*Assessment of Doctor-Patient Communication at Adama Hospital Medical College: A Symbolic Interactionist Perspective

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Abstract

This study followed a symbolic interactionist theoretical framework and positivist paradigm to assess doctor-patient communication at Adama Hospital Medical College (AHMC). Specifically, it assessed the communication competencies of medical doctors (with their own inpatients), investigated how inpatients interact with their doctors and evaluated the major barriers to doctor-patient medical communication. A descriptive, explanatory, and cross-sectional study designs were followed. Out of 66 medical doctors of AHMC, 36 were selected as they were more directly and highly involved with bed-ridden patients in six wards and the remaining 22 were much more occupied with teaching and the management of the hospital and were not readily available for this study. A total sample size of 180 (144 patients + 36 medical) respondents were included. An SPSS 16 was used for presenting quantitative data and emerging themes guided the qualitative data analysis. The study found out that all medical doctors practice greeting socially and treat patients with due respect. The qualitative data indicated that some doctors exhibited communicative competence failures, and some lacked the cultural competence needed to comprehend traditional expressions. Due to heavy workload, some medical doctors show lack of interest. However, almost all doctors confirmed that they show interest in the patient's ideas about their health. Generally, doctors allocated little time with patients who were not in a very critical situation. Almost all medical doctors assumed that they devoted their time to understand the main health concerns of patients and gave much attention. Those patients from the rural communities were often interrupted because they did not talk about their illnesses openly. This implies that some medical doctors lacked a profound knowledge of cultural communicative competence. Patients used traditional and vague expressions. Factors such as avoiding medical jargons, recounting the next steps, giving much care and concern, apportioning sufficient time, and writing legibly have been considered as major elements influencing medical communication. In the three factors (showing interest, understanding, and giving attention), doctors have been evaluated good communicators. This current study identified communication barriers and their possible causes. Some of these barriers have been caused due to poor communication skills, lack of the proper sense of confidentiality, the misuse or inappropriate use of medical jargons, lack of spacious workspace, language difference, the patients' low level of understanding sickness, patients' low level of education, inappropriate use of cultural and vague expressions, poor time allocation, patients' taking too much time due to unnecessary repetitions, the gap between substantive lab evidence versus oral evidence and lack of family partnership and responsibility. Among other suggestions, the study recommends that the hospital needs to design a communication strategy to address these communication gaps.

Key words: Mead's symbolic interactionism, patient- doctor communication, positivism, traditional communication, sick role, communication barrier, communication competence and effective communication

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*Citation: Woldemariam, H.Z. and Hundessa, AB. (2021). Assessment of Doctor-Patient Communication at Adama Hospital Medical College: A Symbolic Interactionist Perspective. *Arsi Journal of Sciences and Innovations. 6(2)pp 35--75.* https://www.arsiun.edu.et/index.php/2015-11-01-15-27-32/research-publication-dissemination/arsi-journal-of-science-innovation/current-issue

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1.1. Introduction

The existence of effectual medical (humane) communication systems in a hospital setting can augment the quality and the relevance of societal health care delivery systems, which, in turn, can increase patient's contentment. The barriers to effective medical communication between medical doctors and patients are glaringly huge and often remain unaddressed. Neither medical doctors nor strategic leaders of the hospital give equal and prior attention to medical communication failures in the manner they give due attention to biomedical or infrastructure related problems. Without being heard or properly communicated, patients may go home. Often the poorest of the poor and the voiceless suffer critically due to traditional, linguistic, and communicative competence barriers. The poorest of the poor and the sickly may face critical health problems and fail to get equal medical access to medical treatment opportunities. Failure to communicate effectively with the patient is a critical problem especially in government hospitals as compared to private ones in Adama city. To the dismay of medical doctors, traditional communication and outmoded practices continue to surface in the hospitals. Some patients may not express their pain openly due to traditional and personal barriers.

Comparatively although there are some improvements in the health care delivery systems in the hospitals in Ethiopia, it is acknowledged that there is a high rate of morbidity, mortality and disability and the health status remains relatively poor. Research also has shown that the major health problems of the country are largely preventable communicable diseases and nutritional disorders. Deeply rooted cultural and societal norms are tyrannically griping the growth of modern health communication and practices. As the interactions between medical doctors and patients remain inefficacious, the causes of illness may not be properly communicated even to the patients. Medical doctors, medical researchers and clinical practitioners have not yet reduced the fast spread of disease, water borne illness, maternal and child mortality and morbidity. We can list down thousands of health-related problems in Ethiopia. One major causes of the problem can be ineffective medical communication between doctors and patients.

The review of previous studies shows the existence of a research gap. A handful of researchers conducted studies on medical communication and related issues in Ethiopia. These studies were cross-sectional studies of the effectiveness of medical communication and patient satisfaction; see for example, Wamai (2009); Getachew and etal (2014); Eyerusalem (2011); Daniel, Kifle and Sosena (2011). However, the efficacy of doctor-patient communication has not suitably been studied and described at Adama Hospital Medical Colleges. In relation to medical communication, there is, therefore, a strong need to study the causes of patient dissatisfaction, barriers to effective medical communications and the impacts of social interactions in medical contexts in government hospitals in general and Adama Hospital Medical College in particular. Though a study of this nature touches barriers to communication and patient dissatisfaction, the focus of this research is directed only to the evaluation of the interactions between medical doctors and patient following a symbolic interaction perspective. The symbolic interactionism lens allows the researcher to investigate the problem from three perspectives: **Mind, Self and Society** (Mead, 1934). Following this interactional theoretical perspective and a positivist paradigm, the researcher assumes that there exists a glaring gap between the patient's communicative competence and the practitioner's medical communicative competence in Adama Hospital. Specifically, therefore, this research generally evaluated the efficacy of doctor-patient communications in Adama Hospital Medical

College following a symbolic interactionist perspective and guided by the following three basic research objectives.

It has been clearly said that ineffective communication is the most frequently cited category of root causes of sentinel events. Effective communication, which is timely, accurate, complete, unambiguous, and understood by the recipient, reduces errors and results in improved patient safety (State of Victoria, 2010, p.3). Therefore, there is a strong need to properly explore the extent of the problem and bring medical communication barriers to the notice of the strategy developers, medical practitioners, patients, medical curriculum developers and the top management of Adama Hospital and Medical College (AHMC) to enhance medical communication effectively and efficiently.

1.2.Research Objectives

This study followed Mead's symbolic interactionist theoretical framework in line with the positivist research paradigm. Generally, this study has aimed assessing the efficacy of doctor-patient communication at Adama Hospital Medical College (AHMC). The following specific research objectives guided the basic stream of the research:

1. assess how medical doctors evaluate their own medical communication competence with their own inpatients at AHMC;
2. investigate how inpatients assess their interactions with their medical doctors at AHMC;
3. study the major barriers to doctor-patient medical communication at AHMC.

2. Research Methods and Procedures

This study followed a mixed research method approach considering and focusing sample studies from the hospital. This study specifically targeted samples selected from 231 bed-ridden patients who were getting bed services in wards: surgery, internal medicine, pediatrics, gynecology/obstetrics, and ophthalmology departments during the study period. Those patients who were critically ill, emergency cases and under aged children, who were not attended by their parents or custodians were excluded. In all cases, we followed a systematic sampling procedure, as the list of patients was readily available. Though other medical staff could provide valid data, 36 (out of 66) medical doctors of the hospital were directly related to the current study. Therefore, a total of 231 in-patients and 36 medical doctors working in the Hospital were the focus of the study and formed the study population and though nurses, psychiatrists and hospital managers assisted the study.

A descriptive, explanatory, and cross-sectional study was followed among in-patients. The hospital is selected because the researcher (personally) experienced the existence of communication problem in government hospitals in general and assumed Adama Hospital's case is critical. Out of 231 inpatients, 144 were selected following a systematic sampling procedure to fill out a questionnaire. In each ward, nurses assisted me identify 24 patients using the list of patients (a sampling frame) systematically. Whenever patients could not read and write, the nurses interviewed and filled out the questionnaires. Secondly, out of 66 medical doctors of the hospital, we found out 36 were directly and highly involved with bed-ridden patients in these six wards and the remaining 22 were much occupied with teaching and the management of AMHC and were not available easily. Again, out of 66 doctors, 36were selected following a systematic sampling

procedure and approached to fill out the questionnaire. A total sample size of 180 (144 patients + 36 medical) respondents was selected following a systematic random sampling procedure for quantitative data, which is determined through the table designed by Krejcie and Morgan (1970).

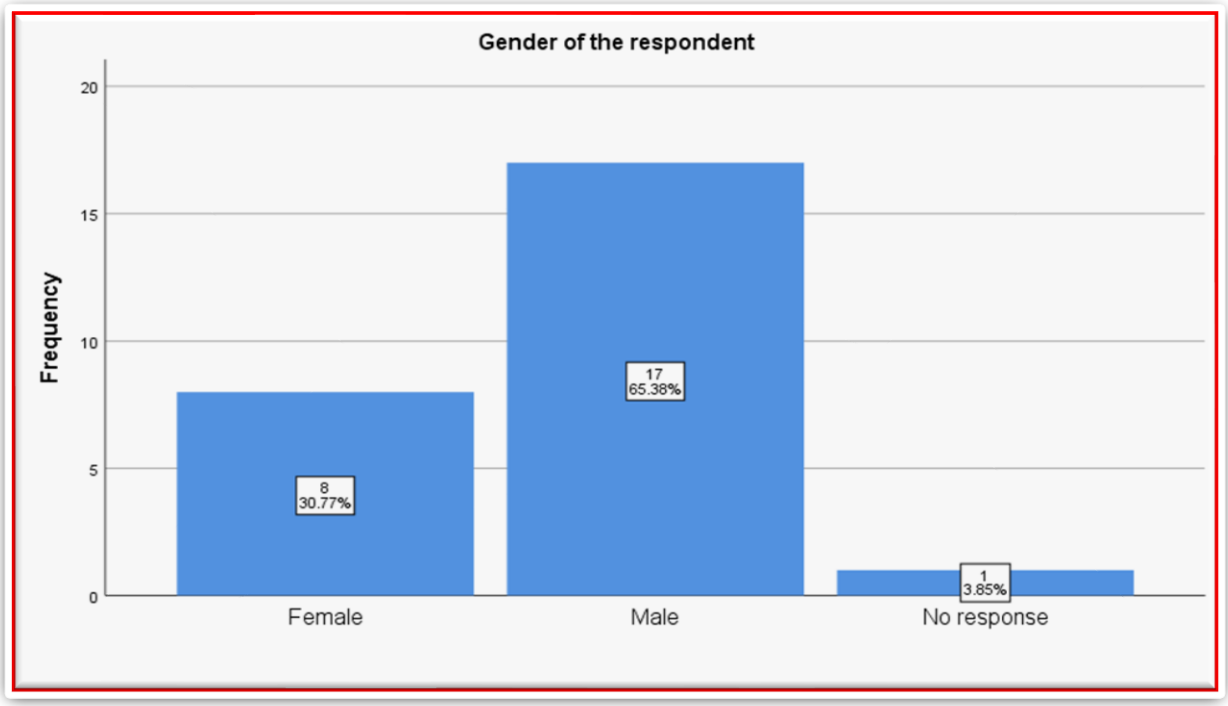
As cited by Oppong (2013,p202), Mack et al notes that the application of purposive sampling entails categorizing subjects in accordance with ex ante identified criteria based on the research problem. The sample size is more of function of available resources, time constraints and objectives of a researcher's study. This implies that sample size may or may not be fixed ex ante prior to data collection. Generally, the sample size that is selected based on purposive sampling procedure is determined in line with theoretical saturation (p.1). In line with this argument, out of the 144 sample inpatients, 12 bed-ridden patients and six (6) medical doctors were purposely selected for the qualitative data. Following a purposive sampling procedure, during 5 December 2019 until 15 January 2020, six (6) medical doctors were approached for observations while they were visiting and consulting patients in surgery, internal medicine, pediatrics, gynecology/obstetrics, and ophthalmology wards. The intention was to record a minimum of two conversations between doctors and patients and identify possible problems. These doctors and patients already completed the questionnaire and knew about the research objectives. Immediately after recoding each interaction, we continued an interview (6 interviews) with each medical doctor for 30 minutes and later with each patient. Since the doctors did not have time, we focused on identification communication barriers. On the other side, as patients had sufficient time, we had conducted interviews with 12 patients with a minimum of one hour each. In each ward, we managed to interview two patients. The interview took longer period than expected (between December and January). We focused on communication barriers. We really enjoyed this part of the study and allowed me to understand the context and we also took several pictures. In all cases, we considered the consents of medical doctors and patients. The Communication Assessment Tool (CAT) developed by Makoul et al (2007) was modified to measure the views of patients towards the physician's communication skills in Adama Hospital.

