An Evaluation Of Doctor-Patient Communication: A Case Study Of Meridian Medical
Clinic At The Nation Centre In Nairobi

by

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AN EVALUATION OF DOCTOR-PATIENT COMMUNICATION: A CASE STUDY OF MERIDIAN MEDICAL CLINIC AT THE NATION CENTRE IN NAIROBI

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In accordance with Daystar University policies, this thesis is accepted in partial

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ii

AN EVALUATION OF DOCTOR-PATIENT COMMUNICATION: A CASE
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NAIROBI

I declare that this thesis is my original work and has not been submitted to any

other college or university for academic credit

Signed: _____   Date: _____
            Jedida Ochuodho

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iii

it. I also appreciate that you understood when at times, Mummy had to neglect some stuff. I promise to make it up to you.

I pay special tribute to my late parents, Dr. Wasonga and Mama Grace who instilled the virtue of hard work in me. Not a day goes by that my soul does not miss you. You have a special place in my heart and I hope your spirits can look down today, and yet again be proud of me. As the cliché goes "those we love never die because love lives eternally in our hearts".

To my dear friends, Ruth and Moses; you taught me that one never grows old, only better. You pushed me on when I felt like giving up. I cannot forget Steve Yuri Sakwa, my very efficient research assistant. Be blessed. Thanks to my special friend and niece Dr. Daisy Odundo. Your great study tips saved a mature student's sanity.

Finally, I want to thank all who contributed in whatever way towards the completion of this project, Asanteni sana na mubarikiwe.

v

ABBREVIATIONS

CATS	Consultation Analysis by Triggers and Symptoms
HIV	Human Immunodeficiency Virus
IPC	Interpersonal Communication
KNH	Kenyatta National Hospital
MMC	Meridian Medical Centre
SMS	Short Message Service
SSPS	Statistical Package for Social Sciences
SPT	Social Penetration Theory
STI	Sexually Transmitted Infection
URT	Uncertainty Reduction Theory
UTI	Urinary Tract Infection
WHO	World Health Organization

vi

TABLE OF CONTENTS

ix

x

xi

LIST OF TABLES

LIST OF FIGURES

xiii

ABSTRACT

In Kenya, cases of patients accusing medical practitioners of negligence resulting in damage to health or even death are on the rise. These complaints are not necessarily due to professional incompetence but some result from improper diagnosis or incorrect adherence to prescribed treatment due to ineffective communication.

This study comprised three research objectives. The first objective was to evaluate factors that affected doctor-patient communication. The second objective was to determine barriers to effective doctor-patient communication and the third objective was to establish ways of improving doctor-patient communication. Uncertainty Reduction Theory (1975) and Social Penetration Theory (1973) were the theoretical basis of this research to evaluate doctor-patient communication.

The research used both qualitative and quantitative approaches to collect data that was analyzed to get findings. Questionnaires were administered to 200 patients. Subsequently, in-depth interviews were conducted with four doctors and six patients. Secondary sources were also used to strengthen the research.

A content analysis of the transcribed interviews was performed while the responses from the questionnaires were analyzed using SPSS 17. Findings revealed that 89% of the patients were satisfied with the way the doctors communicated with them.

The major elements of communication the respondents highlighted were effective listening, trust, doctors' communication style and self-disclosure. A lot of factors such as use of jargon, differences in age, gender and culture and length of interaction also hindered effective communication. It was observed that doctor – patient communication can be improved by training doctors in communication skills and exploiting other channels of communication like online services.

DEDICATION

This work is

Lovingly dedicated to:

Gemma Ochuodho, My late baby who

"will never bear the burden of ill-health

And will remain forever young".

Fondly dedicated to:

All the patients battling the burden of disease;

I pray that in due course, you will understand it all.

and

All the doctors trying to help them win the battle;

Keep up the struggle, victory is in sight.

Specially dedicated to:

Rachel Rege.

You inspired me to conduct this study and encouraged me to complete it.

Thank you for affording me a chance to walk beside you on your very special journey.

Your experience has taught me fortitude and courage,

and to thank God in all circumstances.

Yes, I now look up to God more and do not fear death so much.

Rachel, In God's appointed time, you will overcome.

Nya Ngere, "this one's for you".

CHAPTER ONE: INTRODUCTION AND BACKGROUND TO THE STUDY

Communication is a complex process involving a multitude of variables that affect physician-patient interaction and impact on health outcomes (Sibille, Greene & Bush, 2010). It is intricately tied to the art of medicine and as the core of the doctor-patient relationship; communication forms the basis of all decisions and interventions proposed by medical practitioners (Beisecker & Beisecker, 1990).

The traditional consultation is a face to face interactive process between provider and patient in an examination room. This complex engagement is influenced by multifaceted variables (Nahon-Serfaty, Ahmed, Grosjean & Bonneville, 2009). For maximum benefit, all technical, environmental and human factors that serve as positive communication channels must be identified and used.

The needs of both patients and doctors are inextricably linked as both parties seek quality care. This complementary interaction demands that the doctor listens carefully to the kind of problem/need the patient has; while the patient also needs to listen to the explanation or advice given by the doctor so that they make the right decisions. Therefore, the first communication principle between the doctor and patient is that,

> communication should serve the patient's need to tell the story of his or her illness and the doctor needs to hear it. The telling of the story is the method by which the meaning of illness and the meaning of disease are integrated by both the doctor and the patient (Roter & Hall, 2006, p.6).

This telling of the story is therapeutic and provides cathartic release.

Effective doctor–patient communication is critical in determining the patient's medical outcomes for all kinds of ailments. It facilitates accurate diagnosis; appropriate counseling, gives therapeutic instructions and establishes caring

1

relationships with patients (Ha & Longenecker, 2010; Abdulahi, Shafaee, Freudenthal, Ostenson & Wahlstrom, 2007). Stilling, Jenkins and Fallowfield (2003) observed that good communication helps patients make informed choices, adhere to advice on treatment and accept life threatening conditions while deficiency in talk reduces accuracy in diagnosis (Roter & Hall, 2006).

Doctor-patient communication uses both verbal and nonverbal cues (Roter & Hall, 2006). Patients who "understand their doctors are more likely to acknowledge their health problems, understand their treatment options, modify their behavior accordingly and follow their medication schedule" (Traveline, Ruchinskas & D'Alonzo, 2005, p. 13). In fact, Sussman, William and Shelley (2010) said that simple communication strategies can overcome communication barriers and improve both the doctors' performance and the clinic experience for patients.

Patients with chronic medical conditions like cancer have especially high informational and emotional needs. They are anxious about their mortality, medical tests and the probable side effects of prescribed procedures. They also worry about both social and financial issues. Unfortunately, several doctors fail to recognize and cater for these needs because, though they are highly trained in medicine, their proficiency in the field of communication is insufficient (Butow, Brown, Cogar, Tattersall, & Dunn, 2002). Butow et al. quoted Meyer and Mark (1995) that a doctor's appropriate response to a patient's informational and emotional needs reduces the patient's distress.

Though many factors impact on the outcomes of doctor-patient interaction, communication is a very important one. Ineffective communication can lead to misunderstanding between the doctor and patient. Dissatisfaction with the doctors' interaction with their patients led to the establishment of the Morris Moses

2

Foundation to lobby for affordable healthcare for all. The founders felt that some

patients died due to doctors' negligence (www.morrismosesfoundation.org).

A study by Kim, Figueroa, Martin, Silva, Acosta, Hurtado, Richardson and

Kols (2002) found that consultations that focus on patient concerns, comfort and

needs are more satisfying than those that simply concentrate on diagnosis and

treatment of conditions. They contended that increased client participation

theoretically leads to improved outcomes because providers help clients choose the

best treatment and identify and correct clients' misunderstandings. Patients'

participation in decision making reduces unrealistic expectations and fosters

confidence in these decisions.

Despite many studies being conducted on doctor-patient communication,

(Price, Clark, Rogers, Garry & McKinley, 1993; Kattel, 2010), very few have been in

Africa and other parts of the developing world (Roter, Rosenbaum, Negri, Renaud,

Brown & Hernandez, 1998). One study on provider-patient interaction in Sub-Saharan

Africa concluded that interpersonal communication is vital to successful

communication (Labhardt, Schiess, Manga & Langewitz, 2008).

Labhardt et al. further contended that, although the benefit of interpersonal

communication in the medical visit is known, so far, no study has been conducted on

the direct relationship between communication during routine visits and patients'

knowledge about the disease and their health beliefs. In fact, most studies conducted

so far have concentrated on the technical aspects of communication while ignoring the

interpersonal dimension (Roter et al., 1998) which is widely acknowledged as a

crucial aspect of healthcare.

A further study in Cameroon by Labhardt, Cerruti, Foscher, Manga and Stoll

(2010) observed that training antenatal clinic workers in communication skills

3

subsequently led to positive health outcomes. This audit in primary healthcare revealed that when the physician had good communication skills, the patients asked more questions, aired their view freely and understood both the doctor's explanations and how to use prescribed drugs. Though this study was limited in scope, as it only dealt with pregnant women, the findings underscored the importance of interpersonal communication in doctor-patient interaction. Furthermore, doctors in Mfou, Cameroon, raised concern that many patients either did not comply with treatment recommendations or seek alternative treatment from traditional healers because they did not understand the diagnosis (Larbhardt et al., 2008). More research is however needed into the impact of various situational factors on these positive outcomes.

The Internet has changed the way people conduct business and gather information with Internet-literate patients increasingly turning to the World Wide Web for health care solutions. But, in spite of supplying health information to both doctors and patients, the Internet can antagonize the doctor and patient (Wilde, 2007). A cancer patient read on the Internet that the use of steroids could increase her body mass and subsequently she challenged her doctor why he had not offered her the treatment. When the doctor asked her whether steroids were really necessary in her condition, she got offended. Consequently, she accused him of denying her an intervention which an alternative source claimed was a necessary and beneficial intervention (Personal communication with the patient).

Moreover, the increased presence of medical information and support groups on the Internet leads physicians to query the significance of their role (Traveline et al., 2005). Younger patients, less than 65 years of age, are more critical and dissatisfied with aspects like communication of the diagnosis, treatment and side effects (Stilling et al., 2003). This has led to the rise of Internet services like "Ask a Doc" where one

sends questions online and gets feedback immediately (http://askadoc.co.ke).

Wilde (2007) added that the quality of readily available online information is debatable as unfortunately, not everything on the net is accurate. Furthermore, this extensive choice potentially creates a danger of self-medication. Use of over-the-counter drugs could result in proliferation of drug resistant strains of bacteria and viruses like the virulent tuberculosis strain which is difficult, long and very expensive to treat (Bartlett, 2006).

Evidently, many elements are involved in effective doctor-patient communication. To evaluate these elements, the research studied doctor-patient communication at the Meridian Medical Clinic (MMC) in Nation Centre.

<div align="center">Meridian Medical Centre</div>

Meridian Medical Centre (MMC) is a modern, fully equipped medical facility that provides outpatient services to organizations, institutions, families and individuals. It was founded in 1994 at Asili Cooperative House, Nairobi by Dr. Peter Wambugu who previously worked at the Kenyatta National Hospital (KNH). Dissatisfaction with the way some doctors interacted with patients prompted him to start a service using a more patient-centered approach (Personal communication with Dr. Wambugu on 8th October, 2010).

Due to steady growth from the onset, a second branch was opened in the year 2000 at the Norwich Union Towers. The two centers were later consolidated into the Nation Centre clinic. This is a one-stop outpatient general practice offering comprehensive clinical, medico-legal and pre-employment examination services to corporate and individual clients (www.meridianmedicalcentre.com).

A third clinic opened in August 2006 at Yaya Centre to cater for more up-

<div align="center">5</div>

market clients followed by the fourth in January 2007 at the Mall in Westlands. A year later, a clinic opened at the Caltex Business Centre in Donholm to serve the dense population in the area. Due to Donholm clinic's success, a sixth clinic was opened in Buruburu in August of the same year. Meridian then spread its wings to the densely populated Ongata Rongai area before going to the peri-urban regions with clinics opening in Thika and Kitengela (MMC, Public Relations Strategic Plan for 2008-2009).

In early 2010, MMC opened the Landmark clinic directly opposite Nairobi Hospital, Kenya's presumed premier medical institution, to attract patients disgruntled with the inordinately long wait at Nairobi Hospital. The tenth clinic opened at City Square clinic along Harambee Avenue and the eleventh MMC acquisition in late 2010 was the former Equator Hospital in Nairobi West. Known as Meridian Equator Hospital, this was the first in-patient and out-patient hospital run by Meridian. The latest clinic opened in May 2011 at the Al Imran Centre in Kisumu town (www.meridianmedicalcentre.com).

All the twelve centers are equipped with Electro Cardio Gram (ECG) units and advanced laboratory and x-ray equipment. The medical services are well supported by full-time doctors, well stocked pharmacies and dedicated medical and support staff. MMC struggles to surpass its competitors by managing its market share effectively. It distinguishes itself from other facilities by offering its clients increased accessibility, dependability and efficiency. The center seeks to provide high quality service lacking in other medical facilities and its vision is to be the leading provider of private healthcare in Kenya.

