concerns whether it is noticed and interpreted; response concerns what the clinician does with it. These are not guaranteed to align. A patient may express distress that is not recognized, or a clinician may recognize distress but respond in a way the patient experiences as dismissive. Emotional communication is thus proposed as a regulator of interpretive openness rather than a universal pathway to better outcomes.

Listening, validation, and recognition

Listening becomes clinically meaningful when it changes the informational or relational state of the encounter. In telehealth goals-of-care work with Black patients with chronic kidney disease, patients and stakeholders emphasized respect, trust, patient stories, cultural awareness, and the handling of difficult conversations as elements relevant to e-empathy [14]. The finding is context specific, but it demonstrates why listening cannot be reduced to silence while the patient speaks.

Recognition also depends on whether patients judge disclosure to be safe. In a national US survey, comfort sharing social needs was associated with trust, patient-centred communication, social isolation, and experiences of discrimination [15]. A clinician may therefore invite disclosure without creating conditions in which disclosure feels viable. This distinction is especially important for stigmatized concerns, social hardship, or experiences of prior disrespect.

The proposed conceptual threshold in this article is that listening becomes recognition when the patient's contribution is treated as potentially capable of altering shared interpretation, the next communicative move, or the decision frame. Validation does not require agreement with every claim. It can instead acknowledge that the concern is intelligible, consequential, and worthy of response. Because attentive listening, validation, and consequential recognition can appear similar at the surface while performing different relational functions, their distinctions are made explicit below **(Table 1)**.

Table 1. When Listening Becomes Recognition: Discriminating Relational Functions in the Clinical Encounter

Signal	Interpretive function	Emotional meaning	Relational response	Participation effect	Verification limit
Encounter pattern — Attentive reception					
Communicative operation	Gives space and follows the patient's account	**What becomes possible for the patient**	More complete narration	**Recognition-sensitive condition**	Time pressure and communication modality
Competing interpretation or uncertainty	Silence may indicate attention or disengagement	**Consequence for human connection**	Listening alone does not establish recognition		
Encounter pattern — Clarifying engagement					
Communicative operation	Checks meaning and revises initial understanding	**What becomes possible for the patient**	Correction of assumptions and elaboration	**Recognition-sensitive condition**	Language and communication access
Competing interpretation or uncertainty	Repetition can still leave contextual meaning untranslated	**Consequence for human connection**	Interpretation becomes jointly testable		
Encounter pattern — Emotional acknowledgement					

Communicative operation	Identifies or responds to expressed concern	**What becomes possible for the patient**	Emotional content can enter the clinical frame	**Recognition-sensitive condition**	Cultural norms and patient preference
Competing interpretation or uncertainty	Acknowledgement can become formulaic	**Consequence for human connection**	Recognition requires responsiveness rather than scripted empathy		
Encounter pattern — Validation without agreement					
Communicative operation	Treats the concern as understandable while preserving disagreement	**What becomes possible for the patient**	Participation can continue without forced consensus	**Recognition-sensitive condition**	Diagnostic authority and perceived safety
Competing interpretation or uncertainty	Validation may be mistaken for endorsement	**Consequence for human connection**	Relationship can remain open despite disagreement		
Encounter pattern — Recognition with consequence					
Communicative operation	Allows the patient's account to modify explanation, priorities, or next steps	**What becomes possible for the patient**	Speaking demonstrates practical relevance	**Recognition-sensitive condition**	Organizational flexibility and clinician discretion
Competing interpretation or uncertainty	Change may be constrained by resources or clinical necessity	**Consequence for human connection**	Human connection becomes actionable rather than symbolic		
Encounter pattern — Proposed boundary case					
Communicative operation	Invites speech while leaving no realistic route for the contribution to influence interpretation or action	**What becomes possible for the patient**	Voice is present without practical influence	**Recognition-sensitive condition**	Power asymmetry, discrimination, or workflow rigidity
Competing interpretation or uncertainty	Participation may appear present while agency remains restricted	**Consequence for human connection**	Apparent dialogue should not be equated with communicative empowerment		

Health literacy and comprehension

Health literacy is often positioned as an individual patient attribute, but communication research supports a broader view. A scoping review of interventions for disadvantaged groups found substantial heterogeneity and greater attention to functional and interactive literacy than to critical or scientific literacy [16]. This matters because comprehension depends not only on what patients can read or recall, but also on whether they can question information, relate it to their circumstances, and evaluate its significance.