3. Major Findings and Discussions

3.1.Doctors' Demographic Data

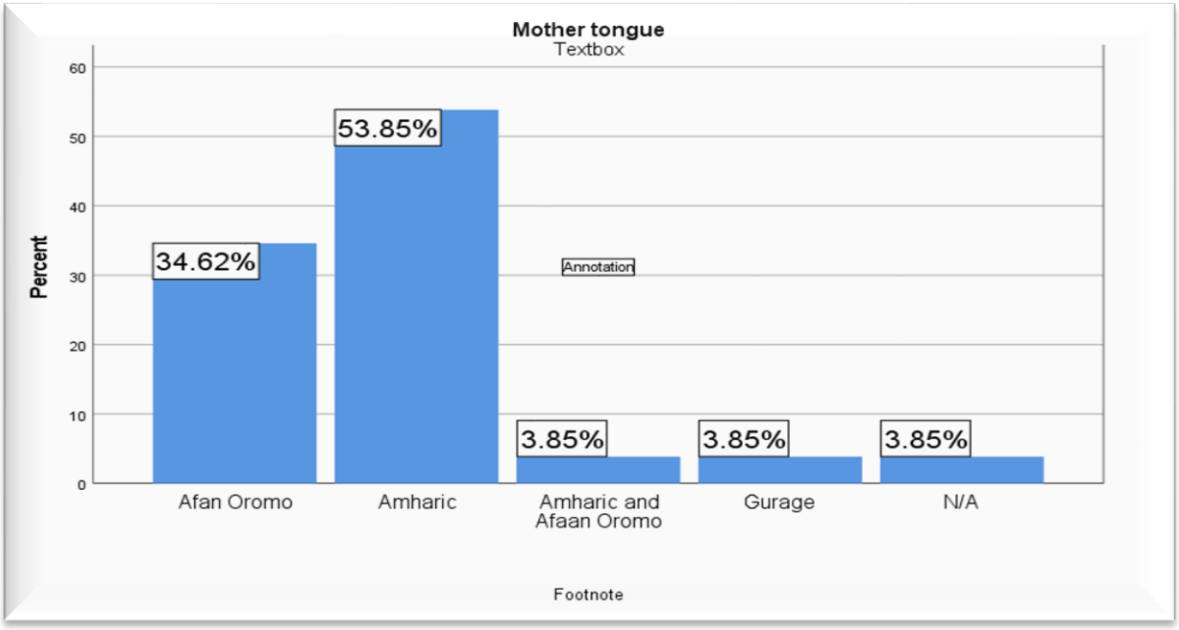
The research instruments designed for this research generated demographic data with the assumption that societal and personal factors such as age, experience, language, ethnicity, and religion might affect deleteriously or positively the way medical doctors communicate with patients in any hospital setting. Some of these demographic factors are not directly related to the current study but in the future, researchers in the Ethiopian context might plan to link medical communication with age, gender, religion, experience, ethnicity, income, and workload. This study assumes that language use and the ways we communicate in social contexts play critical roles. All other factors have stated have been presented to supply the background information about the characteristics of the respondents of the study and lay the social context of the study. As indicated in the bar graph below, gender was the first demographic factor:

Fig1. Medical Doctors' Gender



As indicated in the chart above, 17 (65.38%) male and 8 (30.77%) female and 1 (3.85%) unidentified medical doctor completed the self-assessment questionnaire and took an active part in the study. The second factor was the medical doctors' language use.

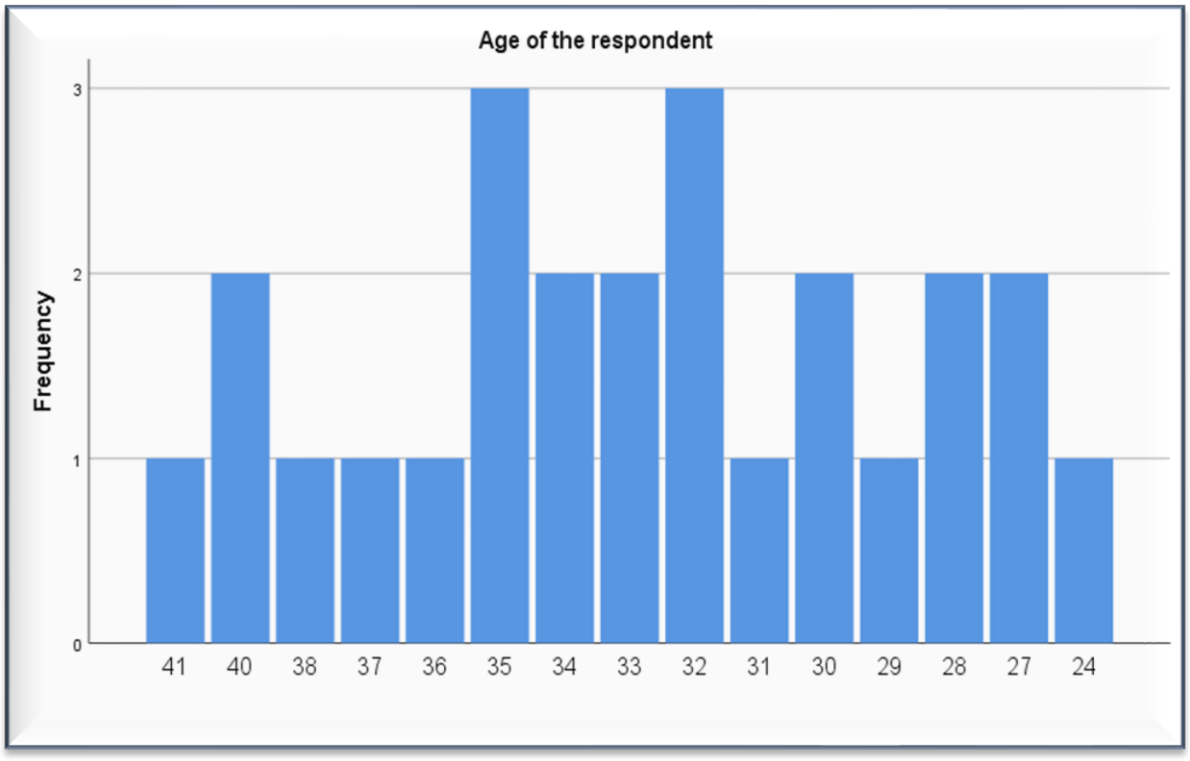
Fig 2: Medical Doctors' Mother Tongue



The language dilemma in a hospital setting is huge. As reported in the previous chapter, based on the Population and Housing Census 2007 Report, the four largest ethnic groups reported in Adama

were Oromo (39.02%), Amhara (34.53%), Gurage (11.98%) and the Site (5.02%), all other ethnic groups made up 9.45% of the city population. Obviously, this number might have changed over time and increased by now. Amharic was spoken as a first language by 59.25%, 26.25% spoke Oromiffa and 6.28% spoke Guragigna, the remaining 8.22% spoke all other primary languages and 63.62% were Orthodox, 24.7% Muslim and 10.57% were Protestant (2007). Many are expected to interact with the medical doctor in Amharic as it is the working language through there were some patients form the nearby villages who could not converse in Amharic. As indicated in the graph above, most medical doctors (14 or 53.85%) can speak Amharic as their mother tongue and 9 or 34.62% speak Afan Oromo and the remaining 3 speak other indigenous languages each. Some have indicated that they are bilingual. Commonly, it is understood and expected that these medical doctors can speak English and Amharic with patients. However, there were several cases where the patient could not understand neither English nor Amharic. Though it was not directly connected to the current study, the third factor was age.

Fig 3: Doctors'Age



The maximum age was 41 and the minimum 24. Does age matter at all in a doctor-patient communication in a medical setting at all? Culturally, an elderly medical doctor might have a high sense of cultural communicative competence and show greater respect for the elderly patients due to societal practices. On the contrary, a novice and young medical doctor might show due respect for the patients due to upbringing. An elderly medical doctor with huge medical experience might show disrespect due to heavy workload. A young medical doctor might be equipped with latest ICT competencies and communicate with much ease and giving much comfort to the patient. Therefore, the link between age and medical communication requires further study and consultations.

As indicated in the charts below, it has been cumbrsom to establish a strong or weak link between ethnicity and religion with medical communication in this research. Does ethnicity influence medical communication at all? Does the medical doctor's religious background influnce his/ her cultural or communicative comptence at all? The charts below are presnted so that the idea might ignite other researchers for further studies.