Using these strategies, the centre has been able to maintain and increase its overall turnover. It provides a patient-focused service where the doctors listen to

6

patients keenly and ensure they explain their diagnosis and treatment clearly. This is

in contrast to many other facilities where the doctors neither listen nor give patients

clear explanations (MMC, Public Relations Strategic Plan for 2008-2009).

Problem Statement

Ineffective communication can result in improper diagnosis or incorrect

adherence to prescribed treatment. This hinders positive medical outcomes desired by

both the doctor and the patient.

Butow et al. (2002) observed that failures in healthcare can result from

ineffective communication between the patient and the doctor and not from

insufficient technical aspects of medicine. Non-adherence either due to

misunderstanding of the physician's instructions or deliberate noncompliance could be

fatal. A physician prescribed "suppositories for a patient who proceeded to take them

orally" (Burgoon, Berger &Waldron, 2000, p.17). Since suppositories look like oral

tablets and the doctor was not explicit, the patient did not understand they were meant

to be inserted in the anal cavity.

Exposure to technology and globalization has also created more demands from

patients, who when dissatisfied with outcomes resulting from ineffective

communication, seek medical solutions from other sources like the Internet (Wilde,

2007). This is dangerous as not all information on the Web is accurate. Therefore, the

physician needs to confirm beyond reasonable doubt that the patient has fully

understood all the instructions and will subsequently comply with them fully.

Purpose of the Study

The purpose of this study was to evaluate the various elements of

communication used in the doctor-patient interaction at MMC.

Objectives of the Study

The study sought:

1. To evaluate the factors that affected doctor-patient communication.

2. To determine barriers to effective doctor-patient communication.

3. To establish ways of improving doctor-patient communication.

Research Questions

1. What factors influenced doctor-patient communication?

2. What led to lack of effective doctor-patient communication?

3. How could doctor-patient communication be improved?

Rationale of the Study

Delivery of effective healthcare in the Sub–Saharan Africa region is one of the priorities of the governments. However, its achievement remains elusive and consequently, many curable diseases still thrive in Africa causing thousands of unnecessary deaths, despite the outstanding milestones of modern medicine (London, 2002).

Over the last two years, in the course of spending considerable time with a friend battling cancer, the researcher's interest was piqued by the observation that not all hospital visits were the same. The researcher further realized that not all doctor-patient encounters produced similar health outcomes. Arising from these observations, the researcher sought to identify the elements that affected doctor-patient communication. The researcher further hoped that the study would contribute to significant improvement in doctor-patient communication and subsequently positive medical outcomes.

8

Significance of the Study

This study is of significance to medical institutions which are meant to offer treatment to sick people. Evaluation of doctor-patient interaction will give doctors insight into how to improve communication with their patients. The findings will guide MMC and the entire medical fraternity in Kenya in their quest for a high degree of service delivery as detailed in the Hippocratic Oath (Hsieh, 2010).

This study is also significant to corporate communication because it seeks to evaluate the effects of the different elements on IPC between the doctor and the patient. Corporate communication usually just focuses on communication between an organization and its publics.

Scope of the Study

This study focused on the communication patterns between doctors and adult patients at the MMC in Nation Centre. It excluded children visiting the facility since either the parents or care-givers participate in any substantive communication with the doctors on their behalf.

Limitations and Delimitations

1. Though MMC currently has eleven branches in diverse locations, only one clinic was studied. This limitation was tackled by studying the Nation Centre clinic which is both the biggest branch of MMC and is also located in the city centre hence boasting of a diverse clientele. The research therefore captured the core practices of MMC in relation to doctor–patient communication.

2. Although doctor-patient relationship and medical outcomes are influenced by several factors which would take a very long time to study, the research only focused on the communication-   related factors.

9

3. Organizations do not divulge their information easily. To overcome this obvious drawback, the researcher laid the objectives of the study on the table to both the doctors and patients in order to get 'free' entry from all the gatekeepers and elicit open discussion in order to access the needed information for this study.

4. The views and responses were based on the respondents' perception and so could be subjective. To overcome this, there was intense briefing before administration of any questionnaires or interview. The researcher succinctly explained to the respondents that the study was anonymous and for academic purposes only.

5. Most of the interviewees declined to be recorded. This was overcome by note taking and transcription of the notes immediately after the interview while the memory was still fresh.

Assumptions

This study assumed that:

1. MMC and their patients would grant permission for the administration of the research instruments and also avail other required documentation and information.

2. All the respondents would cooperate and answer the questions in the standardized questionnaire truthfully and objectively.

Definition of Terms

The *clinic encounter* is the meeting between the doctor and the patient (Tjornhoj-Thomsen, 2009). In this study, it referred to the face to face encounter between the doctor or other medical personnel and the patient for purposes of gathering

10

information, establishing a trusting relationship as well as offering health information and counseling.

Communication refers to any interaction which leads to sharing of information, ideas and feelings between people (Montana & Charnov, 2008). Communication uses various media of transmission like speaking, writing or using a common system of signs and behavior with the ultimate goal being to create understanding (Smith, 1992). In this study, communication referred to the two-way process of exchange of information between the doctor and the patient which would normally be face to face.

Effective doctor-patient communication is the active listening and conversations between people, while sharing messages and their meanings at the same time (Witzany, 2008). Consequently, there is a high likelihood of an individual understanding, accepting, conveying and implementing the message. In this study, it referred to the clarity of understanding between the patient and doctor with the interpretation of messages by the doctor/patient   being similar to the intended message sent by the patient/doctor.

Evaluation is the process of assessing or analyzing the value of something (Oxford Thesaurus of English, 2009). In this study, it referred to assessing the effects of different elements on doctor-patient communication.

Interpersonal communication refers to communication that is a "selective, systematic, unique, processual (is an ongoing process) transaction that allows people to reflect and build personal knowledge of one another and create shared meanings" (Wood, 2010, p. 19). In this study, it referred to the process of the doctor and patient communicating directly with each other.

A patient is a recipient of services to promote, maintain, monitor or restore health (Runciman, Hibbert, Thomson, Van der Scaaf, Sherman & Lewalle, 2009). In this

11

study, it meant a person seeking medical treatment for some ailment or just consulting the doctors with a view of making some decisions.

Positive medical outcomes are the extent to which a change in the patient's functioning or well-being meets his or her need or expectation (Ware, 1993). In this study, it referred to the situation where both the doctor and the patient attain their desired goal through the clinic encounter.

Treatment is the management and care of a patient to combat disease or disorder. It includes all methods of curing, minimizing or controlling the effects of, or preventing a disease, disorder or injury (Booker, 2008). In this study, it referred to the application of remedy or therapy to a patient to alleviate the symptoms of illness.

Summary

Chapter one provided the background to the study, problem statement, the purpose, objectives, rationale, significance, scope, limitations and delimitations to the study. The chapter outlined the importance of communication in the clinic encounter and how this interaction has changed in the recent past. The next chapter sets the theoretical basis for this study by reviewing relevant literature on doctor- patient communication.

12

CHAPTER TWO: LITERATURE REVIEW

Introduction

Communication forms the core of the doctor-patient interaction and healthcare delivery. The previous chapter examined the importance of effective doctor-patient communication in the outcomes of the clinic encounter and how this interaction has changed in the recent past. This chapter reviews literature on the various factors that affect doctor-patient communication. It introduces interpersonal communication theories and outlines how Uncertainty Reduction Theory and Social Penetration Theory can be applied to effective doctor-patient communication for positive medical outcomes.

Interpersonal Communication in the Medical Context

Effective communication is the two-way process whereby people share ideas, knowledge and feelings through transmission of symbolic messages. It is essential to social interaction and the building and maintenance of all relationships. The main purpose of communication is to deliver messages clearly so that both the sender and the receiver understand the information in the same way (Matin, Jandaghi, Karimi & Hamidizaden, 2010).

Communication occurs in a continuum ranging from impersonal to interpersonal. Wood (2010) referred to Buber's (1970) exposition of communication as outlined in Figure 1. At the lowest level, impersonal communication or I-it treats others as objects not individuals for example a doctor regarding a patient as an AIDS or cancer victim and not a person.

13

Impersonal		Interpersonal
It	You	
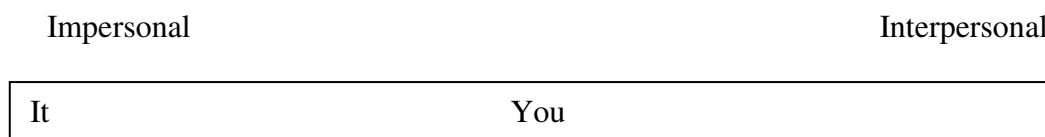
Figure 1: The Communication Continuum (Wood, 2010, p. 20).

Most interactions lie on the second level; I-you. Though communicators acknowledge each other as more than mere objects, they do not engage fully (Wood, 2010). For example, the doctor refers to the patient as a person but just dwells on the disease while ignoring all social or psychological concerns that also affect the patient. This denies the patient a chance to air their fears, concerns or ask for preferred treatment.

The final part of the continuum, I-thou, is the highest form of human dialogue where communicators affirm each other as whole, unique individuals. Due to mutual trust, they self-disclose and discard all guises (Stewart, 1986; quoted in Wood, 2010). They engage in "being"; revealing who they really are and how they really feel and not the usual "seeming" or preoccupation with image as in the preceding levels.

Therefore, interpersonal communication (IPC) is the "selective, systematic, unique, processual (is an ongoing process) transaction that allows people to reflect and build personal knowledge of one another and create shared meanings" (Wood, 2010, p. 19). It is not merely the process of sending and receiving messages, but involves negotiating meanings. The process is complicated by the communicators' expectations, attitudes, prejudice, history, values and beliefs, moods, likes and dislikes.

The transactional model of communication stresses both the dynamic nature of IPC and the multiple roles people assume during the communication process (Wood, 2010). Noise is perpetually present during the process of IPC and the concept of time

is paramount as messages, noise interferences and communicators' field of experience

vary at different points in time.
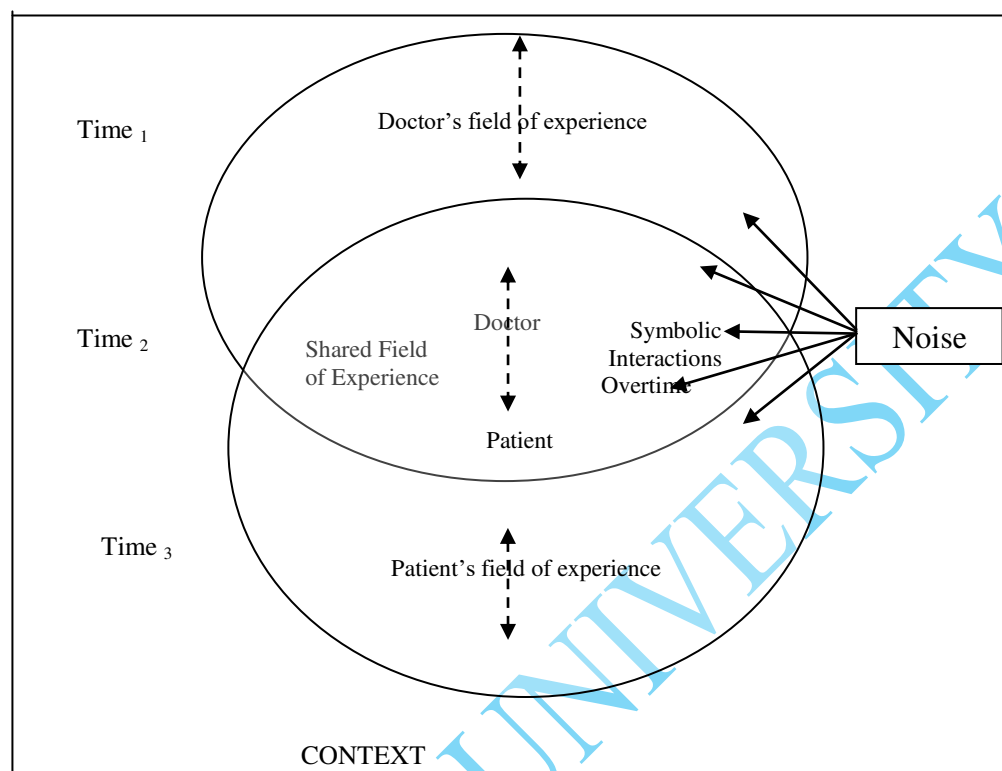
Figure 2: Doctor-patient transactional model of communication (Wood, 2010, p. 18).

Time in Figure 2 indicates that the doctor and patient's individual fields of

experience plus their shared field of experience vary over time. A shared field of

experience enables them to share meaning and have effective two-way

communication.

Wood (2010) contended that IPC between doctor and patients occur in

systems like age, language, culture, educational levels and other factors like the

presence of other people. This transactional model does not label any party as the

sender or receiver but both are deemed as co-communicators on an equal and

simultaneous basis.