Evidence linking health literacy to shared decision-making also shows that literacy is multidimensional. Studies have reported associations between literacy domains and perceived shared decision-making, while age, education, deprivation, numeracy, and difficulty asking questions can modify or complicate those relationships; critical literacy does not always show the same pattern as functional or communicative literacy [17–19]. A health-literacy-adapted emergency decision aid, for example, improved knowledge while not producing significant differences in decisional conflict or satisfaction [20].

Accordingly, this article treats communicative accessibility as a joint property of information, encounter demands, patient resources, and opportunities for clarification. Comprehension is necessary, but it should not be used as a proxy for agreement, trust, empowerment, or good outcome. Nor should limited comprehension be attributed solely to the patient when professional language, time pressure, numeracy demands, digital interfaces, or inaccessible explanations contribute to the difficulty.

Dialogue, shared understanding, and relational trust

Dialogue is more than reciprocal speech. It requires that contributions can influence the developing interpretation of the problem. Shared understanding is likewise not identical to agreement; two parties may understand each other well and still prefer different options. Trust is a further construct, shaped by both interaction and context. These distinctions are visible in outpatient evidence showing that communication quality and longer consultations were associated with greater satisfaction but not necessarily greater decision involvement, while trust mediated several observed relationships [21]. A scoping review of shared decision-making interventions and trust likewise found heterogeneous evidence and identified a need to understand intervention characteristics and populations with lower baseline trust [22]. Conversation-analytic synthesis adds an interactional mechanism: particular practices can encourage or constrain patient participation within decision sequences [23].

The article therefore defines shared understanding as an achieved but revisable relational state in which parties have sufficiently tested what each understands, values, and expects to continue decision-making without assuming consensus. Relational trust concerns willingness to rely on the clinician or care process under uncertainty; it may support dialogue, but it can also depend on prior institutional experience, role expectations, and perceived respect. Because the same encounter can contain comprehension, satisfaction, trust, and participation in different combinations, the implementation register below separates these states before they are translated into clinical action **(Table 2)**.

Table 2. Recognizing When Dialogue Has—or Has Not—Produced Shared Understanding and Relational Trust

Patient or care-context state	Immediate communicative task	Observable indication of progress	Inference that should be avoided	Condition requiring adaptation	Proposed decision response
Patient has information but remains uncertain	Elicit interpretation rather than recall alone	Patient can explain what the information means for the decision	Comprehension does not establish preference	High uncertainty or complex trade-offs	Continue sense-making before requesting a final choice
Patient understands options but hesitates to speak	Create explicit opportunities for participation	Questions, concerns, or preferences influence discussion	Silence does not establish agreement	Power asymmetry or low perceived safety	Test whether participation is practically possible
Patient and clinician disagree	Establish mutual understanding while preserving difference	Each can accurately represent the other's reasoning	Shared understanding does not require consensus	Diagnostic or treatment urgency	Separate understanding from agreement and retain unresolved priorities
Patient reports high satisfaction	Determine whether involvement matched preference	Desired decision role is explicitly discussed	Satisfaction does not prove participation	Deference or strong clinician direction	Avoid satisfaction as the sole relational endpoint
Trust appears fragile	Clarify uncertainty, responsibility, and accountability	Recommendations can be questioned without relational penalty	Additional information does not automatically restore trust	Prior discrimination or institutional mistrust	Address credibility and communicative safety alongside content
Proposed implementation boundary	Make constrained choice visible rather than presenting it as unrestricted autonomy	Structural limits are acknowledged and negotiated where possible	Apparent choice does not establish meaningful agency	Resource, access, workflow, or policy restrictions	Treat constrained participation as distinct from empowered choice

Communication as an empowerment mechanism

Empowerment is frequently invoked as an outcome of patient-centred communication, but the construct becomes unstable if it is treated as equivalent to knowledge, adherence, satisfaction, or independence. A systematic review of patient-empowerment measurement found substantial variation in instruments and psychometric properties [24]. It is therefore unsafe to infer empowerment from any single proxy.