Fig 4: Doctors' Ethnic Background

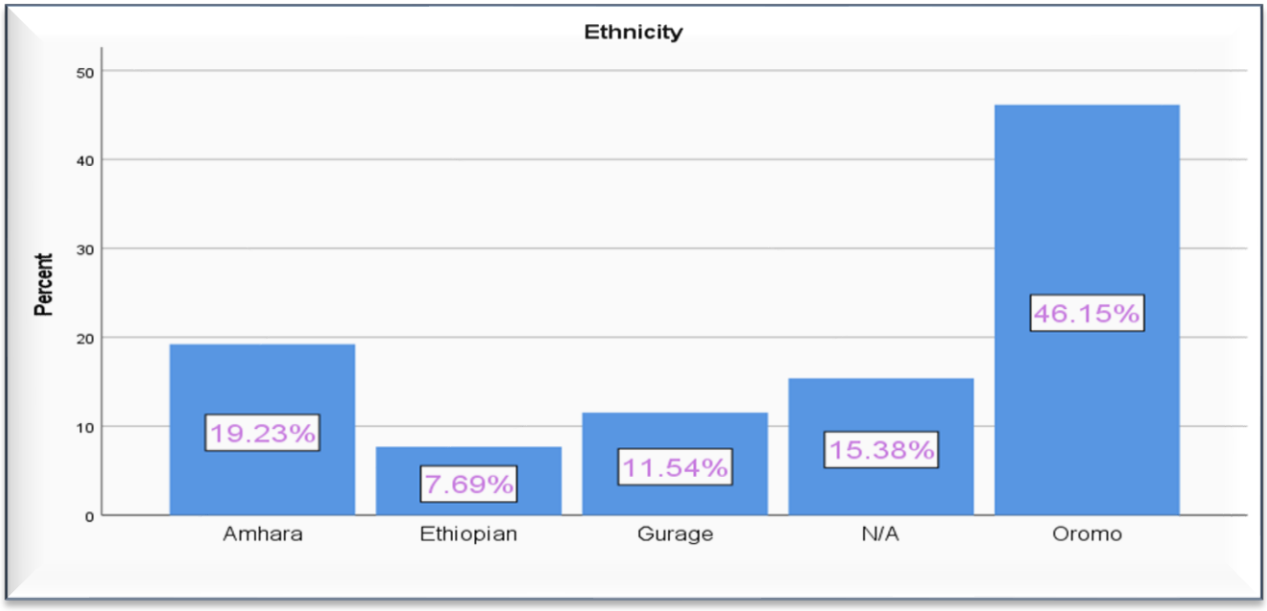


Fig 5: Doctors' Religion

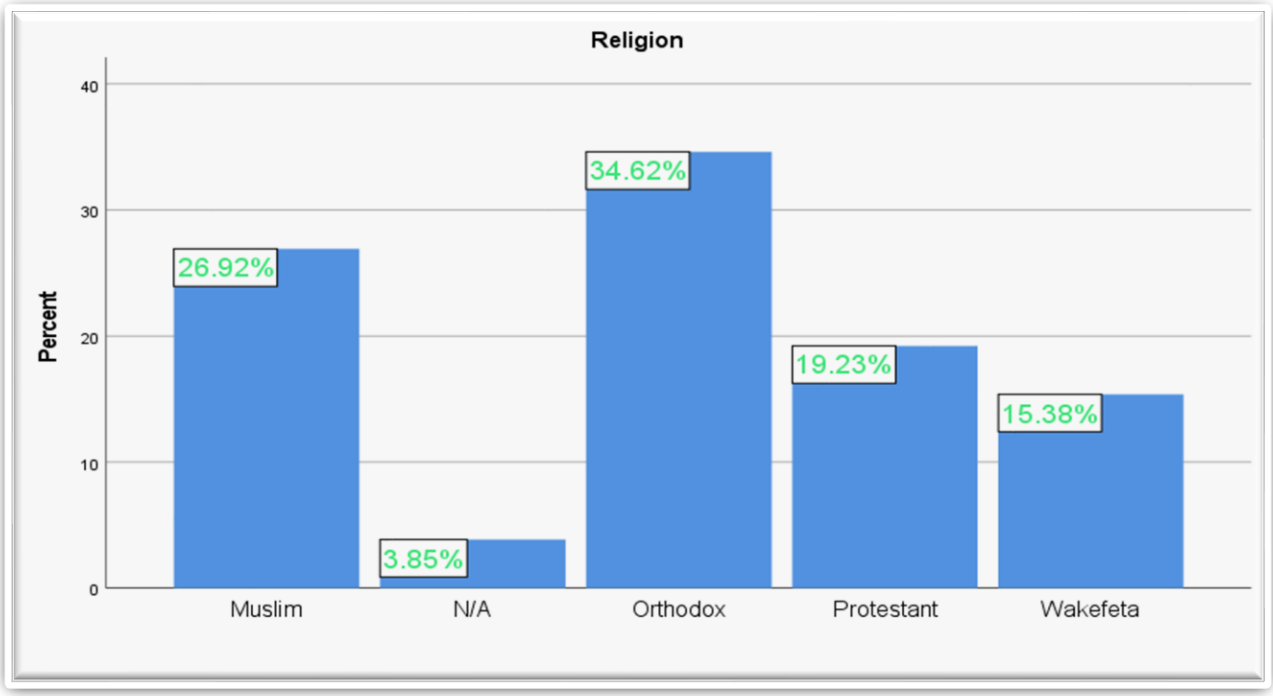
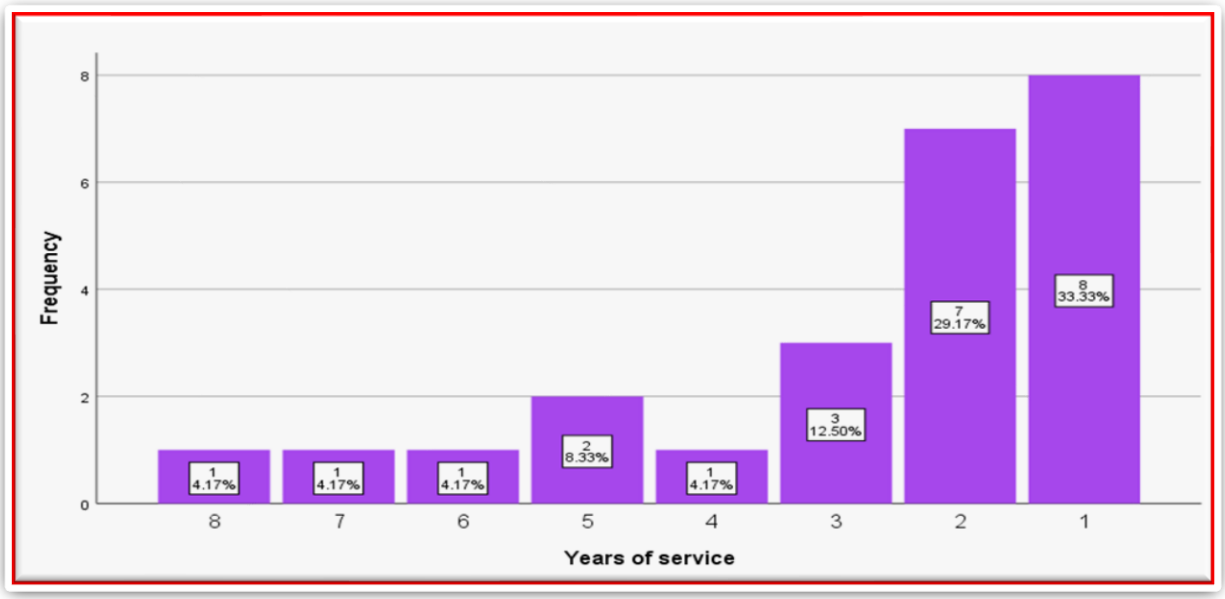


Fig 6: Year of Services



Obviously, the link between years of medical practice and medical competence is clear. We assume that as the number of years of medical services increases the doctor's medical communicative and cultural competence are expected to increase. Many of the respondents of this research (62.5%) have an experience of 1 and 2 years. This lack of medical experience might have affected the way medical doctors communicate with patients.

3.2.Medical Doctors Self Evaluation of their Communication with Patients

Social interactionism assumes that a human being must be understood as a social person. It is the constant search for social interaction that leads us to do what we do. Instead of focusing on the individual and his or her personality, or on how the society or social situation causes human behavior, symbolic interactionism focuses on the activities that take place between actors. Individuals are created through interactions; society too is created through social interaction. What we do depends on interaction with others earlier in our lifetimes and it depends on our interaction right now. Social interaction is central to what we do. Similarly, in a medical communication situation, the patient assumes the sick role (seeking help) and the doctor the roles of a healthy person (giving help). In the following section, we will be presenting the reflections of medical doctor's self-evaluation of their own communication with their patients. Out of 36 medical doctors, 32 were part of the sample size and received the questionnaire. Only 26 (81.25%) completed the questionnaire successfully. Some were discarded as they were incomplete. In all situations below, medical doctors have been described as healthy social beings and giving medical support. Factors such as greeting the patient, treating the patent with due respect, showing much interest, understanding the patient, paying much attention, giving the right type of information, expounding information, recounting the next steps, giving much care and concern, apportioning sufficient time, and writing legibly have been considered as major elements of effective medical communication. Doctors were asked to evaluate their own communication.

The Communication Assessment Tool (CAT) developed by Makoul et al (2007) was modified to measure the physician's communication skills AHMC. The CAT is a 15-item survey that is easily

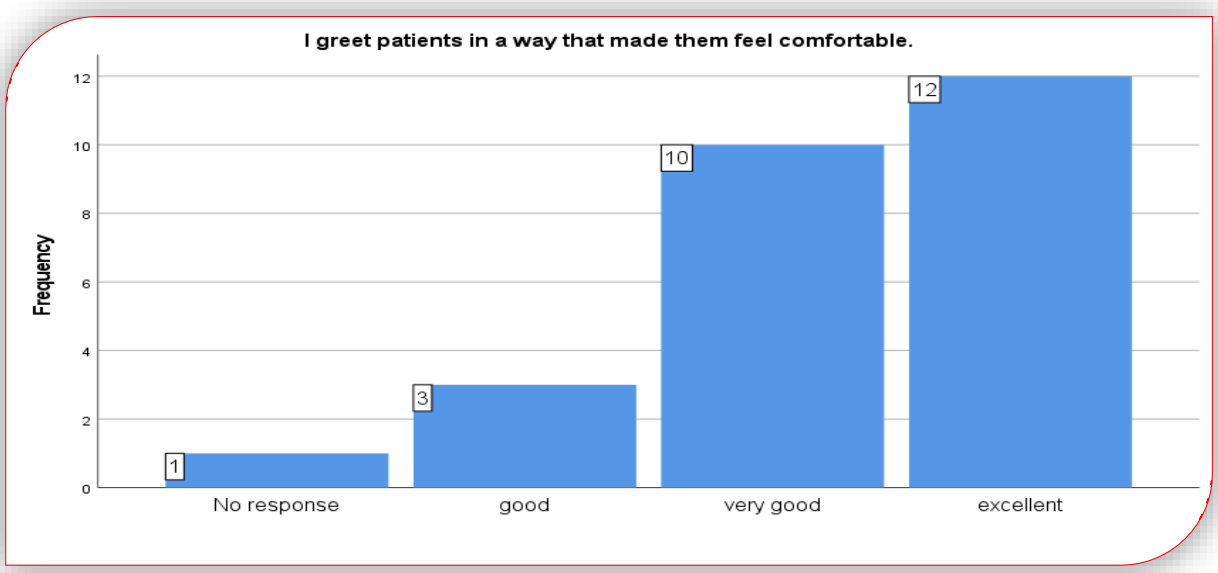
administered in a paper-and-pencil format or via the phone or Internet (Makoul et al 2007, pp.333-42). Copies of the English version of the questionnaire were distributed first to medical doctors and then the Amharic version to the inpatients. The table below summarizes the responses from the doctors who took part in the study. In many of the questions, doctors evaluated their communication competence as very high. However, as the summary table below shows, medical doctors evaluated their communication competence relatively low in the factors such as asking questions, interrupting patients, understanding patients, giving information and patients involvement:

Table 1: Doctors' CAT Summary Table

Factors	**Descriptive Statistics**					
	Mean		Std. Deviation	Variance	Kurtosis	
	Statistic	Std. Error	Statistic	Statistic	Statistic	Std. Error
1. I encourage patients to ask questions.	3.77	.217	1.107	1.225	4.102	.887
2. I let patients talk without interruptions.	3.81	.222	1.132	1.282	3.963	.887
3. I check to be sure the patient understands everything	3.85	.198	1.008	1.015	7.964	.887
4. I give patients as much information as they want.	3.85	.220	1.120	1.255	4.257	.887
5. I involve patients in decision as much as they want.	3.85	.240	1.223	1.495	2.531	.887
6. I show interest in patient's ideas about their health.	4.04	.211	1.076	1.158	7.153	.887
7. I talk in terms the patients could understand	4.04	.204	1.038	1.078	8.689	.887
8. I discuss next steps, including any follow-up plans.	4.08	.214	1.093	1.194	6.915	.887
9. I spent the right amount of time with patients.	4.12	.237	1.211	1.466	4.200	.887
10. I pay attention to patients (look at them, listen carefully)	4.15	.213	1.084	1.175	7.969	.887
11. I greet patients in a way that made them feel comfortable.	4.19	.215	1.096	1.202	7.881	.887
12. I understand the main health concerns of patients.	4.23	.202	1.032	1.065	11.260	.887
13. I write legibly and clearly.	4.23	.217	1.107	1.225	7.860	.887
14. I show care and concern.	4.31	.198	1.011	1.022	13.529	.887
15. I treat patients with respect	4.31	.213	1.087	1.182	9.484	.887