Verbal and nonverbal communication channels afford individuals a lot of

15

potential information. The content, structure, message sequence as well as cues, gestures and facial expressions all contribute to IPC (Burgoon et al., 2000). Ha and Longenecker (2010) observed that in the doctor- patient interaction, the doctor is in a powerful position hence their verbal and nonverbal communication can either enhance or diminish the patient. However, effective communication creates good interpersonal relationships, facilitates information exchange and includes patients in decision making.

Elements of Effective Doctor-Patient Communication

Schiavo (2007) contended that effective doctor-patient communication has various elements. The elements are discussed below.

Environment

The exterior environment delivers a message about an organization's services and quality, even before the actual encounter. For the patient to be optimistic and relaxed, the clinic environment should have favorable and conducive physical amenities that encourage healing (Vellakkal, Juyal & Mehdi, 2010).

Research at the Muhimbili National Hospital, Dar es Salaam, by Muhondwa, Leshabari, Mwangu, Mbembati and Ezekiel (2008) observed that patient satisfaction was determined by the time spent waiting for treatment and the duration of the consultation. They concluded that for an overall satisfactory rating, patients need to be treated well at the entrance, reception and medical records even before they meet the doctors.

Other factors in the physical environment that affect the doctor-patient interaction include provision of privacy for undressing and examination, noise levels, colors used in the decor and provision of amenities like drinking water, reading

16

material and entertainment like television. Further research is however needed on the

impact of the various situational factors like self disclosure, trust and effective

listening.

<center>Self-disclosure</center>

Self-disclosure is the revealation of intimate details that the other person

would not normally know or discover (West & Turner, 2009). People tend to disclose

more freely to those they like while withholding from those they do not like (Berger

& Calabrese, 1975). Though risky and unpredictable as it makes the discloser

vulnerable, self-disclosure is vital in the current medical setup where data is obtained

from tests and self-report (West & Turner, 2009). The discloser normally hopes for

reciprocity as mutual self-disclosure creates trust between the communicators which

enhances patient reciprocity and continued treatment where necessary.

Champion (2007) contended that patient disclosure depends on gender

dynamics, patient overall concealment tendencies and the physician's verbal behavior.

He added that doctors can influence self-disclosure by use of open-ended questions,

display of concern and mode of salutation and farewell.

Lussier and Richard (2007) quoted Altman and Taylor (1973) that intimacy of

communication in a role-bound relationship like the doctor-patient one with less

reciprocity is affected more by contextual factors than in an egalitarian relationship.

Although the doctor self-discloses through his/her dress, speech, office décor and any

displayed family pictures, this disclosure should be done strategically since it could be

either beneficial or detrimental (Champion, 2007; Lussier & Richard, 2007).

When a doctor self-discloses similar things to a patient, he becomes less

attractive as he appears incompetent and inexperienced. Self-disclosure of different

things on the other hand, may also reduce attractiveness and breed negative feelings

<center>17</center>

(Patterson, nd). This situation worsens if the doctor crosses the line between professional and personal life as too much intimacy between the two can distort judgment and even lead to seduction (Lussier & Richard, 2007). Doctors should therefore mainly disclose social comparison data.

Conversely, self-concealment is the "predisposition to actively conceal from others personal information that one perceives as distressing or negative" (Larson & Chastain, 1990; cited in Champion, 2007, np). Champion added that self-concealment can affect the clinic encounter if the concealed information is vital for treatment. Palmieri & Stein (2009) contended that self-concealment exists on both sides of the doctor-patient dyad. While patients and their families usually hide crucial information, doctors also commonly lie by hiding bad news or concealing any medical errors.

Evidently, though self-disclosure is a vital element in doctor-patient communication, it must be exercised prudently as its careless use can totally ruin the interaction.

<div align="center">Trust</div>

Trust or feeling safe is vital for satisfactory progress of the doctor-patient interaction. Berrios-Rivera et al. (2006) said trust is associated with continuity of care, satisfaction with care, adherence to treatment and better health outcomes but lamented that very few studies have examined the effects of specific components of this interaction in the development of trust. Though patients have varied needs during hospital visits, most value trust and respect. They need to feel prioritized because sickness heightens vulnerability especially where the disease is severe, chronic or life threatening (Butow et al., 2002).

Patients with sexually transmitted diseases have a propensity to self-medicate

<div align="center">18</div>

due to fear of stigmatization by insensitive doctors (Gordon, Mosure, Lewis, Brown, McNagy & Schmid, 1993). This poses the danger of inadequate treatment and the consequent development of drug- resistant strains of viruses (Bartlett, 2006). The doctor must therefore strive to foster trust and relieve the patient's anxiety as trust also fosters self-disclosure.

<div align="center">Effective Listening</div>

Active listening is paying attention in a relaxed way and using both verbal and nonverbal cues. It encourages doctor-patient information exchange (Beck, Daughtridge & Sloane, 2002) leading to proper message delivery. Though patients have varied needs during hospital visits, most appreciate the doctor listening to them and explaining things candidly (Schiavo, 2007).

The doctor can listen actively by sitting on the edge of the chair in an open stance. Other active listening skills are nodding, using open-ended questions to elicit more disclosure, paraphrasing the patient's sentences for clarification, summarizing then offering an opinion (Beck et al., 2002). Though Beck et al. called for maintaining eye contact and avoiding interruptions, in the African context, it is considered disrespectful and aggressive to maintain direct eye contact with a person in higher authority like a doctor (Foster, 2002). Unfortunately, conflicting priorities and stringent managed-care requirements constrain doctors' listening style, making them interrupt and deny patients a chance to express their concerns (Schiavo, 2007).

<div align="center">Doctor Communication Styles</div>

The quality of communication between doctor and patient is vital for satisfactory medical outcomes for both parties (Levinson, Stiles, Inui & Engle, 1993). Poor communication interferes with provision of best medical care and causes personal distress. The doctor's ability to gather information for accurate diagnosis,

<div align="center">19</div>

appropriate counsel, therapeutic instructions and establishment of caring relationships

with patients is a core skill (Ha & Longenecker, 2010; Champion, 2007).

The doctor needs to build a relationship using open-ended questions, avoid

interruptions, and provide verbal encouragement and personal warmth to elicit candid

self-disclosure by the patient (Weiner, Barnet, Cheng & Daaleman, 2005). It was

found that:

> during the clinic encounter, physicians make nuanced
> choices regarding the words, questions, silences, tones
> and facial expressions he or she will use. These choices
> ultimately either enhance or detract from the overall
> level of excellence of the physician's delivery of care
> (Traveline et al., 2005, p. 14).

Doctors' communication styles range from doctor-centered to patient centered.

In doctor-centered or paternalistic approach, the patient abdicates all power to the

doctor; there is high doctor control, use of complex jargon and little regard for

biomedical topics (Bradley, Sparks & Nesdale, 2001). The opposite extreme is

patient-centered where the patients exercise their rights and view doctors as the hired

help (Bradley et al., 2001). In the middle of this spectrum is a participatory style

where the patients actively participate in making decisions related to their treatment

and care.

Patient-centered clinical care focuses on the patient and not only on disease

mechanisms and fragmented health care practices (Finset, 2011). It is "sharing bi-

directional information, deliberating upon a menu of relevant options and making a

decision" (Ruiz-Moral, 2009, p. 3). Patients prefer this style as it recognizes and

responds to the patient as a whole person and not a case (Mobeireek, Al-Kassim, Al-

Majid & Al-Shimemry, 1996). Consequently, it raises patient satisfaction and

adherence to regimen, health care utilization, less malpractice litigation and better

20

health outcomes.

Murtagh and Thorns (2006) found that in places like the United Kingdom, patient autonomy and choice is currently high. They stressed that patients must consent to all medical interventions to ensure their autonomy is protected and any discussions with relatives or friends need to match patients' expressed wishes.

Between the doctor-centered, participatory and patient-centered communication styles, the preferred style is the participatory one according to Bradley et al. (2009) and the patient's direct involvement cuts down on multiple consultations.

<p style="text-align:center">Barriers to Effective Doctor-Patient Communication</p>

Despite doctors' awareness of the benefits of effective communication, there is still room for improvement (Schiavo, 2007). This is because various factors can block this communication (Korsch, Gozzi, & Morris, 1968). Communication needs to be based on the specific context because "understanding the nature of these frustrations could reduce the frequency of their occurrences, improve clinical care and lead to enhanced physician satisfaction" (Levinson et al., 1993, p. 285).

Other barriers to effective doctor patient communication include lack of listening, vagueness, interruptions and the use of jargon. Others are lack of knowledge of the patients' world, insufficient consultation time and incentive to generate lots of money by seeing as many patients as possible (Weiner et al., 2005). These barriers can be from either the patient or the doctor and some of them are discussed in the following section.

<p style="text-align:center">Misunderstanding between Doctor and Patient</p>

Misunderstanding between the doctor and patient can have a negative impact on doctor-patient interaction. Misunderstanding can occur when the patient challenges

<p style="text-align:center">21</p>

the doctor by demanding procedures and treatments not offered to them or rejecting prescribed ones. The frustrated doctor, however, rarely discusses this phenomenon and it becomes 'the elephant in the room'; or something big that is however ignored or assumed not to be there (Wilde, 2007). Levinson et al. (1993) quoted Groves that unfortunately; "hateful patients" may miss the most appropriate care as sometimes doctors punish them subconsciously.

Culture

Culture is "a pattern of values, beliefs, ideas and symbols shared by a group of people" (Samover & Porter, 1991; cited in Nahon-Serfaty et al., 2009). Culture pervades and permeates all of human life. Moreover, studies highlight the need for sensitivity to cultural diversity during medical training (Tucker, Herman, Pedersen, Higley, Montrichard & Ivery, 2003).

Cultural differences between doctor and patient affects the clinic encounter due to differences in perspectives as variance in health-care beliefs and practices between the health-provider and the patient can hamper communication (Geist-Martin, Ray & Sharf, 2003; Nahon-Serfaty et al., 2009). For instance, some cultures forbid mentioning some body parts leading to the use of euphemisms which may not convey the intended meaning adequately. Nonetheless, more research is needed on patient-defined cultural effects on health-care since Tucker et al. (2003) lamented that the little done has only been from the doctor's view point.

Since culture plays a key role in the doctor-patient encounter, communication must be adjusted to cater for intercultural needs. All medical staff should be trained on cultural sensitivity as not only the doctor but even nurses or receptionists can offend the patients.

Gender

22

In Sub - Saharan Africa, defined gender roles seem to favor men over women. In doctor-patient communication, because women feel inhibited having to confide in male doctors, they resort to concealing their real complaint or problem and talk of general things that they deem less awkward (White, 1988).

Moreover, gender relational theory states that men and women relate differently to health, premised on gender scripts founded on their particular social structures or cultures (Lichtenstein, 2004). Studies conducted on gender and medical care found that the role of gender in desiring more participation varied and Lichtenstein established that because most men were unwilling to participate in health issues, they routinely concealed their health concerns to avoid doctor visits.

Similarly, studies showed that as patients, women seek more care and ask more questions than men (Arora & McHorney, 2000; Roter, Lipkin & Korsgaard, 1991). Because women disclose more emotional issues, they end up being given more information than men (Waitzen, 1985; cited in Champion, 2009). They also interact more with their physicians.

Because female doctors were found to take more time with their patients, they were deemed more satisfying than their male counterparts (Champion, 2007; Delgado, Lopez & Luna, 1993; Hall, Irish, Roter & Ehrlich, 1994). However, the effects of gender on doctor-patient communication are intricately bound to culture and communication styles.

Age and Educational Level

Patients' characteristics determine their level of participation in their health-care decisions. Though "preferences vary; younger, educated patients prefer more active roles" (Arora & McHorney, 2000, p. 335). This is because they have more exposure on which they base their decisions. With a more literate clientele, the doctor

23

has to be very keen and also keep abreast with all the latest developments. Discovery of any gap between the doctor's knowledge and what is elsewhere like the Internet, leads to considerable loss of faith in the doctor. This loss of faith affects trust which is a key component in full disclosure that promotes healing (Butow et al., 2002).

This scenario differs with older patients who stick to their familiar doctors and only change them involuntarily due to either relocation or a change in their insurance plans or financial situation. Such change frequently results in an unfortunate disruption or discontinuation of care (Mold, Fryer & Roberts, 2004). These older patients are also less willing to question their doctors (Roter & Hall, 2006).

The magnitude of the effects of age and educational levels are however mitigated by culture.

<div align="center">Language and Use of Jargon</div>

Schiavo (2007) noted that patients prefer simple and easily understood information as jargon and scientific terms impede effective communication and hamper clear understanding. He quoted Lukoschek, Fazzari and Marantz (2003) that educational levels and language barrier can lower patients' comprehension of medical information. The situation can be worsened by vulnerability occasioned by sickness which can lower the understanding of even highly educated patients.

In some cases, physicians have to rely on translators due to language barrier (Jacobs, Chen, Karlinger, Agger-Gupta & Mutha, 2006). Unfortunately, translation increases the chances of errors in prescribing or appropriate drug use by patients. Geist-Martin et al. (2003) found that in America, minorities receive lower healthcare as they forgo asking questions due to difficulties in communicating with doctors. Encounters with Spanish-speaking patients were less "patient centered' than those with English speaking ones (Laws, Heckscher, Mayo, Li & Wilson, 2004). These

<div align="center">24</div>

Spanish patients end up feeling disrespected which does not augur well for communication.