Communication can nevertheless create conditions that make agency more practicable. The Ask 3 Questions intervention illustrates how question asking can be deliberately supported as a participatory behavior, while also showing that implementation requires local adaptation rather than assuming a universally transferable script [25]. Prospective evidence in insulin-treated diabetes further suggests time-linked relationships between patient empowerment and communicative or critical health literacy [26]. These findings are consistent with reciprocity: greater communicative capacity may support agency, while greater agency may increase question asking, reflection, and information use.

Randomized evidence also establishes an important boundary. A patient-centred intervention for poorly controlled type 2 diabetes improved some autonomy-support and self-management measures but did not produce a significant intervention effect on the primary glycemic outcome [27]. Empowerment should therefore be treated as a psychosocial and participatory process, not as a guarantee of biomedical improvement.

This article proposes that communication functions as an empowerment mechanism when it expands actionable interpretive and participatory capacity: the patient can understand what is at stake, express concerns and values, question assumptions, and influence the decision process to the extent that clinical and structural constraints allow. Empowerment remains preference sensitive. Some patients may want clinicians to carry greater decisional responsibility, and respecting that preference can be compatible with empowerment when the delegation itself is informed and voluntary. The central theoretical claim is therefore conditional: communication can support empowerment when it changes the patient's practical capacity to participate, but it cannot simply confer empowerment through information provision or stylistic warmth.

Power asymmetry and communicative constraint

Communication does not occur between actors with equal authority, resources, or freedom to define what counts as clinically relevant. Professional expertise legitimately gives clinicians particular responsibilities, but interactional authority can also determine whose interpretation becomes the working account of illness. Patients may resist diagnostic closure while formulating that resistance cautiously enough to preserve the clinician's epistemic authority [4]. In such encounters, the opportunity to speak is not equivalent to an equal opportunity to shape interpretation.

Language creates another layer of asymmetry. Interpreter-mediated encounters can lose narrative and emotional information through summarization [8], while partial language concordance may strengthen rapport and simultaneously increase the risk of inaccurate understanding [9]. Communication accommodations therefore matter not because linguistically diverse patients inherently communicate less effectively, but because healthcare systems impose linguistic demands that differ in accessibility [10].

Similar caution applies to social disclosure. Experiences of discrimination and lower trust have been associated with reduced comfort in sharing social needs [15]. Health-literacy research also indicates that deprivation and difficulty asking questions can constrain participation independently of whether information has technically been supplied [18]. Conversation-analytic evidence further demonstrates that clinicians' interactional practices can expand or restrict opportunities for patients to influence decisions [23].

These encounter-level conditions sit within a wider institutional environment. Repeated US surveys during the COVID-19 pandemic documented substantial changes in trust in physicians and hospitals, demonstrating that trust is historically and socially situated rather than created anew within each consultation [28]. An individual clinician may communicate skillfully while encountering skepticism generated by prior discrimination, institutional failures, political conflict, fragmented care, or previous clinical experiences.

The proposed model therefore distinguishes communicative invitation from communicative agency. Invitation refers to formal opportunities to ask, disclose, choose, or disagree. Agency requires that those contributions can be expressed safely, understood, and given practical relevance. This distinction prevents superficial participation from being mistaken for empowerment.

The following table separates observable communication conditions from the interpretations that can legitimately be drawn from them **(Table 3)**.

Table 3. Distinguishing Communicative Opportunity from Communicative Agency Under Conditions of Unequal Power

Mechanism–context case	What may be observed in the encounter	What the observation can reasonably indicate	Interpretation that exceeds the evidence	Constraint that must remain visible	Implication for the proposed model
Diagnostic authority	Patient accepts or cautiously questions the clinician's framing	Participation occurs within an asymmetrical knowledge relationship	Lack of overt disagreement proves full agreement	Professional authority and consequences of challenging expertise	Interpretation depends partly on whether alternative meanings can remain discussable
Interpreter-mediated communication	Information passes through a third party	Language access has been provided	Meaning, narrative emphasis, and emotion have necessarily been preserved	Interpreter practice, language structure, and contextual loss	Semantic transmission and interpretive equivalence must remain separate
Partial language concordance	Clinician and patient use a shared non-dominant language	Shared language may support rapport	Shared language guarantees accurate clinical understanding	Fluency limits and availability of qualified interpretation	Relational connection can coexist with interpretive uncertainty
Social-needs invitation	Clinician asks about social or material concerns	A formal opening for disclosure exists	Non-disclosure means no relevant need exists	Trust, stigma, discrimination, privacy, and anticipated consequences	Recognition requires conditions in which disclosure is practically safe
Shared-decision invitation	Options are presented and patient preference is requested	Participation is explicitly invited	Choice automatically constitutes empowerment	Literacy demands, perceived authority, urgency, resource restrictions	Agency depends on usable opportunity, not the presence of a choice question
Institutional mistrust	Patient questions recommendations or institutional motives	Credibility is uncertain in the present relationship	Skepticism is an individual communication deficit	Historical experience, institutional conduct, and wider social context	Trust must be treated as relational and institutional, not merely interpersonal
Proposed boundary case	Patient speaks freely but nothing material can change	Expressive opportunity is present	Voice alone constitutes meaningful participation	Fixed policy, unavailable treatment, cost, access, or organizational rules	Communication may support recognition while remaining unable to produce practical agency