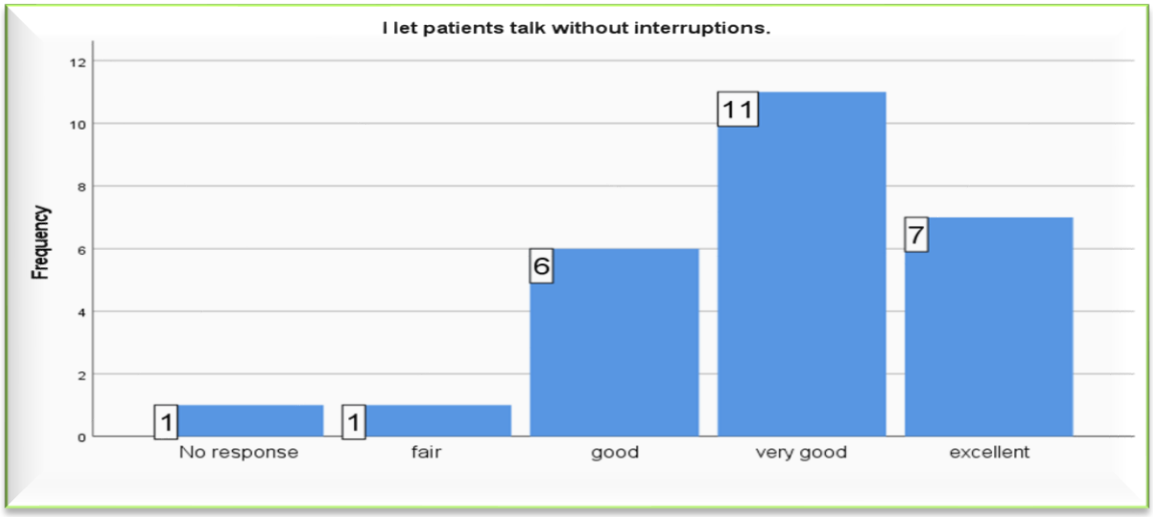
The summary table above is self explnatorty. For many of the questions/factors, medical doctors evaluated their own communication comptence favorably.The data must be trangulated through interviews, observations and questionniares from patients studied. Hereunder, few questions were handpicked for further analyses and will be compared with the responsses from patients at a later satge. The first grpagh presnts 'greetings.'

Fig 7 : Greeting Patients



Culturally, elders expect the young to stand up and shake hands while greeting. However, in a medical context, doctors are not expected to stand up and shake hands but verbally they must greet patients. It shows their significant role in the communication. As indicated in the graph above, almost all medical doctors practice greeting socially. Due to heavy workload, the patients we interviewed expressed concerns that some medical doctors show lack of interest. However, almost all doctors confirmed that they show interest in the patient's ideas about their health. During the observation of medical consultations, it can be noticed that doctors allocate little time with patients who are not in a very critical situation. Patients also confirmed cases where wrong prescriptions were given due to the doctor's failure to understand the main health concerns of the patients. In some cases, some drugs were commonly prescribed for all types of illnesses. As indicated above, however, almost all medical doctors devoted their time to understand the main health concerns of patients.

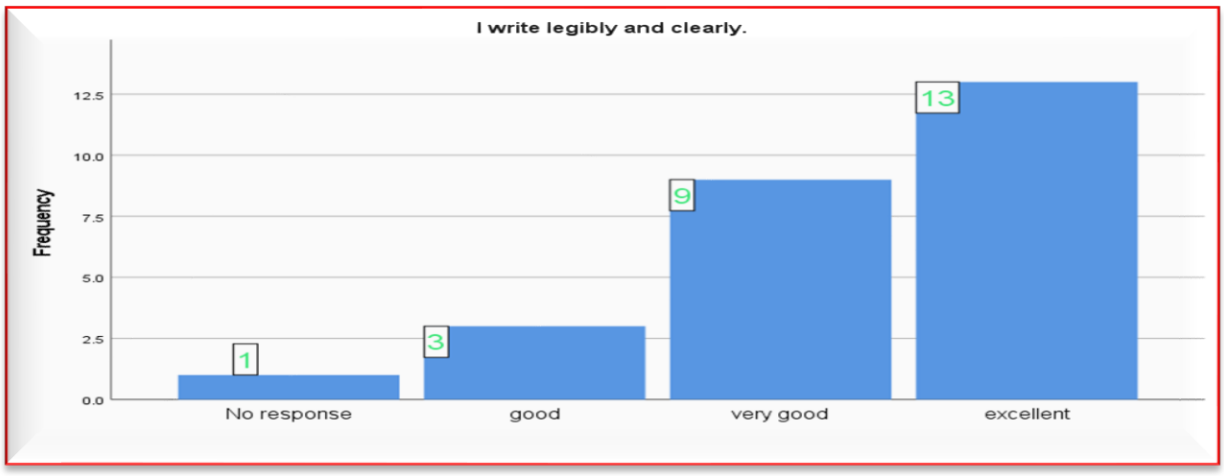
Fig 8: Intrrupting patients



A study found out that physicians interrupted patients after a median of only 11 seconds and that patients who were not interrupted only spoke for a median of six seconds (Phillips, Ospina & Montori, 2019). Those patients from the rural communities were often interrupted because they do not talk about their illnesses openly. They are indirect. Expressions such as "*Something is piercing me! It is going to kill me! Something is moving up and down inside my stomach! Something is making me unconscious! Something is upsetting me inside out and the like*.'' The doctor then intervenes and begins physical examination without much consultation or questioning though many assumed that patients are not interrupted as in the table above. Factors such asavoiding medical jargon, recounting the next steps, giving much care and concern, apportioning sufficient time, and writing legibly have been considered as major elements of effective medical communication.

Patients often tell that doctors writing looks like "chicken scratch/feed," it might not be legible, except to other chickens. In many cases, the doctor's handwriting can be read and understood by a pharmacist. Only the pharmacist could explain the prescription to the patient though doctors claim they are writing legibly as in the diagram below:

Fig 9: Writing Legibly

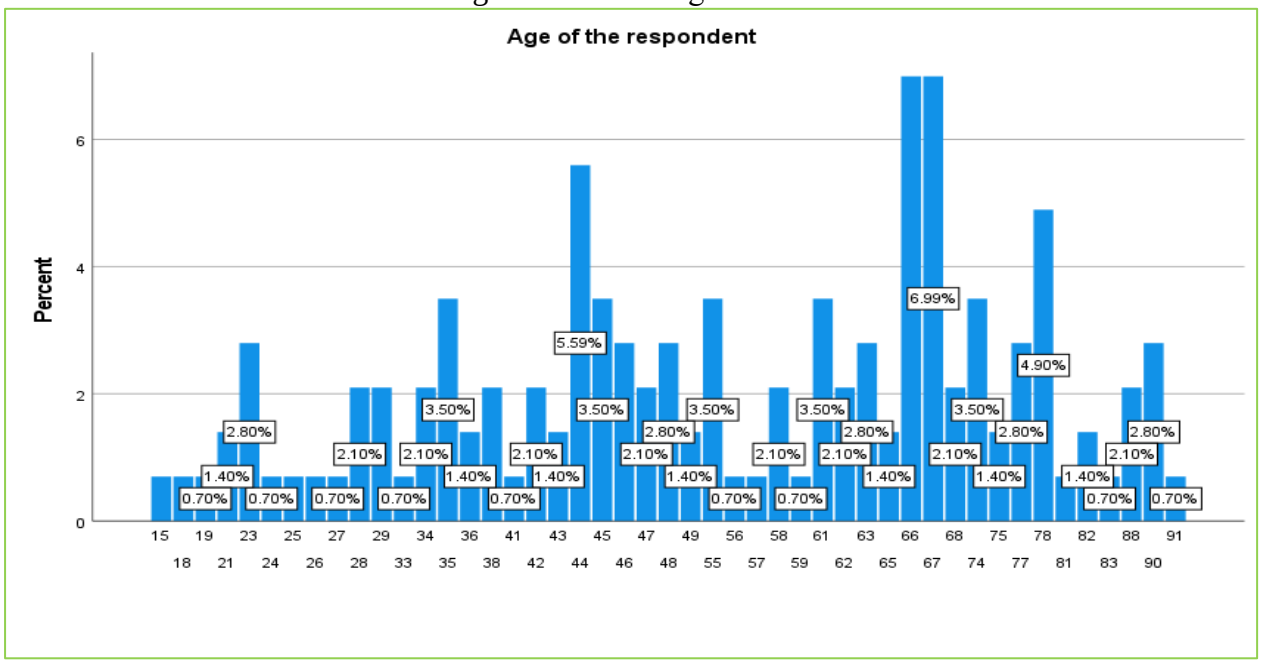


3.3.Patients' Demographic Data

Charon (2007) argues that **SOCIETY** "arises in social interaction; it continues through social interaction; it ends without social interaction" (p.157). From the symbolic interaction perspective, the essence of a society is the interaction and communication of individuals through symbols. Typical qualities associated with being a society include embedded patterns, relationships, and roles; diverse people linked together in joint activities over space and time; and people who interact in small social networks that exist and interact with a larger social structure. "Society, then, is individuals interacting over time: acting with one another in mind, adjusting their acts to one another as they go along, symbolically communicating and interpreting one another's acts" (p.158). In line with the argument above, this study targeted 144 samples selected from 231 bed-ridden patients who were getting bed services at AHMC wards: surgery, internal medicine, pediatrics, gynecology/obstetrics, and ophthalmology departments during the study period. Those patients who were critically ill, emergency cases and under aged children, who were not attended by their

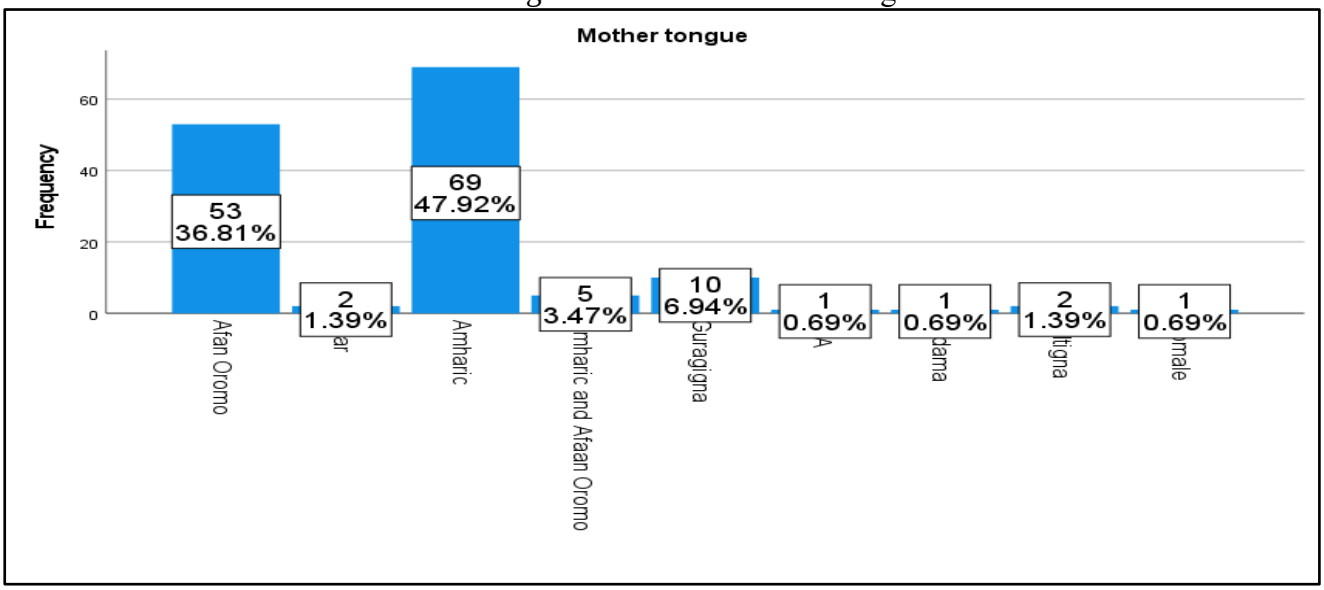
parents or custodians were excluded from the study. In all cases, we followed a systematic random sampling procedure, as the list of patients was readily available. Nurses working in these wards assisted administering and translating the questionnaire. As indicated in the graph below, the maximum age was 91 as opposed to the doctors' age : 41 and the minimum was 15 (the doctors was 24). Culturally, as many of the patients are elderly, they need to be greeted with respect and need more time to explain their medical situations. Elderly patients might even expect the doctor to rise up and extend the handshake first. They might express their ailment using cultural expressions such as "tebesekegn/piercing me", "wegagn/penetrating me" and "nedagn/ with running diarrhea" which might confuse the youngest medical doctor. Therefore, the link between age and medical communication requires further study and consultations.