In the Kenyan context, language is an even bigger impediment as there are forty-seven languages and even more dialects. The educational standards are also relatively low among many of the people.

Lack of Continuity of Care

Continuity of care is the "longitudinal relationship between patients and their care givers that transcends multiple illness episodes and includes responsibility for preventive care and care coordination" (Saultz, 2003, p. 134). Initially it was viewed as care by one provider from the cradle to the grave.

Most patients desire a strong relationship with their doctor as they are vulnerable during sickness and wary of giving intimate details to a stranger. Longer interaction elicits more information-seeking and strengthens self-disclosure. Those who stick to one primary doctor over a long period tend to be more satisfied, adhere to their medical regimen more and lead healthier lifestyles (Abdulahi et al., 2007).

Lack of continuity of care can seriously impede effective doctor-patient communication (Abdulahi et al., 2007). This is because every time a patient meets a new doctor, they have to start the process of reducing uncertainty. The situation is worsened by the fact that, although patients shuttle from doctor to doctor, these doctors do not communicate with each other, leading to a regrettable loss of continuity of care (Weiner et al., 2005). Irrefutably, lack of cohesive care leads to impaired communication between the doctor and the patient.

Doctor's Behavior

Certain extrinsic factors like interrupted consultation privacy, lack of encouraging questions, lack of expressions of concern and lack of transfer of medical

25

information can impede doctor-patient communication. Patients further cited the medical practitioners' behavior as a major barrier to communication (Abdulahi et al., 2007). While Ray (2005) stated that doctors should show respect by introducing themselves and addressing the patient by name. Korsch, Gozzi and Francis (1968) accused some doctors of neither greeting the patient nor introducing themselves at the initial encounter.

Usually, a power imbalance is manifested in the doctor-patient interaction with the doctor in a position of high power due to more knowledge (Waitzen, Cabrera, Radlow & Rodriguez, 1996). The doctor initiates the questions, interrupts and can neglect to delve into the patient's life world. Ray (2005) added that sometimes, though the doctor salutes the patient, they end up calling the shots throughout the consultation without involving the patients. The patients are thus reduced to spectators in an interaction that affects their well-being. This situation is worsened by time constraints and unfamiliarity with patients. When the doctor interrupts the patient, it trivializes what the patient is saying yet this is the basis of the eventual decisions on treatment (Ray, 2005). Doctors should therefore behave in a manner that fosters cordial relations between them and their patients.

<center>Use of Computers and Time</center>

Despite computers being a component of 21st Century medicine, some patients complain that their use leads to loss of eye contact, reduced psychosocial talk and decreased sensitivity to patient response due to missed verbal cues (Irani, Middleton, Marfatia, Omani & D'Amico, 2009). Computers should therefore be used with care during consultation as the patient can feel ignored.

Time can also impede a satisfactory relationship with the patient. Though patient satisfaction depends on the time spent with the doctor, clinic inefficiencies like

<center>26</center>

patient tardiness or physician delay may affect the time allocated to each patient (Davis, Larson & Caplan, 2010). Patients particularly resent the long waiting times despite prior appointments (Abdulahi et al., 2007).

Therefore, though showing concern by asking more questions adds a little more time to the consultation, the doctor should do it as it leads to better outcomes and reduces the likelihood of later problems. From this section, it is evident that very many factors can impact negatively on doctor-patient communication.

Current Trends in Doctor-Patient Communication

Because today's consumer is very discerning, there is increased public pressure for accountability and competition among systems (Nelson, Gentry, Mook, Spritzer, Higgins & Hays, 2004). Therefore, doctors have to contend with empowered patients with increased access to medical information from other sources like the Internet.

Unfortunately, some patients visit the doctor with predetermined ideas about their assumed need, while others approach the doctor after self-diagnosis. Instead of describing their symptoms and letting the doctor decide or investigate their condition, they state their presumed illness and demand a specific prescription. This hinders effective doctor-patient communication as it not only irks the doctor but also annoys the patient, who faults the doctor's professional and communication skills if the prescription is not offered immediately.

Some major trends in doctor-patient communication are the use of online sources by both patients and doctor and communication skills training for doctors.

Use of Online Sources

Communication is changing rapidly in the world and new communication

27

technologies enable both the collection of large amounts of information and tailoring of persuasive messages (Wilde, 2007). Frymoyer and Frymoyer (2000) contended that advances in technology have resulted in a corresponding decline in effective doctor-patient communication. Meryn (1998) added that the unfortunate breakdown of communication in the 'net generation' has resulted in increased dissatisfaction, more complaints and malpractice suits and abandonment of conventional medicine for unproven alternative therapy.

Though healthcare remains largely practiced in hospitals, there has been a large exodus to the Internet. In 1997, almost half of the Internet users reported looking for health information and support. This rapidly increased to 24.8M in 1998 and 10.8M in 1999 (Rice & Katz, 2001). Rice and Katz added that the Internet largely fulfills the need for health information to be accurate, accessible, timely and effective. They further cautioned that for information technology to be taken seriously, it must fulfill a need in the particular context.

Wilde (2007) averred that recently, both the Internet and health issues have gained public salience as patients have more choice of medical care. Conversely, Katz, Nissan and Moyer (2004) clarified that although online communication can reduce barriers associated with traditional communication, its spread has been slow as not all patients are conversant with electronic sources. Other disparities that affect the use of online communication are age, educational levels and ethnicity.

Online information not only helps to reduce both the patients' anxiety and cost of treatment but also gives them a chance to evaluate potential doctors keenly. The gathered information subsequently forms a basis for deeper discussion between the doctor and the patient. Other benefits for the patient include eliminating the need for scheduling visits, looking for parking slots and wasting time in crowded waiting

rooms just to talk to the doctor for a few minutes. Currently, a routine visit to Nairobi Hospital can take a whole day due to the large number of patients there.

Email can be used for recommending therapy, updating the patient's health status and varying drug dosage (Breen & Matusitz, nd). However, some doctors avoid it for fear of liability, misinformation and misrepresentation, and privacy infringements. This is because online sources lack patient confidentiality, a key requirement in the medical encounter. Though encryption increases confidentiality, it cannot guarantee it. Other fears for physicians are that email though widely used with enormous reach and compatibility across operating platforms has setbacks like extra work for staff and the digital divide that would hurt the most vulnerable patients. The origin of email cannot always be authenticated and it can be forwarded accidentally and seen by third parties.

Katz et al. (2004) praised the use of web-based portals for online communication as having all the advantages of email with the added strength of storing and exchanging information. Web-based communication can be tracked and evaluated and security is enhanced through encryption. Furthermore, the messages cannot be forwarded. All in all, Katz et al. stressed that health providers must develop new ways of communicating or lose their patients. However, in spite of the numerous advantages of online communication, its extensive use is still not possible especially in Kenya. Apart from limited spread and reach, there are also technical issues to be solved as already discussed.

Communication Skills Training

Dissatisfaction with ineffective doctor-patient communication has revealed the central role of communication skills in clinical practice. McManus, Vincent, Thom and Kidd (1993) said that poor communication results in medical accidents and

29

subsequent litigation. Since doctors are often judged more on their communication skills than clinical competence, McManus et al. advocated training in history taking, involving patients in decision making and giving treatment, advice, support and counseling.

Kidd, Patel, Peille and Carter (2005) claimed that the reductionist paradigm of teaching communication skills separately from clinical skills limits the coherence needed for satisfactory communication. This is because the scenario does not mirror the clinic experience. Kidd et al. therefore advocated communication skills learning to be incorporated in the embryonic stages of clinical study by making clinicians work beside social scientists.

A study conducted in Milton Keynes by Price et al. in 1993 observed that because the patient was usually too exhausted and confused to grasp much, they benefited if doctors summarized the consultation and wrote everything out. Patients also appreciated these written summaries feeling the doctor cared enough to put things down in writing.

Frymoyer and Frymoyer (2000) singled out orthopedic surgeons as having high technical skills but very low communication skills with the weakest activity being interviewing. Good communication skills lead to higher satisfaction, better compliance with prescribed treatment, improved health outcomes, sounder decisions and reduced costs. Consequently, Frymoyer and Frymoyer recommended the incorporation of communication skills in residency training by medical schools.

Theories Guiding the Study

A theory refers to "a framework for explaining phenomena by stating constructs and laws that inter-relate these constructs to each other" (Mugenda, 2008,

p.34). This study used two theories of interpersonal communication; uncertainty reduction theory and social penetration theory.

Uncertainty Reduction Theory

Uncertainty Reduction Theory (URT) was introduced in 1975 by Charles R. Berger and Richard J. Calabrese to predict and explain relational development (or lack thereof) between strangers. This theory refers to the ability of strangers to accurately predict and how the other will behave during an encounter (Hebbani & Frey, 2007). Time is a factor in these encounters as when people interact over time, they understand each other more. URT assumes that "there is a human drive to reduce uncertainty about self and others in initial interactions by information seeking through self-disclosure, nonverbal warmth and familiarity " (Bradac & Solomon, 2001, p. 458). This is done by questioning; starting with small talk before moving on to deeper things or by asking indirectly; for example, seeking recommendation for a good medical specialist.

At the start of a particular encounter, each person attempts to predict the most likely action the other person is likely to take. However, before selecting the probable response, the individual must reduce his or her anxiety about the other by narrowing the range of alternatives about the other person's probable future behavior. Therefore, both parties have to verbally communicate in order to reduce uncertainty or increase predictability about each other.

Breen and Masutzi (nd) argued that uncertainty is reduced by asking questions, observing and analyzing the other person's personality, tendencies and understanding. The reduction of anxiety helps people decide whether to initiate a relationship with the other person or not. Additionally, Hebbani and Frey (2007)

31

contended that attitudinal similarity, interpersonal attraction, frequency of communication and use of interactive uncertainty reduction strategies (asking direct questions and disclosing to get the other to talk) have positive effects on attitudinal confidence. This leads to increased disclosure and cross examination.

There are different strategies for reducing uncertainty (Berger, 2005), namely: 1). Passive strategies through which the information seeker collects information about a target by observing his or her behavior.

2). Active strategies which involve proactive efforts to gain knowledge about another person, usually by asking a third party about the target person and,

3). Interactive strategies that require direct communication with a target for information seeking.

A major interactive strategy in uncertainty reduction is self-disclosure. Breen and Masutzi (nd) said that once uncertainty is reduced, self-disclosure and trust follows. Normally, as one self-discloses; the other person tends to reciprocate. However, Berger (2005) observed that when people seek information, they weigh their desire against the probability of getting negative feedback. He therefore added that in URT, individuals routinely integrate the possibility of events or outcomes with the event's valiance to determine their response to potential outcomes. Uncertainty reduction becomes difficult when negative outcomes have a high probability of occurring or when the probability of positive outcomes is low.

Berger updated URT in 1982 and 1987 after observing that uncertainties are present in ongoing relationships and the process of uncertainty reduction goes on even in developed relationships. Furthermore, " while uncertainty reduction may be rewarding upto a point, the ability to compelely predict another's behavior might lead to boredom" (Berger & Calabrese, 1975, p.10). Similarly, Theiss and Solomon

32

(2008) observed that although complete certainty is unlikely due to the dynamic

nature of interpersonal relationships, its achievement can be stifling.

A decade after publishing the theory, Berger (2005) admitted that some of its

propositions were not wholly valid. The third axiom suggesting that high uncertainty

causes high levels of information seeking was problematic as wanting knowledge, not

lacking knowledge, is what promotes information seeking. West and Turner (2007)

quoted Brashers (2001) after September 11th, that more information results in greater

uncertainty.

However, URT is clearly formulated; precisely demarcated, logically derived

and easily tested hence it provides a starting point for understanding the relationship

between social attraction and self-disclosure (Bradac & Solomon, 2001). It is also

parsimonious and the only theory that examines initial encounters (West & Turner,

2007). Unfortunately, the theory is narrowly confined and self-limiting and its central

assumption that humans strive to reduce uncertainty is questionable. West and Turner

(2007) quoted Sunnafrank (1986) that reducing uncertainty in the initial encounter is

not a primary concern but more a maximization of relational outcomes. Consequently,

he called for a consideration of predicated outcomes value.

<center>Application of URT to this Study</center>

Berger and Calabrese (1975) introduced seven axioms or assumed truths and

by combining them, came up with twenty one theorems about URT.

Axiom 1: Strangers enter a relationship with high levels of uncertainty about each

other. However as they begin to talk to one anothet, the level of anxiety decreases. In

turn, as the uncertainty decreases, the interactants will talk more.

Axiom 2: As nonverbal affiliative expressiveness increases, uncertainty levels will

decrease in an initial interaction situation. In addition, decreases in uncertainty level

<center>33</center>

will cause increases in nonverbal affiliative expressiveness.

Axiom 3: High levels of uncertainty cause increases in information seeking behavior. As uncertainty level decline, information-seeking behavior decreases.