An interpretation–emotion–empowerment model

The evidence assembled across the preceding sections supports several recurring distinctions, but it does not establish one validated mechanism linking communication to health outcomes. The Interpretation–Emotion–Empowerment model proposed here is therefore an integrative theory to be tested rather than an empirical result.

The first process, interpretation, concerns how communicated information acquires patient-specific meaning. Interpretation includes semantic comprehension but extends to relevance, credibility, implications, uncertainty, and the perceived possibility of clarification. Language, health literacy, prior knowledge, illness experience, and the organization of the encounter all condition this process.

The second process, emotion, concerns both affective communication and the relational handling of affect. Emotional expression can signal uncertainty, threat, shame, grief, disagreement, or hope. Recognition can make those signals available to the shared clinical frame, whereas missed or formulaic responses can leave them functionally outside it. Emotion may also influence interpretation: information experienced as threatening or dismissive may be processed differently from the same

facts delivered within a relationship perceived as respectful.

The third process, empowerment, concerns actionable communicative capacity. It is not defined as independence from clinicians, nor as adherence to professional recommendations. It refers to the practical ability to understand what is at stake, communicate concerns or values, ask questions, negotiate responsibility, and influence deliberation to the extent permitted by clinical and structural conditions. Existing empowerment measures remain heterogeneous [24], so empirical testing of the model will require careful construct selection.

The three processes are proposed as reciprocal rather than linear. Improved interpretation may reduce uncertainty or generate new emotional responses. Recognition may make further disclosure possible. Greater communicative agency may produce additional questions that revise interpretation. Conversely, misunderstanding, emotional threat, or constrained agency may create negative feedback, including withdrawal, information avoidance, superficial agreement, or reliance on external information sources.

The model also includes four boundaries. Accessibility boundaries concern language, literacy, disability, and modality. Relational boundaries concern trust, role expectations, and interpersonal safety. Structural boundaries concern resources, discrimination, organizational rules, and institutional credibility. Outcome boundaries separate improvement in communication processes from improvement in behavior, utilization, or clinical outcomes. The model predicts neither that all three processes must be maximized in every encounter nor that more patient participation is universally preferable. Preference-sensitive delegation can remain empowering when it is informed, voluntary, and revisable.

Clinical and organizational applications

The proposed model changes what should be assessed when communication improvement is attempted. A single satisfaction score cannot identify whether failure occurred in comprehension, interpretation, emotional recognition, participatory opportunity, or institutional trust. Clinical communication assessment should therefore distinguish these functions rather than treating "good communication" as one undifferentiated exposure.

Individual tailoring is also important. In an experimental oncology study, responses to patient-centred communication varied with psychological characteristics and affected trust, satisfaction, and intentions concerning online health-information seeking [29]. Such findings caution against assuming that one communication style will produce uniform responses across patients or situations.

At the organizational level, implementation evidence is similarly mixed. An umbrella review of shared decision-making reported outcomes ranging largely from neutral to positive while emphasizing heterogeneity and limitations in the underlying review evidence [30]. Communication redesign should therefore be evaluated as an implementation problem as well as a clinician-skill problem.

System interventions can create opportunity without necessarily transforming the encounter. In high-risk cancer care, clinician- and patient-directed communication strategies produced only limited improvement in documented serious-illness conversations [31]. Documentation itself also cannot establish whether conversations achieved shared understanding, emotional recognition, or meaningful participation.