Fig 10: Patients'Age



As indicated in the previous section, most of the medical doctors 14 (53.85%) can speak Amharic as their mother tongue and 9 (34.62%) speak Afan Oromo and the remaining 3 speak other indigenous languages in the context of bed ridden population of 36.81% (53)b % speaking Afan Oromo and 47.92 % (69) Amharic and the remaining group of patients could speak other local languages. There were several cases where the patient could not understand neither English nor Amharic and the doctor was required to ask for a translator. Language difference has been a critical problem and caused confusions and misunderstands. Piling up the problem, the doctors wrote all prescriptions only in English.

Fig 11: Patients' Mother Tongue



Within the contecxt of the present study, as expressed in the previous section, it has been really gripping to establish a strong or weak link between ethniciy, religion and gender with medical communication in this hospital setting. Does the patients ethic background influence medical communication at all? Does the patients relious background or gender influnce his/ her cultural or communicative comptence at all? The charts below are presnted so that the idea might ignite other researchers for further studies.

Fig 12: Patenits' Ethnicity

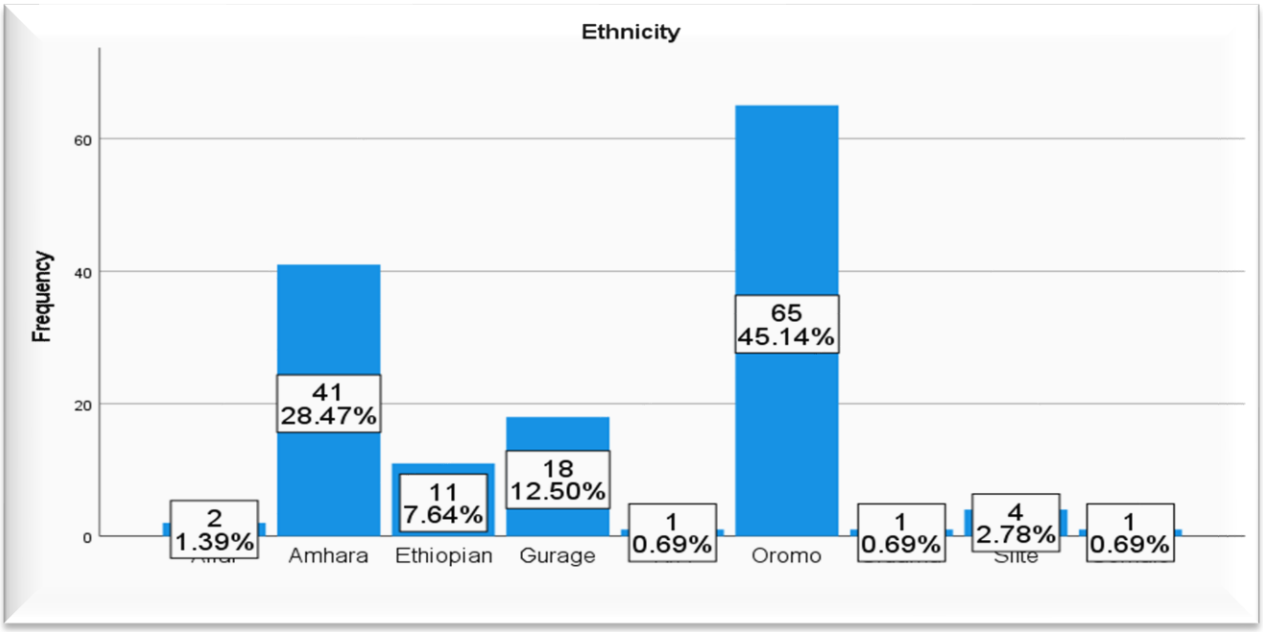


Fig 13: Patenits' Religion

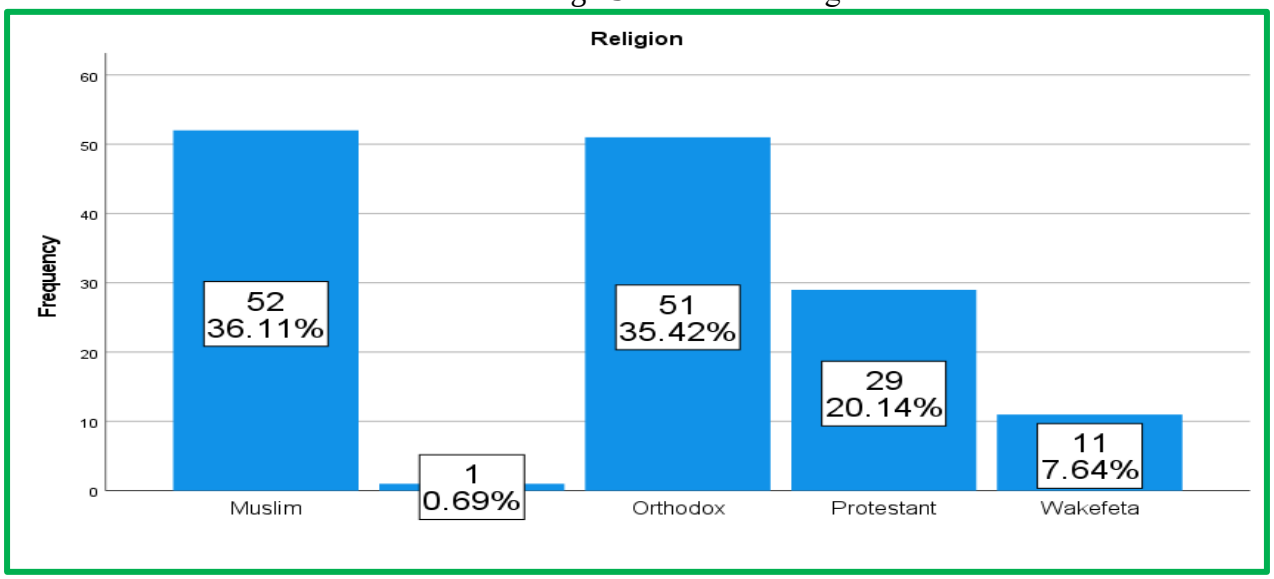
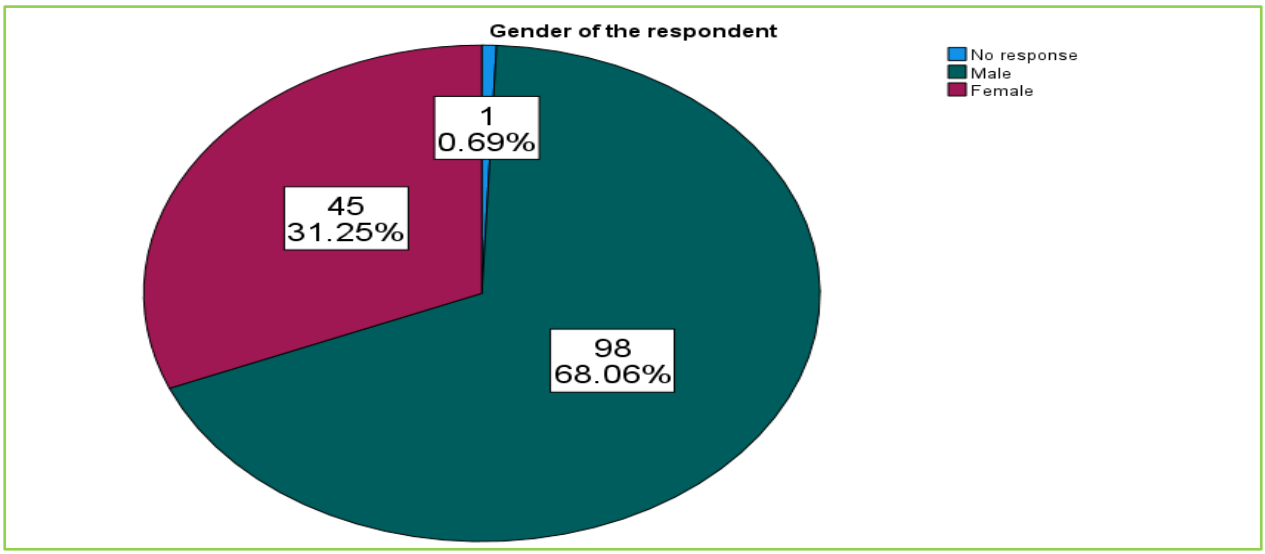


Fig 14: Gender



Most patients (nearly 80%) of Adama Hospital live in nearby towns like Modjo, Welenchiti, Metehara and Minjar. Only 20.83% came from Adama. As can be seen in the graph below, patients do not stay in the hospital too long.

3.4. Patients Evaluation of Doctors' Communication

Traditionally, the elderly patients expect doctors to greet them politely and treat them with due respect. Some patients may not even take a seat without getting the doctors' permission. While the doctor is visiting a bedridden patient (in many cases accompanied by nurses and medical interns), the doctor is expected to greet and not shake hands as the patient is lying on bed. In many observations, doctors open conversations with neutral topics: food, appetite, sleeping situation, and bedroom comfort even before consulting the medical problem. The table below summarizes

the responses from the inpatients who took part in this study. In many of the questions, patients assessed the doctors' communication competence as very low as opposed to the doctors' self-assessment presented under Table 2 above.

Table-2: Patents' CAT Summary Table

Descriptive Statistics		
Communication Item	Mean	Std. Deviation
1. The doctor greets patients in a way that made them feel comfortable.	4.76	.570
2. The doctor treats patients with respect.	2.43	1.244
3. The doctor shows interest in patient's ideas about their health.	2.42	1.054
4. The doctor understands the main health concerns of patients.	3.20	.632
5. The doctor pays attention to patients (look at them, listen carefully).	2.84	.951
6. The doctor lets patients talk without interruptions.	2.13	.977
7. The doctor gives patients as much information as they want.	2.28	1.138
8. The doctor talks in terms the patients could understand.	2.27	.617
9. The doctor checks to be sure the patient understand everything.	3.71	.657
10. The doctor encourages patients to ask questions.	2.72	1.112
11. The doctor involves patients in decision as much as they want.	1.93	.763
12. The doctor discusses next steps, including any follow-up plans.	3.65	1.066
13. The doctor shows care and concern.	2.72	1.138
14. The doctor spent the right amount of time with patients.	1.74	.916
15. The doctor writes legibly and clearly.	2.09	1.121

The CAT summary Table-2 above presents a different perspective to the doctor patient communication problems. Under Table-1, medical doctors evaluated their own communication comptence very high as opposed to the pateints evalution of medical doctors. As can be seen from this table above and the graphs below, doctors were evaluated poorly for involving patients in decision making as much as the patients want, allocating the right amount of time with patients and writing legibly.