Axiom 4: High levels of uncertainty in a relationship cause decreases in the intimacy level of communication content. Low levels of uncertainty produce high levels of intimacy.

Axiom 5: High levels of uncertainty produce high rates of reciprocity. Low levels of uncertainty produce low levels of reciprocity.

Axiom 6: Similarities between persons reduce uncertainty, while dissimilarities produce increases in uncertainty.

Axiom 7: Increases in uncertainty levels produce decreases in liking; decreases in uncertainty produce increases in liking.

 Although URT has all these axioms and theorems, this study only used the first axiom which states that,

> given the high level of anxiety present at the onset of the entry phase, as the amount of verbal communication increases, the level of anxiety for each communicator in the relationship will decrease. As uncertainty is further reduced, the amount of verbal communication will increase (Berger & Calabrese, 1975, p. 102).

During a patient's initial visit to the doctor, there is anxiety and uncertainty because the patient and the doctor are new to each other. The doctor attempts to reduce uncertainty by greeting the patient and trying to put them at ease. The doctor further questions the patient to elicit more information about the patient's medical condition. The patient also seeks information about the doctor either by asking former patients or observing the doctor's "beside" manner. Once uncertainty is reduced, communication becomes effective.

34

In a seeming contradiction, Bradac and Solomon (2001) found that uncertainty arises during the progress of a yet to be diagnosed illness. They contended that some individuals who test for serious illness may attempt to evade the results as a way of coping with their apprehension about potentially unfavorable diagnosis. In such situations, communication increases uncertainty. Similarly, in certain instances, doctors cloak unfavorable diagnosis in vague language and "in healthcare contexts where life threatening outcomes are frequently faced, such manner may be deployed quite often" (Berger, 2005, p. 422). Berger however found that absolutist language from a doctor can reduce uncertainty especially if it is coupled with high authority.

During consultation, the doctor and patient need to develop a strong relational and interpersonal bond. Self-disclosure during the interaction enables the patient to explain his/her symptoms candidly and clearly. Thereafter, the doctor is able to explain his or her diagnosis and present the recommended treatment in an understandable manner. Due to the rapport already achieved, the patient adheres to the treatment and the resulting medical outcome is positive for both parties.

Axiom one is used because it clearly outlines the actions of both communicators when they first meet. This is applied to the initial encounter between the doctor and patient as the impression and rapport created affects subsequent encounters.

<div align="center">Social Penetration Theory</div>

The second theory guiding this study is Social Penetration Theory (SPT) by Altman and Taylor (1973). This theory describes the development and progress of interpersonal relationships (Guerrero & Gudykunst, 1996-7). It postulates that self-disclosure plays a crictical role in the development of intimacy in relationships. SPT

<div align="center">35</div>

focuses on how self-disclosure moves from superficial to intimate details during the development and progress of relational closeness (Breen & Matusitz, nd).

Altman and Taylor compared people to a multilayered onion whose layers can be penetrated one by one till the core. They said that each opinion, belief, prejudice and obsession is layered around and within the individual. As people get to know each other, the layers "shed away" to reveal the core of the person. These layers have both breadth and depth. Breadth refers to the number of topics discussed in the relationship while depth is the degree of intimacy that guides the topic discussions. Initially, the relationship has narrow breadth and shallow depth. Altman and Taylor (1973) said that as intimacy increases, more topics (breadth), are discussed with several of them discussed intimately (depth). This ties in with how uncertainty is reduced in URT.

Self-disclosure; the gradual process of unfolding one's inner self is only possible after establishing intimacy. The more time spent together, the more likely the parties are to self-disclose intimate and detailed information. Guerrero and Gudykunst quoted Altman and Taylor that "people are generally believed to let others know them gradually first by revealing less intimate information and only later making more personal aspects of their lives accessible" (Guerrero & Gudykunst, 1996-7, p. 45).

Self-disclosure has four stages, namely orientation, exploratory affective exchange, affective exchange and stable exchange. Guerrero and Gudykunst (1996-7) contended that orientation occurs when strangers or distance acquaintances meet and begin to talk to one another with stereotypical responses and limited verbal interaction. They added that the second stage or exploratory affective exchange involves friendly, relaxed and casual interaction. As uncertainty decreases, talk increases. The communication is smoother and synchronized, and most interactions

stop at this stage.

The third stage or affective exchange occurs in relationships with extensive history of association. Here, there is synchrony of communication, displays of affection, broken barriers and free exchange. The final stage or stable exchange is attained in relatively few relationships; usually friendships and romantic liaisons.

This theory explains self-disclosure in economic terms of social exchange or reciprocity. Altman and Taylor's (1973) SPT suggests that a discloser anticipates a benefit in allowing others to know more about himself or herself. The level of self-disclosure depends on each relationship in terms of costs and rewards and liking someone is a prerequisite to high levels of self-disclosure. Individuals expect a reward from receivers for self-disclosure and subsequently create obligations to reciprocate, which is known as the norm of reciprocity (Omarzu, 2000).

Self-disclosure occurs in dyads and Jourad (1959) referred to the tendency to disclose in established relationships as the 'dydacic effect' – the more information one recieves, the greater his or her willingness to self-disclose. Dydacic effect suggests predominance of self-disclosure in dyads.

Unfortunately, SPT is not fully backed by data and it has been observed that the highest reciprocity may be at the middle. The penetration is also not linear but has cycles of disclosure and reserve. Furthermore, it has been observed that self-disclosure increases during the deterioration of a relationship. Finally, the development of SPT is affected by gender as the penetration metaphor has both power and sexual connotations.

<center>Application of SPT to this Study</center>

SPT applies to this study because in the doctor-patient relationship, the two weigh the relationship and interaction with each other on a reward-cost scale. If the

<center>37</center>

rewards outweigh the costs, the clinic experience will be good but if the interaction is unsatisfactory, the relationship will be deemed as non-beneficial. The doctor-patient encounter is an interpersonal communication encounter and if the communication is effective, the medical outcomes will be positive.

SPT talks about increasing levels of self-disclosure as people interact more. In the clinic encounter, the more the patient visits the same doctor with positive outcomes, the more they disclose to them. Patients are comfortable disclosing intimate details to their regular doctor who they trust. Though most patients fear admitting to a new doctor that they are suffering from stigmatized diseases like HIV and Aids or sexually transmitted infections, they readily admit it to their regular, trusted doctors.

However, in the clinic encounter, the doctor does not reciprocate the patient's self-disclosure as this can reduce attractiveness as previously explained. Though the patient never really gets to know the doctor, a good doctor creates a favorable context for the patient to self-disclose. The doctor's major disclosure is to reveal dire diagnosis to the patient.

Although SPT has been developed to explain self-disclosure in face to face interactions, researchers have also successfully applied it to relationships in computer-mediated communication. However, due to the absence of face and voice in email, some doctors and patients find it socially and interpersonally restrictive to develop closeness and high levels of comfort (Breen & Matusitz, nd). Though websites and telemedicine are useful in doctor-patient communication, they cannot replace the doctor visit with all its face and nonverbal cues.

The progress of SPT is theoretically affected by individual personal characteristics, dyadic processes and situational factors (Champion, 2007). SPT also

38

talks of disintegration of the relationship like when a disgruntled patient leaves a particular doctor and seeks a new one or alternative sources of medical help. This can happen when the patient is dissatisfied with the services offered by that the doctor.

<div align="center">Integration of the Two Theories and this Study</div>

Doctor-patient communication is an interpersonal interaction because it tends to be one-on-one unless there is another person supporting or translating for the patient. The theories of uncertainty reduction and social penetration are also theories of interpersonal communication that describe the development of interpersonal relationships (Guerrero & Gudykunst, 1996-7). Both URT and SPT focus on the effect of self-disclosure on relational closeness. The two theories posit that self-disclosure plays a crictical role in the development of intimacy in relationships. The more time spent with others the more likely we are to self-disclose intimate and detailed thoughts as this is a vital element in building relationships.

Uncertainty Reduction Theory (URT) helps predict and explain relational development (or lack thereof) between strangers while SPT talks the development of relational closeness between strangers through increasing levels of self disclosure. Both theories contend that attitudinal similarity; interpersonal attraction, frequency of communication and use of interactive communication patterns (asking direct questions and disclosing to get the other to talk) leads to increased disclosure and cross-examination. The parties end up understanding each other and deciding whether to relate or avoid each other.

In effective doctor-patient communication, use of interactive strategies like self-disclosure and information seeking reduces uncertainty and enhances trust. The more trustful the patient becomes, the more they are able to articulate their condition

<div align="center">39</div>

and internalize the resulting instructions from the doctor. The final result is positive

medical outcomes.

Conceptual Framework

A conceptual framework encompasses all the concepts, assumptions,

expectations, beliefs and theories that support and inform research. It is the

researcher's visual or written product that "explains either graphically or in a narrative

form, the main things to be studied, the key factors, concepts or variables; and the

presumed relationship between them" (Maxwell, 2005, p. 18).

For this study, the conceptual framework had effective communication as one

of the key independent variables. In doctor-patient communication, prediction and

development of relational closeness are achieved through interactive communication

strategies like using verbal and nonverbal communication, active questioning and

mutual self-disclosure to reduce uncertainty between new patients and doctors

meeting for the first time.

The researcher used URT and SPT to explain how other intervening variables

like culture, gender, age, language, communication skills, and channels like internet,

level of trust, frequency of communication and length of relationship interact with this

variable to affect the medical outcomes which is the independent variable

Self-disclosure is the main element that helps in the development and progress

of relational closeness. The context is very important since the doctor does not

reciprocate the patient's self-disclosure; the doctor must create an environment that

encourages the patient to continue self-disclosing. This favorable environment is

created by greeting the patient, listening actively, presence of trust and the doctor's

communication style. Apart from creating the context, the only thing the doctor

40

discloses is the type or severity of illness the patient is suffering from. The doctor also discloses the treatment the patient will undergo.

Various factors like culture, gender, age and use of appropriate language affect the doctor-patient relationship. Other intervening factors are the communication skills of the doctor, level of trust, frequency of communication and length of relationship and the context in which the communication takes place. If the communication is effective, it leads to positive medical outcomes. The conceptual framework for this study was therefore derived from the literature reviewed and the theories discussed as shown in Figure 3.
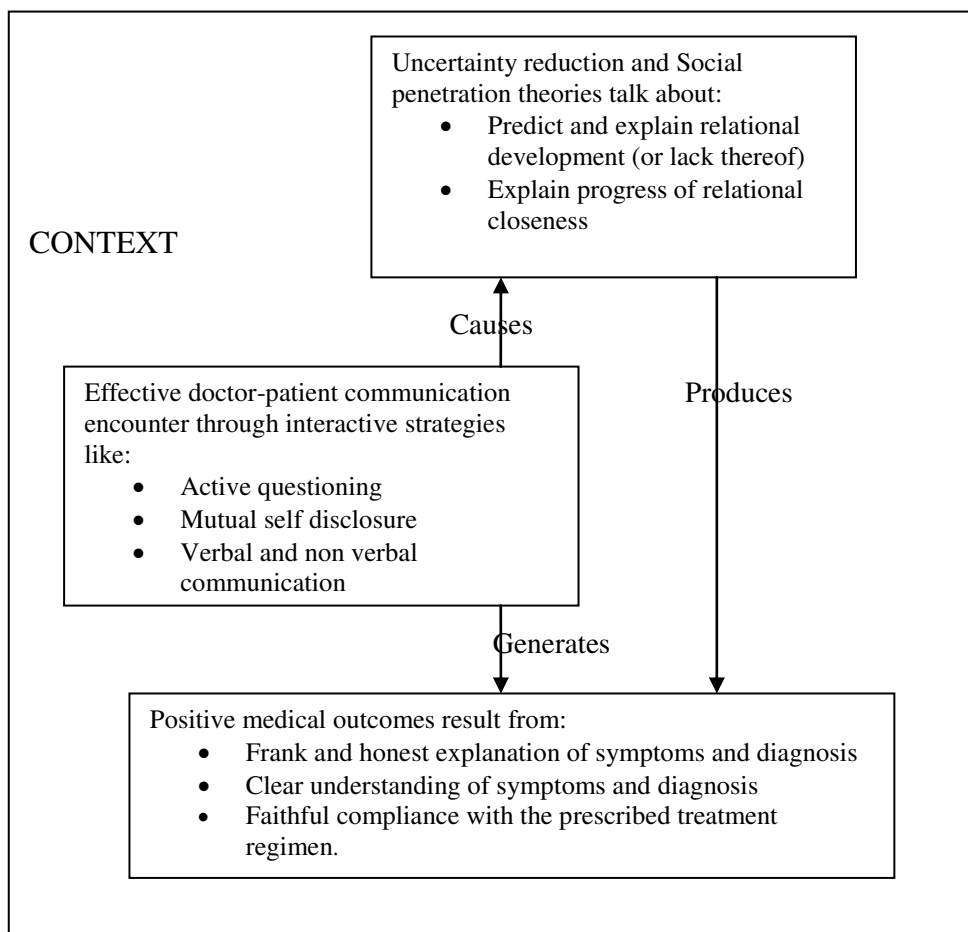
Figure 3: Conceptual framework (Ochuodho:2011)

Key: CONTEXT includes factors like age, gender, culture, length of relationship,

frequency of communication, channels, trust etc.