A stronger organizational evaluation strategy would separately examine whether information was accessible, whether patient meaning was elicited, whether emotional concerns were recognized, whether preferences could influence deliberation, and whether structural barriers prevented otherwise appropriate action. These dimensions should then be related cautiously to downstream outcomes rather than treated as substitutes for them.

Training should follow the same logic. Skills such as open questioning, checking understanding, responding to emotion, explaining uncertainty, and inviting participation may be valuable, but they should not be presented as universally effective techniques detached from workflow, clinical urgency, patient preference, interpreter access, or institutional constraints. Organizations must also avoid assigning clinicians sole responsibility for problems created by short consultation times, inaccessible digital systems, fragmented care, inadequate interpretation services, or restrictive policies.

Results and Discussion

Reimagining health communication as interpretation, emotion, and empowerment changes the unit of analysis. Communication is no longer simply a message

transferred between sender and receiver. It becomes a relational process in which information is interpreted, emotional meaning is negotiated, and practical capacity to participate is expanded or constrained.

The evidence supporting this reconstruction is heterogeneous by design and should remain so. Conversation-analysis studies reveal interactional organization but do not estimate population-wide causal effects. Surveys identify associations among communication, trust, literacy, disclosure, and participation but cannot establish temporal direction in all cases. Qualitative studies provide detailed accounts of meaning and context without proving intervention superiority. Trials can test particular communication interventions but cannot validate the article's broader model.

Several apparent contradictions become more intelligible when constructs are separated. Communication can increase satisfaction without increasing decision involvement [21]. Health-literacy support can improve knowledge without necessarily changing decisional conflict or satisfaction [20]. Patient-centred interventions can strengthen autonomy-related processes without improving a primary biomedical endpoint [27]. Randomized communication interventions likewise demonstrate that improving communication processes does not by itself guarantee improvement in downstream utilization or secondary outcomes [7, 32]. These findings argue against both pessimistic and overly optimistic interpretations. Communication matters, but what it changes depends on which communicative process, patient, outcome, time point, and context are being considered.

The proposed model therefore generates testable questions rather than claims of validation. Longitudinal studies should examine whether changes in interpretation precede changes in emotional security or participation, while allowing reciprocal pathways. Comparative studies should distinguish accurate comprehension from perceived understanding and relational recognition. Measurement work should separate empathy, trust, empowerment, satisfaction, participation, and clinical outcomes. Implementation research should examine whether organizational constraints interrupt otherwise successful encounter-level communication. Equity-sensitive research should test how language access, discrimination, material resources, disability, and institutional history alter these relationships without treating group membership as a psychological explanation.

Digital communication represents an especially important boundary. Telehealth can preserve or expand access while changing how emotional cues, pauses, privacy, and narrative context are perceived. Automated communication systems may improve informational availability while weakening opportunities for clarification or reciprocal recognition. The model therefore predicts that communication technologies should be evaluated not only for message accuracy but also for their effects on interpretability, emotional responsiveness, and communicative agency.

The principal limitation of this article is inherent to its design. It integrates evidence across heterogeneous methods and clinical contexts to construct a new theoretical account; it does not test that account empirically. The Interpretation–Emotion–Empowerment model should consequently be evaluated prospectively, revised when relationships fail to reproduce, and resisted as a universal template where illness, culture, patient preference, urgency, organizational structure, or resource constraints demand different communicative arrangements.

Conclusion

Health communication cannot be adequately understood as the successful movement of information from clinician to patient. Information becomes clinically meaningful through interpretation, is shaped by emotional experience and recognition, and becomes actionable only when patients possess sufficient opportunity and agency to engage with it.

The Interpretation–Emotion–Empowerment model proposed in this article organizes these functions while preserving their distinctions and boundaries. It does not assume that connection eliminates disagreement, that participation always requires autonomous decision-making, or that improved communication automatically produces improved health outcomes. Instead, it identifies human connection as a relational condition through which information can become interpretable, concerns can become recognizable, and participation can become practically meaningful.

The model remains theoretical and requires longitudinal, comparative, measurement, equity-sensitive, and implementation validation. Its immediate value is therefore not as a proven intervention formula, but as a

more precise way to ask what communication is doing, for whom, under which conditions, and where the pathway from information to meaningful participation breaks down.

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