Fig 15: **The doctors' involvement of patients in decision making**

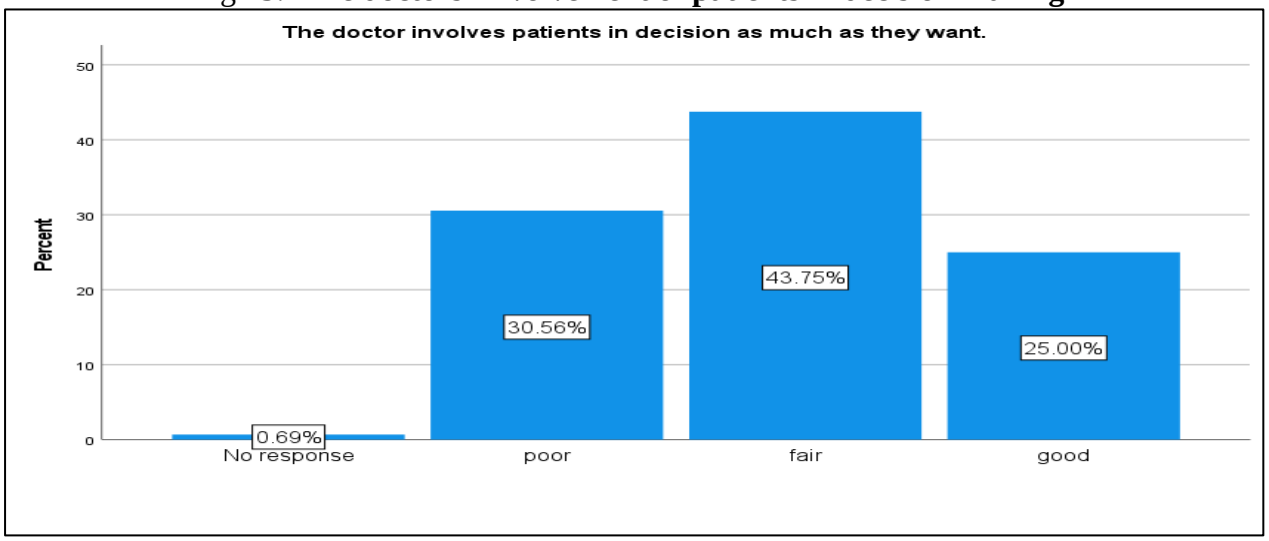


Fig 16: Allocating Sufficient Time

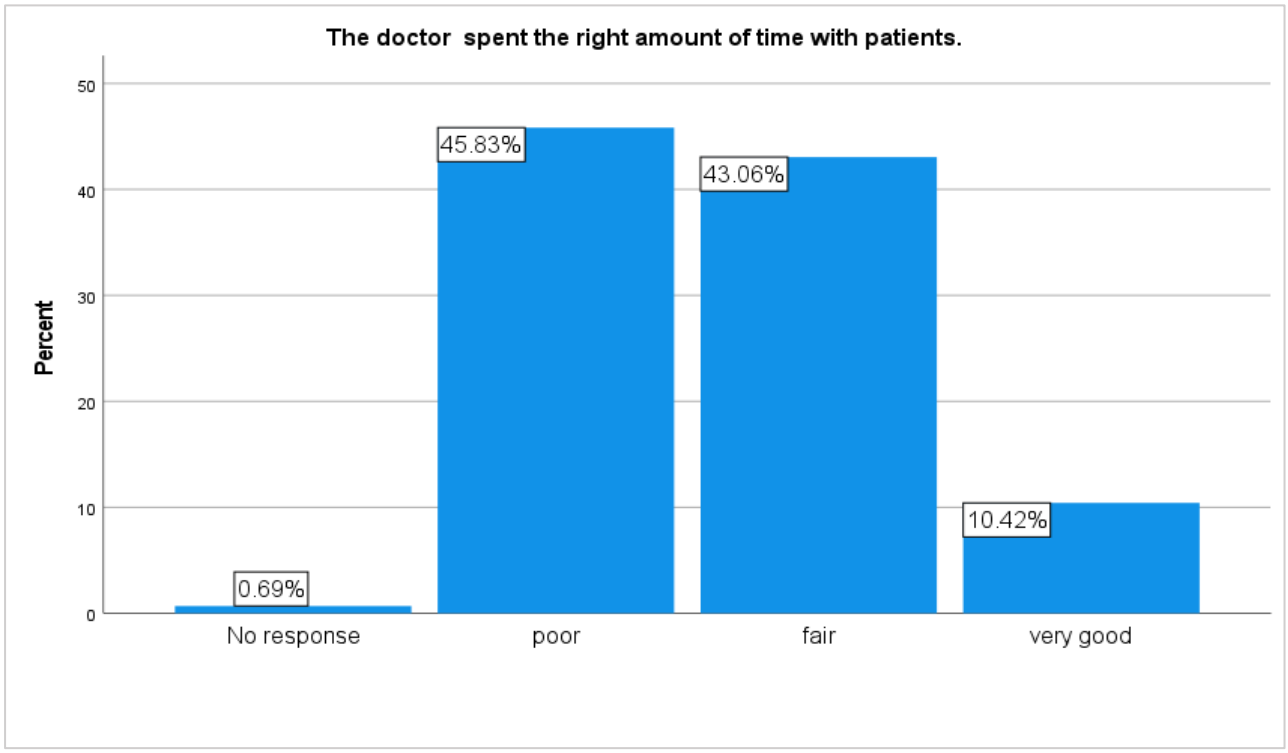
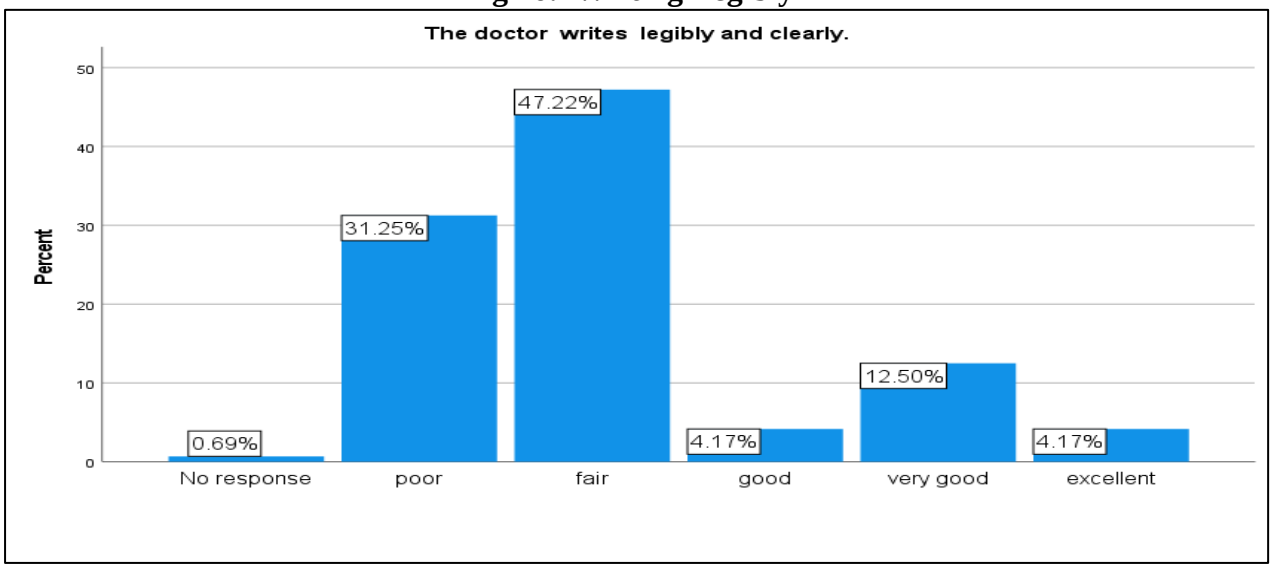


Fig 16: Writing Legibly



However, as indicated in the graph below, almost all medical doctors practice greeting socially. It is seen as treating a patient with due respect as presented in the graph below:

Fig 18: Greeting Bedridden Patients

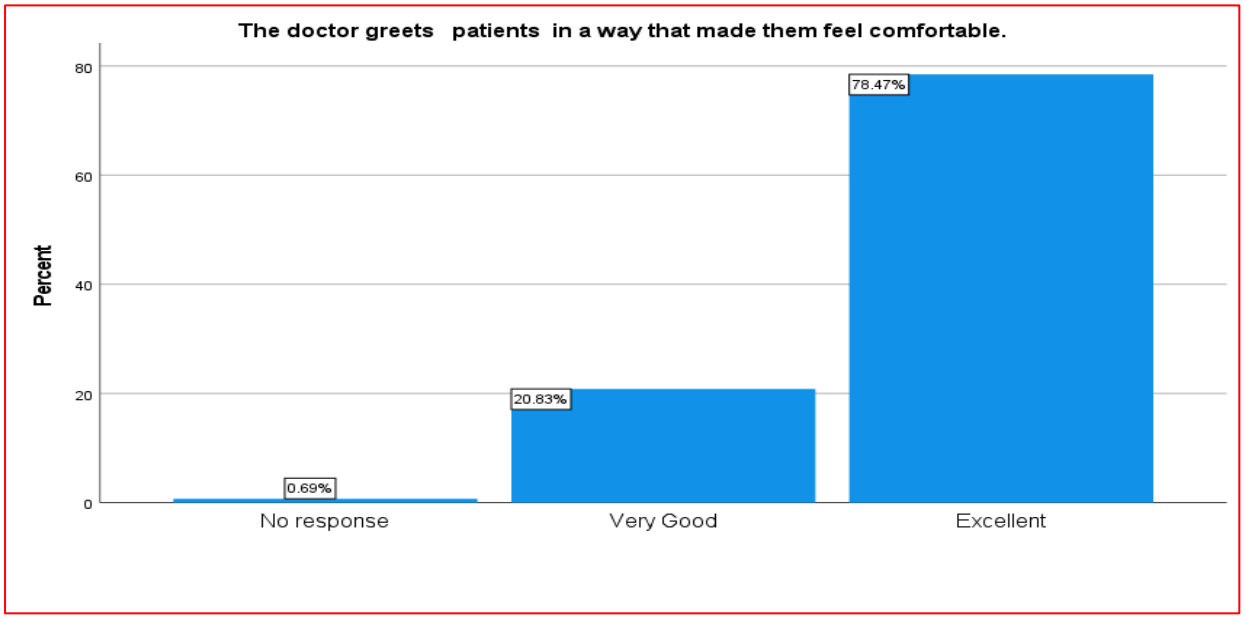
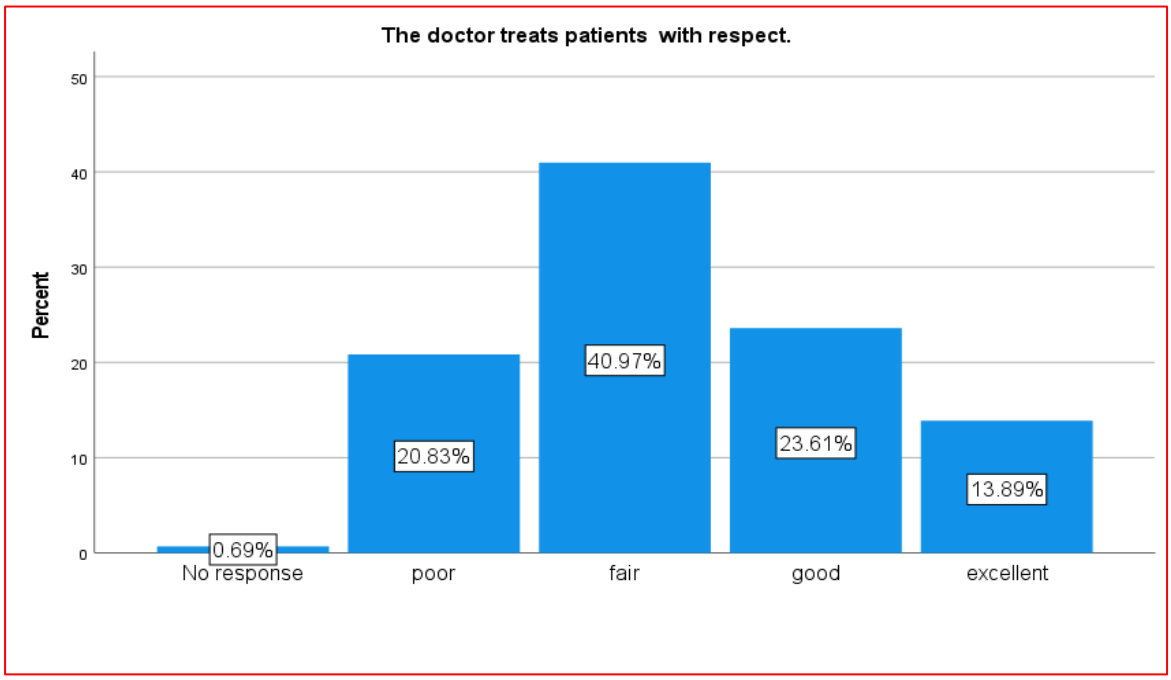
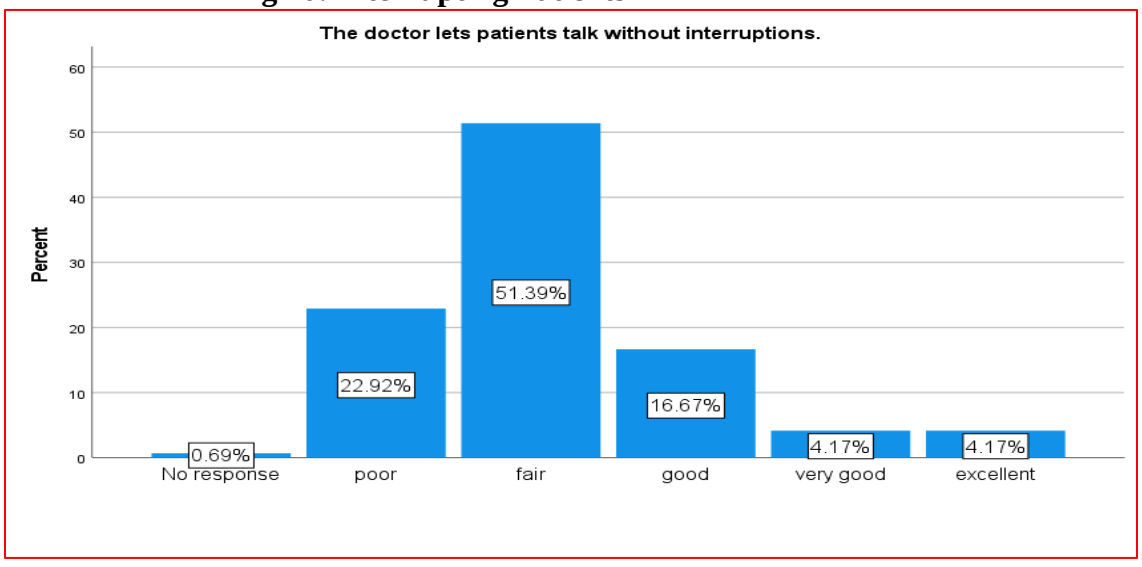


Fig 19: Respecting Patients



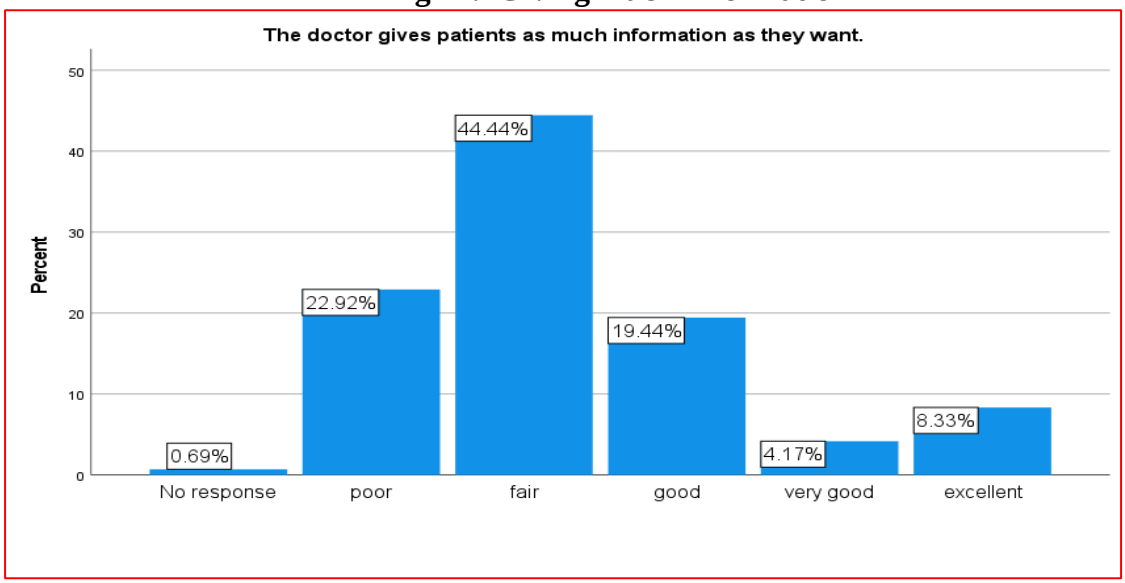
While observing medical consultations and bedroom visits, we noticed that doctors allocate little time with patients who are not in a very critical situation. Patients also confirmed that wrong prescriptions are given due to the doctor's failure to understand the main health concerns of the patients. In some cases, some drugs are commonly prescribed for all types of illnesses. However, in the three factors (showing interest, understanding, and giving attention), doctors have been evaluated good. It has been argued that those patients from the rural communities were often interrupted because they talk about their illnesses in indirect terms. They are indirect. Expressions such as "Something is piercing me! It is going to kill me! Something is moving up and down inside of my stomach! Something is making me unconscious! Something is upsetting me inside out and the like. Patients are often interrupted and given less information about their ailment.

Fig 20: Interrupting Patients



Factors such as avoiding medical jargon, recounting the next steps, giving much care and concern, apportioning sufficient time, and writing legibly have been considered as major elements of effective medical communication. Below is the feedback from patients:

Fig 21: Giving much Information



All in all, as indicated in the analysis section above due to heavy workload, the patients expressed concerns that some medical doctors show lack of interest. However, almost all doctors confirmed that they show interest in the patient's ideas about their health. Generally, doctors allocated little time with patients who were not in a very critical situation. Patients also confirmed that wrong prescriptions were given due to the doctor's failure to understand the main health concerns of the patients. Almost all medical doctors devoted their time to understand the main health concerns of patients and gave much attention. Those patients from the rural communities were often interrupted because they did not talk about their illnesses openly. They used traditional and vague expressions. Factors such as avoiding medical jargon, recounting the next steps, giving much care and concern, apportioning sufficient time, and writing legibly have been considered as major elements of effective medical communication. In many cases, the doctor's handwriting could be read and understood by a pharmacist. Only the pharmacist could explain the prescription to the patient though doctors claim they are writing legibly.

3.5.Barriers to Doctor-Patient Communication

3.5.1. Conversations and Observations

With the objective of identifying the barriers to doctor patient communication and observing the interactions between doctors and patients, 12 bed-ridden patients and six (6) medical doctors were purposely selected. Following a purposive sampling procedure, during 5 December 2019 until 15 January 2020, six (6) medical doctors were approached for observations while they were visiting and consulting patients in surgery, internal medicine, pediatrics, gynecology/obstetrics, and ophthalmology wards. Some of the interactions were very brief and eluded from the study. The intention was to record a minimum of two effective conversations between doctors and patients and identify possible barriers. Conversations which took more than 30 minutes were recoded

following the consents of the doctor and patient. These doctors and patients already completed the questionnaire and knew about the research objectives of the study. Immediately after recoding each interaction, we continued an interview (6 interviews) with each medical doctor for about 30 minutes and later with each patient. On the other side, as patients had sufficient time, we had conducted interviews with 14 patients with a minimum of one hour each. In each ward, we managed to interview two patients. If more than three respondents raise the same barrier again and again, the barrier was recorded and thematized. The following is a summary of data from open ended questionnaire, interviews, and observations:

3.5.2. Communication Barriers

Medical doctors were asked to list down most critical barriers they have encountered while communicating with patients. If more than three doctors raise the same barrier again and again, the barrier was recorded and thematized. Here is the list:

1. Because of poor communication skills, patients spend too much time explaining irrelevant details of their illness. Some assumed that the doctors were treating only one patient per day. Shortage of time was the most critical problem.
2. Culturally, some forms of critical illness (such as Gonorrhoea, Syphilis and HIV/AIDS) are too confidential and private to discuss even with another medical doctor or a nurse. Persistently, the patients demand that doctors should not discuss the illness with none though medical treatment requires team effort.
3. Giving clear information in a jargon free language in a manner that the patient understands is another recurrent problem. There are certain medical terms which cannot be easily translated. Secondly, lack of giving full attention to what the physician is telling, lack of trust and discontinuing follow ups are other challenges.
4. Lack of time due to high patient load is a huge challenge. Lack of isolated, private space to deal with patients are also critical problems.
5. Language barrier among patients and doctors is a common problem. Miscommunication with attendants often creates barriers.
6. Poor understanding level of some patients and high flow of patient and shortage of time.
7. Some patients are arrogant and resist any form of prescription. Some insist that doctors must prescribe injection only (Merfe wugagn).
8. Poor educational level of patients but come to visit a doctor with multiple ideas with critical ailment. Some patients come to the hospital only when they are terminally ill and in a critical condition.
9. Many inpatients do not accept prescriptions while counselling them. Some wish to recover from a terminal illness in a day or two.
10. The number of patients should be limited. There is an overflow. The hospital beds are always full.
11. Inpatients lack expressing their problems clearly. Interference of attendants.
12. The number of inpatients needing for an x-ray even if it is not needed is very high.
13. Patient understanding and interference of their next of kins in the decision-making process. How do you allow a patient or the kin to deliver the final decision?
14. Critical shortage of time to engage in with in depth conversations with patients.
15. Repetition of the same medical message until the patient understands the main idea takes too much time.

16. Over dependence on test results than the decision of a medical practitioner.
17. Men fail to accompany their pregnant wives and created communication gaps.
18. In some cases, critically ill patients can be betrayed by relatives and could be abandoned creating huge communication gaps if the patients die.