Summary

In this chapter, relevant literature on effective doctor- patient communication

was reviewed. Particular emphasis was laid on literature on effects of doctor-patient

communication on the clinic experience, factors hindering this communication and

ways of overcoming them. The chapter also looked at interpersonal theories of communication, namely the uncertainty reduction and social penetration theories and linked them to the study. Finally, a conceptual framework for the study was developed. In the next chapter, we outlined the methods of data collection and analysis.

43

CHAPTER THREE: RESEARCH METHODOLOGY

Introduction

This study sought to determine factors that affected doctor-patient communication. The previous chapter reviewed relevant literature under various sub-headings and set the theoretical framework for the study. This chapter discussed the data collection process and also justified and authenticated the procedures employed in order to meet the set objectives and answer the main research questions of the study. The study was a case study of the Meridian Medical Clinic in Nation Centre.

Research Methodology

Research, according to Kothari (2004), is a scientific and systematic search for pertinent information on a certain issue. This intellectual investigation produces a greater understanding of events, behavior or theories. It also makes practical applications with the help of such facts, laws and theories.

Research methodology, on the other hand, refers to the rational and philosophical assumptions that underlie the use of a set of methods (Mugenda, 2008). It is the section of research that details the procedures used to systematically solve the research problem (Kothari, 2004). These include the population, the sample and sampling techniques. It also incorporates the research design, a description of instruments or tools used to collect data, the measurement of variables and the techniques used in analyzing the data.

Research Approach

The study applied both qualitative and quantitative methods of research to collect data. Merging these two approaches helped to comprehend the purpose of the

44

study and guarded against bias.

Qualitative research is concerned with "subjective assessment of attitudes, opinions and behavior" (Kothari, 2004, p.5). It involves descriptions that do not produce numerical data (Mugenda & Mugenda, 1999). The data collection methods allow the researcher to engage participants in a flexible interaction which yields rich and extensive information (Kothari, 2004). This was the appropriate approach for evaluating factors that affected doctor-patient communication at Meridian Medical Clinic.

On the other hand, quantitative research relies on the principle of verifiability. This means confirmation, proof or substantiation (Kothari, 2004). In this approach, the researcher tries to be detached from the subject of study or respondent and focuses on numerical events according to rules. The numbers are analyzed statistically to prove or disapprove the research questions or test the hypothesis.

Research Design

A research design is the "arrangement of conditions for collection and analysis of data in a way that combines their relevance to the research with economy in procedure" (Kothari, 2004, p. 31). The conceptual framework guides the study from the beginning to the end and facilitates a smooth operation. This study used a descriptive design which is ideal for examining social issues in communities because it is exploratory in nature and allows for the use of instruments like questionnaires. The research questions guided the methodology and sampling strategy and kept the study focused so that the resulting recommendations could assist other medical facilities.

Study Population

45

A statistical population, according to Kothari (2004), is the complete set of all items in the researcher's field of inquiry. Mugenda and Mugenda (1999) referred to it as an entire group of individuals, events or objects having a common observable characteristic. For this study, the population was all patients visiting private health facilities in Kenya. The target population is defined as all individuals, objects or things that the researcher can reasonably generalize his or her findings to (Mugenda, 2008). In this study, it was all patients visiting MMCs in Kenya. Since even this was too large, we sampled from the accessible population which is "that part of the target population that a researcher can practically reach to select a representative sample" (Mugenda, 2008, p. 283). For this study, the accessible population was all registered patients of MMCs in Nairobi.

Sample and Sampling

It is rarely practical, efficient or ethical to study the entire populations unless it is very small (Kothari, 2004). This necessitates the use of a representative sample from the accessible population (Mugenda, 2008). A sample is a selection of people, events, places or objects to be studied (Kothari, 2004) and is used to learn about the universe without the expense of studying every member or object of the universe. Though drawn from the accessible population, the sample must be representative of the target population. The size of the population under study has to be considered during sampling to represent the population adequately (Kothari, 2004).

For this study, non-probability purposive sampling was used. Non-probability sampling does not select units according to any mathematical guidelines hence all the units of the accessible population do not have an equal chance of selection. Purposive sampling, on the other hand, is the deliberate selection of particular units where the

46

researcher uses cases in a particular setting that have the required information to meet set objectives (Mugenda, 2008). Though the population for this study was not homogenous, stratifying the patients would have meant perusing patient records which would breach ethical considerations.

The sample was therefore a portion of all registered patients at MMC in Nation Centre. The clinic has approximately ten thousand patient files in their database though not all files are active as they include dead files of one-off visitors and dead patients plus new ones who are registered daily. Since the clinic sees about a thousand patients weekly, two hundred patients were sampled which came to about twenty percent of the weekly attendance. Therefore, the sample was based on the weekly attendance and not the sampling frame which is all the registered patients at MMC Nation Centre. Further, all the four doctors at MMC Nation Centre were sampled to get their different communication patterns. Because the researcher already had permission to conduct the studies, the receptionist scheduled convenient appointments for the in-depth interviews with the doctors.

Convenience sampling was also done for in-depth interviews with the patients. The units were selected because they were available to the researcher (Mugenda, 2008). Six patients comprising two long-term patients, two new patients and two patients who left the centre for other medical facilities then came back again were interviewed. The patients interviewed were picked from those available in the clinic at the time of the interview. The receptionist informed the selected patients about the study and introduced the researcher.

Because the study focused on interpersonal communication, the study was interested in getting views of repeat patients who had had an opportunity to build a relationship with a doctor. The sampling was therefore done on Thursday mornings

47

which being clinic days, are attended mostly by long term patients who have already

developed a relationship with the doctors.

Data Collection Methods

The study used both primary and secondary data. Primary data are those

collected for the first time by the researcher while secondary data are those previously

collected by someone else and already analyzed and documented ((Kothari, 2004).

This study made use of books, research articles, the Internet, journals and personal

discussions as well as questionnaires and in-depth interviews.

Research Instruments for Data Collection

The study used questionnaires and in-depth interviews. These two instruments

were employed to reduce bias and increase validity.

Survey or Questionnaires

Questionnaires are a purposeful, structured set of questions used to obtain

preliminary data from a large number of respondents. In this technique of data

collection, each person is asked the same set of questions in a predetermined order

(Kothari, 2004). Questionnaires help to test a hypothesis or a relationship between

two or more variables and assist in answering certain research questions.

This study employed self-administered questionnaires which communicated to

the respondents what was intended to elicit the desired response in terms of empirical

data in order to achieve the research objectives (Kothari, 2004). Therefore, the

researcher did not influence the respondents while they were completing the

questionnaire. The questionnaire was short so as not to fatigue the respondents as this

lowers the completion rates (Wimmer & Dominick, 2006). The questionnaire was

drafted in a way that brought out the patients' perception of communication by

doctors at the clinic.

In-depth Interviews

In-depth interviews were subsequently conducted with all the four doctors at the clinic and six patients to capture the nonverbal expressions. An in-depth interview is "a purposeful discussion between two or more people" (Saunders et al., 2003, p. 245). Wimmer and Dominick (2006) observed that interviews are unique because they use smaller samples and provide a detailed background about the reasons why respondents give specific answers. Interviews are most useful when the researcher needs to learn about people's experiences or views in-depth (Kothari, 2003). They also enable collection of sensitive data that cannot be gathered in a large group. The mode of selection for this study was purposeful and convenient, as it was not based on random selection. An interview guide with structured, pre-planned questions was relied upon to question the sampled respondents.

Pre-testing the Research Tools

The questionnaires were pre-tested before being deployed in the field. The questionnaire was given to a few subjects from the target population to determine whether they understood and interpreted the questions in the same and required way (Mugenda, 2008). The pre-test helped the researcher to refine the questionnaire so that the respondents did not have problems answering the questions (Laws et al., 2004). It also helped assess the validity, clarity, friendliness and any other potential challenges inherent in the instrument. The pre-test helped highlight ambiguous and sensitive questions and helped the researcher determine the adequacy of the instrument.

The pre-test was administered on twenty patients which was 10% of the sample. When the responses were analyzed, the researcher found that question one in section two was ambiguous as respondents seemed to understand it differently from

49

what the researcher had in mind. Thereafter, the question was rephrased to make it clear and the pre-tested patients subsequently excluded from the main study.

Reliability and Validity

The researcher attempted to minimize arbitrary mistakes and improve the degree to which the research instruments yielded consistent data when deployed repeatedly (Mugenda & Mugenda, 1999). The study first pre-tested and rectified the questionnaires before administering them with the help of trained research assistants. The questionnaires were administered to the patients individually to eliminate undue influence and subsequent bias. This was an effort to increase validity or the level to which results got from the analysis of the data actually represents the phenomenon under investigation which the researcher did his best to evaluate.

Field Work

Prior to pre-testing and revising the instruments, one research assistant was trained. Once the tools were ready, enough copies were printed and distributed in the clinic. Transport and accommodation was not an issue as the clinic is located in the city and a car was available to drop and collect the research assistant with the materials. Diligent care was taken to ensure that the instruments had all the pages and that the respondents were comfortable with the instruments. This saved time and raised the response rate. The filled questionnaires were coded and kept safely for future confirmation if necessary. The researcher conducted the in-depth interviews personally. Most of the doctors refused to be recorded but all the patients agreed.

Ethical Issues

Ethics is an integral part of research especially where human subjects and health concerns are involved. It is about right and wrong; accountability and

responsibility and its magnitude in research vary from one study to another. Unethical behavior may affect the respondents adversely and at no point of the research should the subjects' human rights be violated (Mugenda, 2008) and all possible harm to the respondents must be avoided. Because the researcher's behavior is affected by the broader social norms of behavior, the researcher observed the ethical norms pertinent to the Kenyan context.

Participation in the study was voluntary hence the researcher sought respondents' informed consent face to face just before the start of the interview. The request was also printed on the cover letter accompanying the questionnaire. Kothari (2004) argued that participants should not be pressurized to grant the interviewer access because if they feel vulnerable, they will not release pertinent information.

Furthermore, the respondents were not required to indicate their names or any identification mark on the questionnaire. They were also briefed on the confidentiality of the information presented and then de-briefed of the purpose of the whole study so that if at any moment an interviewee or participant felt uncomfortable, he or she could stop the interview or choose not to answer. That way, the voluntary nature of the study was ensured. The researcher earlier overlooked the process of getting a research permit from the Ministry of Higher Education. However, the oversight was later rectified and the permit was obtained.

<center>Data Analysis</center>

Qualitative studies attempt to "analyze data in a systematic way in order to come to some useful conclusions and recommendations" (Mugenda & Mugenda, 1999, p. 117). Attempt was made to establish patterns, trends and relationships from the information obtained. Qualitative data from this study was transcribed and analyzed to determine the adequacy of the information and its credibility, usefulness,

<center>51</center>

consistency and validity. It was then organized into emerging themes and patterns and connected to the theoretical concept of the study.

On the other hand, quantitative data derived from the questionnaires was "converted to numerical codes representing attributes or measurements of variables" (Mugenda & Mugenda, 1999). Thereafter, the data was edited and processed for analysis using SPSS to assist in presentation of research. Tables, pie charts, graphs and other graphical means were used to present the captured information. Throughout the research, efforts were made to answer the research questions.

Summary

This chapter defined various terms used in conducting research and collecting data. It also explained the research approach and design that were used and outlined the various tools employed to collect the relevant data. The next chapter presented the data collected in the field. The data was analyzed and the findings presented in a readable and decrypted format.

CHAPTER FOUR: RESEARCH FINDINGS, ANALYSIS AND INTERPRETATION

Introduction

This research set out to study doctor-patient communication at MMC in

Nation Centre. This chapter presents the data collected in the field in a decrypted and readable format.

Two hundred questionnaires were administered at the clinic on three consecutive Thursday mornings (3rd, 10th and 17th March, 2011). The questionnaires were administered to one hundred male and one hundred female adult patients on Thursdays because being a clinic day, there were repeat patients who were the target. Thereafter, the researcher personally conducted in-depth interviews with all the four doctors (three males and one female) and also interviewed six patients (two males and four females). The interviews were held at the clinic from 18th-21st March, 2011. The in-depth interviews were to elicit respondents' salient opinions and perceptions; and to complement and authenticate the data derived from the questionnaires.

The findings from the questionnaires were coded and analyzed using SPSS and the subsequently interpreted in form of graphs, charts and frequency tables. The findings from the in-depth interviews were also summarized and coded into emerging themes and patterns. The findings were analyzed in line with the purpose statement, objectives and theoretical framework outlined earlier.

Findings from the Questionnaires

Demographic Description of the Sample

Table 1 presents the number and gender of respondents who participated in the study. As previously mentioned, the respondents in this study were repeat patients at MMC in Nation Centre on Thursday clinic days.

Table 1: Gender and Number of respondents

	Frequency	Percentage

53

Females	64	53.33%
Males	43	46.67%
Analyzable questionnaires	120	60%
Partially filled questionnaires	43	21.5%
Questionnaires not returned	37	18.5%
Total number distributed	100	100%

Out of the two hundred questionnaires administered to one hundred male and one hundred female adult patients, one hundred and sixty-three questionnaires were returned. However, forty-three of them or 21.5% were classified as spoilt because they were not fully filled. Thirty-seven questionnaires or 18.5% were not returned. Therefore, one hundred and twenty questionnaires were analyzed, translating to a response rate of 60% which is good (Kothari, 2004).

Figure 4 represents the ages of the respondents who took part in this study by filling the questionnaires that were subsequently analyzed to generate findings. According to the findings, the average age of the respondents was 35 years, meaning that the patients at MMC are generally young.
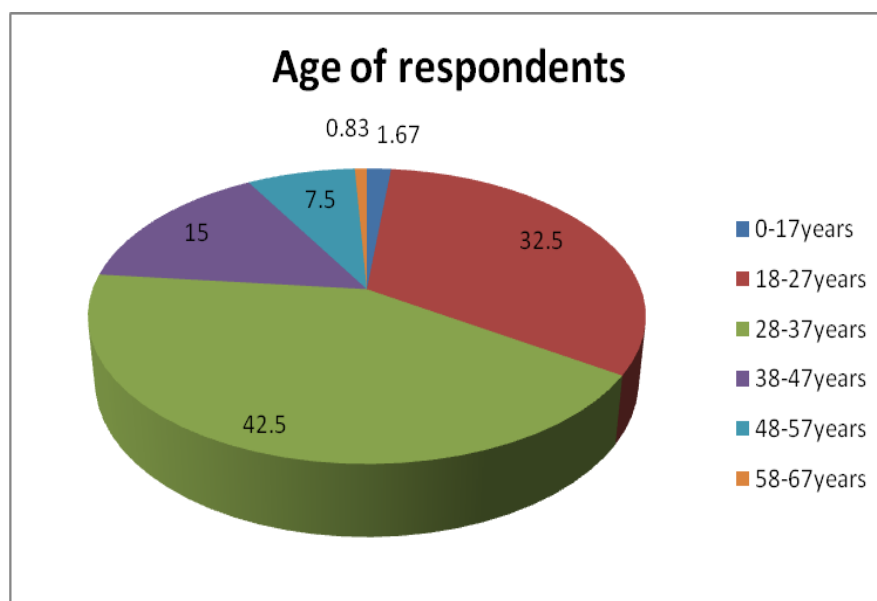
Figure 4: Age of the respondents

In response to the question about their highest academic qualification, 3% of the respondents said they had primary level education, 29% had attained secondary level of education, 53% were graduates while 14% said they had postgraduate degrees. In summary, the patients at MMC are generally young and well educated.

The following tables and figures give a breakdown of the findings that resulted from analysis of the responses from the respondents who filled the questionnaires. The responses were analyzed using the research objectives.

Objective 1: To evaluate the factors that affected doctor-patient communication

Respondents were asked various questions to ascertain factors that led to effective communication between doctors and patients. In response to the question of how long, on average, they waited to see the doctor, 36.67% of the patients said they waited for between one to ten minutes to see the doctor, 21.67% said they waited for 11-20 minutes, 16.67% said they waited for 21-30 minutes while the rest said they waited for more than an hour. The length of time a patient waits to see the doctor is one of the factors that affect the subsequent interaction.

Figure 5 presents the findings from the responses on how long the respondents spent with the doctor.
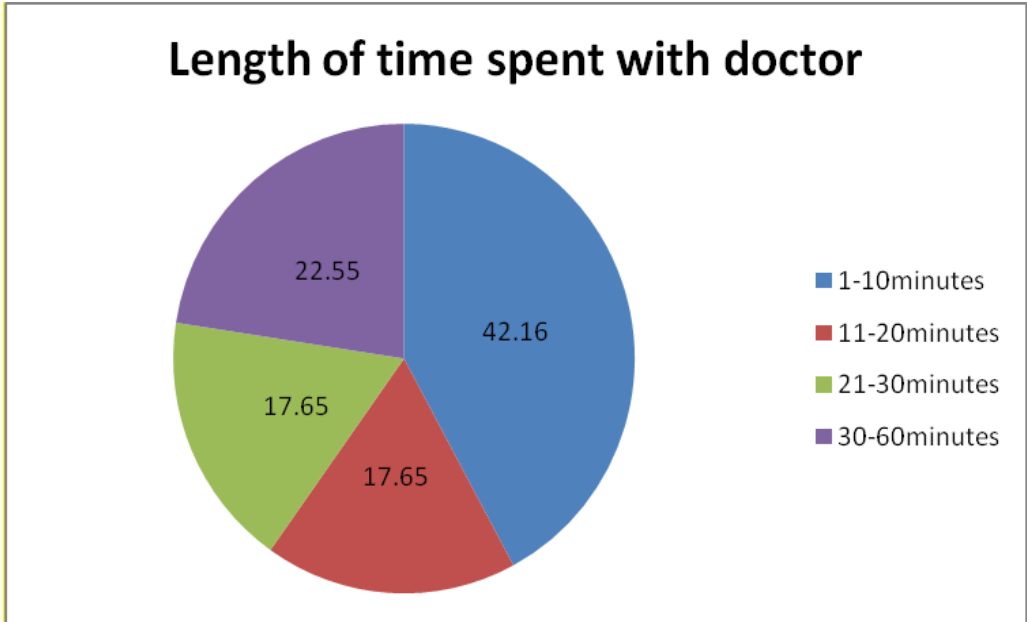
Figure 5: Length of time spent with the doctor

According to the findings, about 84% of the respondents said they spent between 1-30 minutes with the doctor.

Findings from cross-tabulating patients' gender and average time spent with the doctor are presented in Table 2. According to these findings, female patients took slightly longer than male patients. But in a strange twist, seven males took 30 minutes to 1 hour as compared to only two females yet Champion (2007) said because women self-disclose more than men, they tend to take longer with their doctors. This could be due to the specific men's personality where they discussed or questioned intensively.

56

Table 2: Relationship between gender of respondent and time taken with the doctor

Gender of the Respondent	How long on average do you take with a doctor			
	1- 10 minutes	11-20 minutes	21-30 minutes	30 minutes-one hour
Male	25	18	3	7
Female	21	25	9	2
Total	46	43	12	9

In response to whether they communicated with the doctor in any other way apart from the physical visits, 89% of the respondents said that they did not communicate with the doctor in any other way apart from the physical visits while 10% said they communicated in other ways, such as phone calls or the internet, apart from the physical visits.
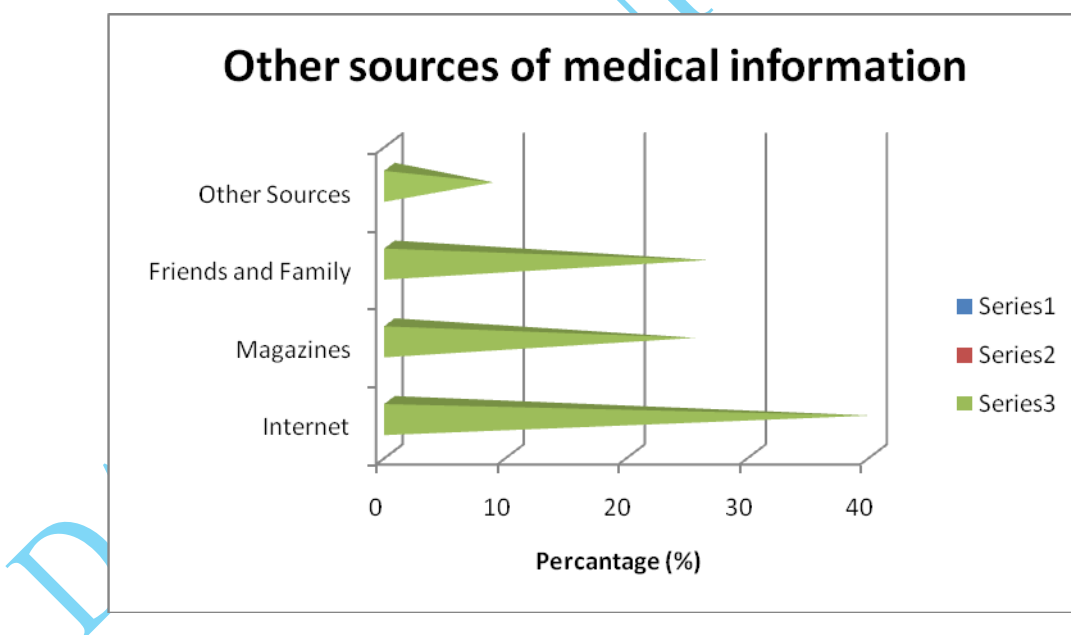
Figure 6: Other sources of medical information

Figure 6 presents findings from the respondents who participated in the study to the question of where else they found medical information. According to the findings, the Internet was the second most used source of medical information after the doctor.

57

Table 3 presents findings from a further analysis on the relationship between the respondents' academic qualifications and their other sources of medical information. These findings indicate that the higher the patient's educational qualifications, the more likely they were to seek medical information from other sources apart from the doctor. The most accessed source was the Internet.

Table 3: Academic qualifications and other sources of medical information

Where else do you get medical information apart from your doctor	Highest academic qualification				Total
	primary	secondary	graduate	post graduate	
Internet	0	19	38	17	74
Magazines	0	20	24	3	47
Friends and relatives	4	15	28	2	49
Other sources	1	5	8	2	16
Total	5	59	98	24	186

Figure 7 presents findings from the respondents who participated in the study to the question of whether they were satisfied with the way the doctor communicated with them. According to the findings, 89.45% of the respondents were satisfied with their doctor's communication style.
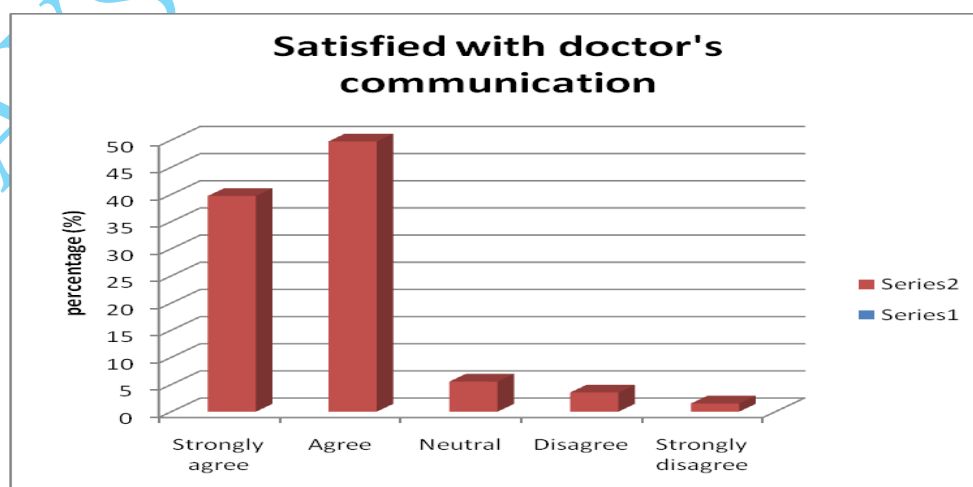
Figure 7: Satisfaction with the Way the Doctor Communicates

Figure 8 presents the findings from the respondents who participated in the study in relation to whether they thought the doctor paid attention to their explanation. Analysis revealed that 47.52% of the respondents strongly agreed, 37.62% agreed, 8.42% were neutral, 5.45% disagreed while 0.99% strongly disagreed. These finding revealed that about 85% of the respondents were satisfied with the doctors' listening skills.
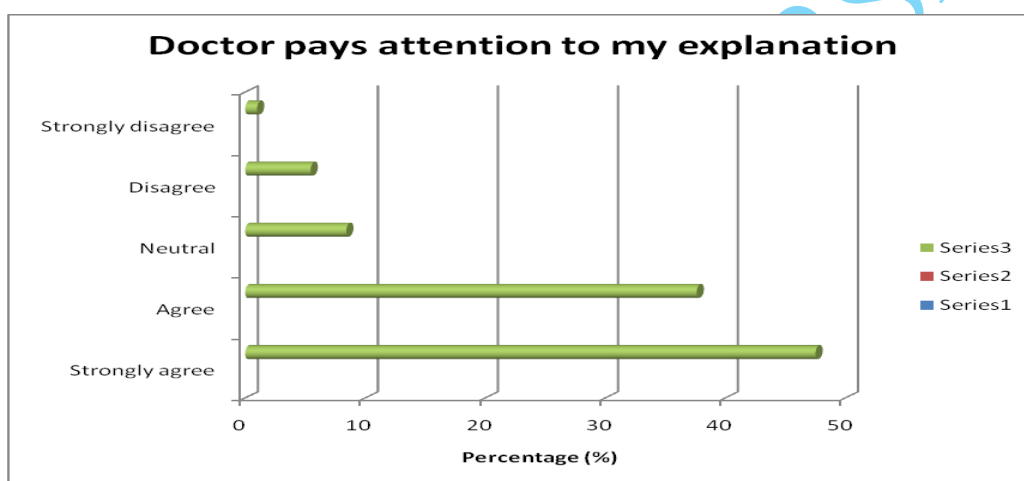
Figure 8: Doctor pays attention to my explanation

From the findings, it emerged that elements of communication included the context in which communication occurred, active listening and the doctor's communication style. This objective has therefore been met.