3.5.3. **Communication Barriers from the Patients Perspectives**

When consulted, patients identified several barriers which impacted their communication with their medical doctors: Patents were asked to list down most critical barriers they have encountered while communicating with their doctors. If more than three patients raise the same or a similar barrier again and again, the barrier was recorded and thematized. Here is the list:

1. Some resident doctors do not give patients full attention to what the patient is telling due to critical shortage of time.
2. Doctors look tired due to heavy patient overload and lack of rest.
3. Due to scarcity of hospital space, there is less confidentiality in the bedroom while talking to your doctor. Other doctors, medical students, or nurses or even another bedridden patient keep listening about your personal pains.
4. Some technical and medical terms are difficult to understand. "The doctor keeps telling the nurse in a medical jargon. We would have appreciated if we had understood what he told the nurse," a patient complained.
5. The number of hospital beds should increase as there is an overflow.
6. Poor information services at the Information Desk causes poor communication between the patient and the medical doctor.
7. Some resident doctors are disrespectful, interrupt your conversations and address you like a small child.
8. Medical doctors must be trained to elicit relevant patient data while the patient is talking much, listen attentively and understand non-verbal communication.
9. As there is no person close to the patient in some cases to interpret and hence provide message in a simple plain language, patients do not follow up prescriptions.
10. Expand the OPP and examining places, so patients can communicate without fear. Increase the number of physicians, so that the health workers will not be overloaded and overworked.

All in all, from the perspectives of patients and medical doctors, the barriers are many and at times very complex. Some of these barriers have been caused due to poor communication skills, lack of a proper sense of confidentiality, misuse or inappropriate use of medical jargons, lack of spacious workspace, language difference, low level of understanding sickness, low level of education, inappropriate use of cultural expressions, poor time allocation, taking too much time due to unnecessary repetitions, the gap between substantive lab evidence versus oral evidence, lack of family partnership and responsibility.

3.6.Discussions

The current study has found out that almost all medical doctors in the hospital under study practice greetings socially and treat patients with due respect though some might lack medical communicative and cultural competencies. Due to heavy workload of medical doctors, some patients expressed concerns that medical doctors show lack of interest in what the patient says. However, almost all doctors confirmed that they show interest in the patient's ideas about their health. This study has also shown that many medical doctors lacked appropriate medical

communication skills. This finding agrees with Daniel and others (2011) who employed a cross sectional study in November 2009 at Tikur Anbessa Hospital. The medical practice at TASH shows the existence of palpable communication skill deficiency among all categories of physicians. The study recommends that physicians' deficiency in communication skills and its impact on health outcome should be addressed by health authorities. Further study by the scientific community is also recommended (passim). Lack of cultural competence has been a major problem and agrees with Witbeen and Woldemariam (2020).

Within the catchment of areas of AHMC and those patients from the rural communities were often interrupted because they did not talk about their illnesses openly. They spoke in traditional and vague expressions which can be understood within their cultures and localities. Similarly, Alemayehu1 and Teshome (2016) assessed the cultural competence of medical doctors at Jimma University Specialized Teaching Hospital. The study has found out that the health care services in the hospital are less in touch with cultural competence. Extending a similar argument, Betancourt et al, (2003) contended that "cultural competence in health care refers to understanding the importance of social and cultural influences on patients' health beliefs and behaviours; considering how these factors interact at multiple levels of the health care delivery system (e.g. at the level of structural processes of care or clinical decision-making); and devising interventions that take these issues into account to assure quality health care delivery to diverse patient populations" (p.297).

This current study identified communication barriers and their possible causes. Some of these barriers have been caused due to poor communication skills, lack of the proper sense of confidentiality, the misuse or inappropriate use of medical jargons, lack of spacious workspace, language difference, the patients' low level of understanding sickness, patients' low level of education, inappropriate use of cultural and vague expressions, poor time allocation, patients' taking too much time due to unnecessary repetitions, the gap between substantive lab evidence versus oral evidence and lack of family partnership and responsibility. This finding agrees with Sara et al (2013) who identified significant barriers of doctor-patient communication including limited time, the patients' distress, inadequate health culture and prior knowledge as well as poor communication skills of some clinicians.

Similarly, Kebede et al (2020) conducted an explorative qualitative study at the Oncology Department of the Tikur Anbessa (Black Lion) Specialized Teaching Hospital (TASH) in Addis Ababa, Ethiopia. A triangulation of data collection methods was used: 91 audio-recorded, semi-structured interviews and 21 video-recordings of authentic interactions during hospital rounds. They found out that workload and time pressure, in combination with restricted space for privacy, limited the possibilities for physicians to deliver detailed information and provide emotional support. Furthermore, patient literacy levels, reliance on traditional and religious treatments, the stigma of cancer, and a fatalistic attitude, resulted in delays in patients seeking care and participating in positive health behaviors, and, subsequently, often resulted in an unwillingness to openly discuss problems with physicians and adhere to treatment. The same study also argued that the paramount role of family in physician-patient communication in Ethiopia (pp.1--16).

In a similar vein, Kebede and etal (2020) identified several factors such as lack of privacy, managing language problems delivering bad news, decision making, illiteracy and cancer

awareness, traditional and religious treatments and stigmatization and fatalism as affecting communication. The research detailed that workload and time pressure, restricted space for privacy, limited the possibilities for physicians to deliver detailed information and provide emotional support as main barriers. As stated by Enyew and Woldemariam (2017,p.1), the communication skills of doctors and researchers of the college can be enhanced through "various active channels (face to face interactions, printed materials, internet, mass media) using communication tactics, seminars, coaching or consultation, tool kits, newsletters, Web sites, newsletters, press release, best practice guides, leaflets, brochures, posters, interactive CD or DVD."

4.1.**Conclusions**

Following social interactionism theoretical underpinning, this research has assumed that a human being must be understood as a social person. It is the constant search for meaningful social interaction that leads us to do what we do. Instead of focusing on the individual and his or her personality, or on how the society or social situation causes human behavior, symbolic interactionism focuses on the activities that take place between actors; in this research between medical doctors (healthy roles) and patients (assuming the sick role). It is after the interactions that patients assume healthy roles again and function properly to assume social roles. Individuals are created through interactions; society too is created through social interaction. What we do depends on interaction with others earlier in our lifetimes and it depends on our interaction right now. Social interaction is central to what we do. Similarly, in a medical communication situation, the patient assumes the sick role (seeking help) and the doctor the roles of a healthy person (giving help). In all situations within the study period, medical doctors have been described as healthy social beings and committed for giving medical support. Factors such as greeting the patient, treating the patent with due respect, showing much interest, understanding the patient, paying much attention, giving the right type of information, expounding information, recounting the next steps, giving much care and concern, apportioning sufficient time, and writing legibly have been considered as major elements of effective medical communication. Society plays with these factors. The following conclusions can be made:

- Almost all medical doctors practice greeting socially and treat patients with due respect.
- Due to heavy workload, the patients expressed concerns that some medical doctors show lack of interest. However, almost all doctors confirmed that they show interest in the patient's ideas about their health.
- Generally, doctors allocated little time with patients who were not in a very critical situation. Patients also confirmed that wrong prescriptions were given due to the doctor's failure to understand the main health concerns of the patients. Almost all medical doctors devoted their time to understand the main health concerns of patients and gave much attention.
- Those patients from the rural communities were often interrupted because they did not talk about their illnesses openly. They used traditional and vague expressions and indicated that medical doctors lacked cultural communicative competence. In some cases, language has been a barrier as many could speak only Oromiffa.

- Factors such as avoiding medical jargon, recounting the next steps, giving much care and concern, apportioning sufficient time, and writing legibly have been considered as major elements of effective medical communication.
- In many cases, the doctor's handwriting could be read and understood by a pharmacist. Only the pharmacist could explain the prescription to the patient though doctors claim they are writing legibly.

In many Ethiopian traditions, the elderly patients expect doctors to greet them politely and treat them with huge respect. Some patients may not even take a seat without getting the doctors' permission. In many observations, doctors opened conversations with neutral and societal topics: food, appetite, sleeping situation, family affairs and bedroom comfort even before consulting the medical problem. In line with the second objective, the following conclusions can be made:

- After observing medical consultations and bedroom visits, it can be concluded that doctors allocate much time with patients who are in a very critical situation. In the three factors (showing interest, understanding, and giving attention), doctors have been evaluated good.
- Patients confirmed that almost all medical doctors practice greeting socially.
- Some patients were indirect. Expressions such as "Something is piercing me! It is going to kill me! Something is moving up and down inside of my stomach! Something is making me unconscious! Something is upsetting me inside out and the like. Patients were often interrupted and given less information about their ailment.
- Factors such as avoiding medical jargon, recounting the next steps, giving much care and concern, apportioning sufficient time, and writing legibly have been considered as major elements of effective medical communication.

It can be concluded that the following factors were barriers hindering the efficacy of doctor patient communication.

- Communication Skill: Because of poor communication skills, patients spend too much time explaining irrelevant details of their illness.
- Confidentiality: Culturally, some forms of critical illness (such as Gonorrhoea, Syphilis and HIV/AIDS) are too confidential to discuss even with another medical doctor or a nurse. Persistently, the patient demands that I should not discuss the illness with no one though medical treatment requires team effort. There was a critical lack of space too.
- Medical Jargon: Giving clear information in a jargon free language in a manner that the patient understands is another problem.
- Workspace: Lack of isolated, private space to deal with patients is also a critical problem.
- Language Difference: Language barrier among patients and doctor. Miscommunication with attendants.
- Level of Understanding Sickness: Poor understanding level of some patients and high flow of patient (shortage of time).
- Level of Education: Poor educational level of patients but come to visit a doctor with multiple ideas with critical ailment.
- Cultural Expressions: Inpatients lack expressing their problems clearly. Some use cultural expressions which are vague. Interference of attendants.
- Time Allocation: Critical shortage of time to engage in with in depth conversations with patients.

- Repetition: Repetition of the same medical message until the patient understands the main idea takes too much time.
- Substantive Lab Evidence versus Oral Evidence: Over dependence on test results than the decision of a medical practitioner.
- Family Partnership and Responsibility: Men fail to accompany their pregnant wives and created communications gaps.

4.2.**Recommendations**

The researchers submit the following recommendations as feasible and practical:

- The efficacy of doctor patient medical communication relies heavily on communication skill, confidentiality, the use of medical jargon, workspace, language difference, level of understanding sickness, level of education, cultural expressions, time allocation, repetition, substantive lab evidence vs oral evidence, family partnership and responsibility. This research strongly recommends further research to determine the link between these factors and medical communication in a hospital setting.
- This research was conducted in a public hospital setting in Adama. To share the best practices and transfer technologies, similar type of research can be conducted in a private hospital setting in Adama or in other major cities in Ethiopia.
  - Some patients might use no-verbal communication to express their pain and therefore doctors might need a short-term training on nonverbal communication.
  - Doctors might be given further on the job training on the significance of cultural competence and medial communication. Some patients might be vague and use traditional expressions.
  - There might be a person close to the inpatient patient, who can interpret and hence provide messages in a plain local language and make sure that the patient does not miss the follow up and prescriptions.
- Expanding the OPD and examining places, so patients can communicate without fear. Increase the number of physicians, so that the health workers will not be overloaded. The relevance of confidentially within the culture might be explained to new medical doctors.
- A regular orientation program might be organized for patients on how communication matters to proper health care.
- Through the use of modern technology and the Internet, the hospital can be transformed into to a high-tech referral hospital and decrease the patient inflow and enhance the quality of medical communication and treatment.
- To reduce the language difference between medical doctors and patients, some translators of major languages can be recruited and assist medical doctors who cannot speak the patients' language or allow in patients to bring a translator.

The present study has followed interactionist theoretical framework to investigate doctor patients interaction. The efficacy of doctor patient medical communication relies heavily on communication skill, confidentiality, the use of medical jargon, workspace, language difference, level of understanding sickness, level of education, cultural expressions, time allocation, repetition, substantive lab evidence vs oral evidence, family partnership and responsibility. This research strongly recommends further research to determine the link between these factors and medical communication in a hospital setting.

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