Objective 2: To determine barriers to effective doctor-patient communication

To determine barriers to doctor-patient communication, the respondents were asked to specify from a list of ten factors, the top three factors they believed affected doctor- patient communication negatively. According to the findings in Table 4, use of technical terms was the top factor that affected doctor-patient communication

59

negatively. It was followed by poor articulation of illness, short consultation time and

negative nonverbal cues by the doctor. Other factors included gender differences, age

differences, length of interaction, lack of salutation and different cultural perspectives

in descending order of importance.

Table 4: Top three factors that negatively affect doctor-patient communication

Factor affecting doctor-patient communication negatively	%
Use of technical terms and jargon	21.42
Poor articulation of illness by patient	17.8
Short consultation time	16.5
Negative nonverbal cues by the doctor	9.7
Gender difference	8.9
Age difference	8.4
Length of interaction	7.8
Lack of salutation	4.8
Different cultural perspectives	3.5
Others	0.8
Total	100

From the findings, various factors were identified as impacting doctor-patient

communication negatively. The second objective has therefore been met.

Objective 3: To establish ways of improving doctor-patient communication.

To meet this objective, the patients were asked various questions. In response

to the question whether the doctor used a friendly tone during consultation, 46.5% of

the respondents strongly agreed that the doctor used a friendly tone during

consultation, 35% agreed, 13.5% were neutral, 1.5% disagreed while 3.5% strongly disagreed that the doctor used a friendly tone during consultation.

In response to the question whether the respondents followed instructions given by the doctors, 92.8% of the respondents agreed that they followed the doctors' instructions while the 7.2% indicated that they did not follow the doctors' instructions. Those who did not follow instructions explained that they failed to do so either because they believed the doctor was wrong or felt better while still meant to be on medication.

Figure 9 presents the responses from the respondents to whether there was privacy for undressing and examination during consultation. According to the findings, 88.9% of the respondents agreed that there was privacy during consultation.
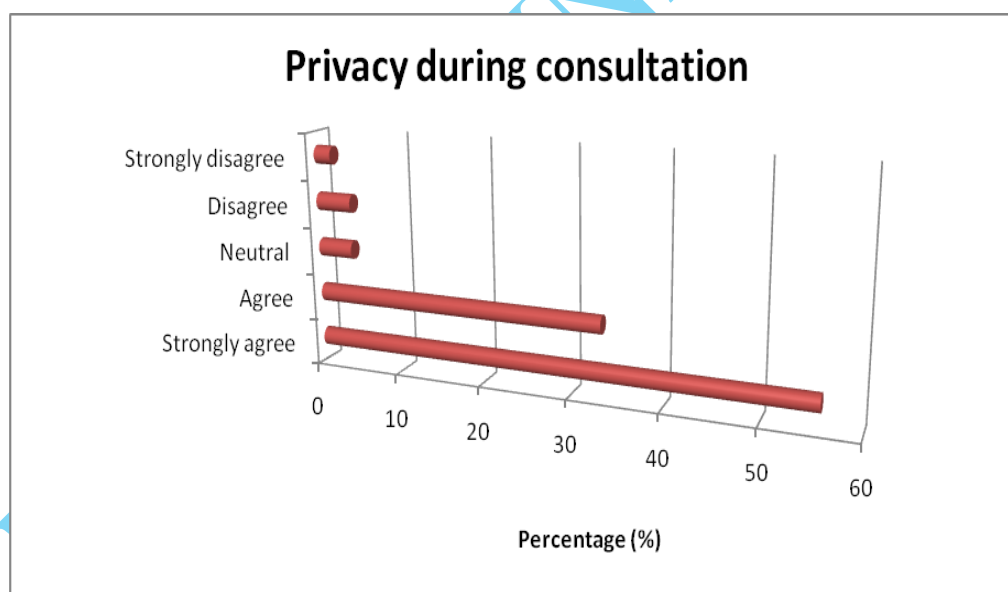
Figure 9: Privacy during consultation

In response to whether the consultation room was pleasant, 45.3% of the respondents strongly agreed that the consultation room was pleasant, 44.8% agreed, 7.39 were neutral, 1.97% disagreed while 0.49% strongly disagreed.

61

The findings about whether the respondents sought alternative medical opinions revealed that 50.75% agreed that they sought alternative medical opinions while 49.25% said they did not seek alternative medical opinions. Table 5 presents findings to further analysis to ascertain whether the respondents sought alternative medical opinions due to lack of satisfaction with their doctors.

Table 5: Relationship respondents' satisfaction with doctors' communication and patients seeking alternative medical opinions

Do you seek alternative medical opinions?		Count	% within am satisfied with the way the doctor communicates with me	% within do you seek alternative medical opinions?	% of Total
	yes	28	36.8%	29.2%	14.4%
	no	48	63.2%	49.0%	24.7%
Total		76	100.0%	39.2%	39.2%

According to these findings, only 29% of the respondents who were satisfied with the way the doctors communicated with them sought alternative medical opinions while 49% of those who were not satisfied with the way the doctors communicated with them sought alternative medical opinions.

In summary, the third objective was met because the study highlighted ways of improving doctor-patient communication as; improving the doctor's communication style through communication training, making the context conducive and ensuring that the medical information uploaded on the World Wide Web is accurate.

62

Findings from In-depth Interviews with Doctors

Demographic Description of the sample

This sample comprised four doctors; three males and one female. The longest serving doctor, a male aged 40 years, had been at MMC for the last 11 years. The next, also a male, aged 28 years, had worked at MMC for only four months. The third doctor, aged 29 years, was the only female doctor at Nation Centre and had been there for almost five years while the last male respondent, aged 32 years, had worked at MMC for two years. Though all the doctors agreed and were interviewed at the clinic, only one doctor allowed the researcher to record the interview. The interviews lasted from 1 hour 15 minutes to 1 hour 54 minutes.

Objective 1: To evaluate the factors that affected doctor-patient communication

In relation to how long the doctors spent with the patients, it emerged that the doctors spent from 10-30 minutes with patients. Furthermore, the doctor who had served longest took the shortest time with his patients.

In relation to their consultation procedure, it emerged that all the doctors tried to break the ice by greeting the patient, introducing themselves and welcoming the patient to create rapport. One doctor said, "since we are computerized, I know who is coming in and greet them by name". The doctors discussed the symptoms with the patients and tried to involve them in the treatment. One doctor said that he tried to involve the patients by explaining to them and seeking their input. This finding is similar to what emerged during interviews with the patients as they also said the doctors discussed with them and tried involving them in the decisions on treatment.

The only female doctor interviewed brought in the aspect of the patient's dignity and privacy. She said that "during examination, I ask them to expose the necessary area only so as to preserve their dignity and privacy".

63

In summary, the study identified the context and style of communication as invaluable factors in doctor-patient communication.

Objective 2: To determine barriers to effective doctor-patient communication.

The doctors' responses to various questions highlighted factors that hindered effective doctor-patient communication. On the issue of whether patients explained their problems clearly, one doctor maintained that patients' clarity depended on their social class. He said that patients from the upper class were generally clearer about their problems. This is because they tended to be more educated and also to have more access to the Internet. He added that patients from the lower classes regarded the doctor as an authority figure, leaving all decisions to him and would wait for him to "fill in the blanks".

Another doctor said that parents explained their children's problems more clearly than their own. He added that the patient's clarity depended on the nature of illness. He said that 'it is easy for patients to explain their respiratory problem saying I am coughing or I have a sore throat but they are vague about abdominal problems because most are not sure of where their stomachs are". The doctors said that the more educated patients were clearer because consulting the Internet improved their understanding. These findings reveal that poor articulation of illness can hinder effective doctor-patient communication.

Negative verbal or nonverbal cues could also hinder effective doctor-patient communication. A doctor said that "when the disease is seemingly self-inflicted or stigmatizing like obesity, gout or HIV, the patients either mumbled or cheated about the symptoms" to avoid negative judgment.

In relation to whether language was a barrier to doctor-patient communication, one doctor said that elderly patients tended to resort to their mother tongue so their

64

chaperones had to translate for them. This hindered communication as translation could distort the message.

In relation to whether it was different communicating with a new patient and a continuing one, all the doctors concurred that it was easier to communicate with a continuing patient. The first doctor said knowledge of the continuing patient's background and the prior interaction made conversation easy. The second doctor concurred that the continuing patient "already trusted the doctor due to the existing relationship" hence self-disclosure was easier and higher. He added that communicating with a new patient was harder as "as one must not only create rapport but also eliminate fear and uncertainty". Findings from the in-depth interviews with patients concurred that it was easier to communicate with a continuing doctor.

In relation to the effect of age, most of the doctors contended that it was harder to deal with young patients especially if they were educated. Young people used the Internet a lot thus had a fairly comprehensive idea of their ailment leading them to self-diagnose. Unfortunately, the information on the internet is not always correct. These findings are similar to the one from the questionnaires where the people with the highest education were the ones who got medical information from other sources especially the Internet the most.

One doctor totally refuted the view that patients followed their instructions. He said that the educated ones who used the Internet confused the doctor's instructions with online information or information from friends and neighbors. The doctor complained that educated patients were difficult to deal with as they consulted other sources like the Internet and magazines more leading them to "second guess the doctor". One doctor said the educated were very critical and challenging as they "insisted on bringing logic to science".

65

In relation to whether gender affected doctor-patient communication, the doctors said the effect of gender depended on the nature of illness and the age of the patient. One doctor said that ladies disclosed more about reproductive and violence related problems as opposed to men who held back to protect their ego.

On the question of the whether culture affected doctor-patient communication, most doctors agreed that it did. A doctor said that Somali ladies were invariably accompanied by a male relative who spoke on their behalf irrespective of the lady's higher status in terms of age or education. Another doctor added that Somalis entered the consulting room in large groups hence blocking candid discussions and limiting self-disclosure. The doctor added that old men also conveyed sensitive information through euphemisms and parables.

Objective two was met because the study identified the factors that impacted doctor-patient communication negatively.

Objective 3: To establish ways of improving doctor-patient communication.

When asked how to improve doctor-patient communication, some doctors said communication could be made better by handling the patients well and involving them in making decisions on treatment. The doctors also called for more communication skills in their syllabus. They said this was especially necessary in government hospitals where the large number of patients made meaningful interaction difficult.

The female doctor wondered whether telemedicine and other online services gaining root in Kenya would "replace the traditional face to face medical encounter". She said that that the young and educated patients use online consultation like askadoc services to clear sensitive questions and prepare themselves to face the doctor.

66

The study met the third objective by identifying incorporation of communication skills in the medical training syllabus, use of patient-centric communication style and use of online sources as ways of improving doctor-patient communication.

Findings from In-depth Interviews with Patients

Demographic description of the sample

This sample comprised six patients; two males and four females. The first, a male aged 28 years, had been a patient at Meridian for only six months while the second, a female aged 47 years, had been a patient for between four to five years. The third, a 29 year old female, had been a patient for four years but briefly moved to Nairobi Hospital before coming back. The fourth, a male aged 37 years had been a patient at MMC for the last five years while the fifth, a female aged 22 years, had been visiting MMC for two years. The last, a female aged 56 years, had only been visiting MMC for four months.

Objective 1: To evaluate the factors that affect doctor-patient communication

In relation to why MMC was their preferred clinic, the patients cited the short waiting time with one saying the clinic "had few patients not like Kenyatta or Nairobi Hospitals". This response was similar to the ones from the questionnaires where 58.3% of the patients said they waited for 10-30 minutes to see the doctor. Some patients said they preferred MMC because the clinic's environment was conducive and welcoming with one patient contending that "it is not like a hospital setting but a friendly interaction".

In relation to the average time taken during consultation, most patients said the consultation ranged from 15 to 45 minutes depending on the situation and the

procedures being done. One patient said the time was adequate as the doctor engaged in social talk so that "by the time I tell him my problem, he has already understood my situation both physically and mentally. It's more of a trust thing". One patient however felt that the time was not adequate as sometimes the doctor just assumed and prescribed medicine.

In response to whether there was privacy during the consultation, all the patients concurred that there was privacy. They cited doctor-patient confidentiality and the rooms with closed doors. One patient said, "the room is sound-proof and one cannot hear sound from outside meaning that people outside cannot also hear sounds from inside". Patients also highly appreciated the fact that no one walked into the room during consultation.

On the question of whether they felt safe during consultation, all patients said they felt safe as the doctors were professional and put them at ease. A respondent said she felt safe "because the talk is just between me and the doctor and I never hear it from anyone else". This safe environment is a precursor to self-disclosure which is a vital element in doctor-patient communication.

In relation to the doctor's tone, one patient said the tone was fatherly although at times, the relationship was businesslike, while another said the tone was comfortable because nothing had gone overboard to cause him concern.

In response to whether the doctors listened to them carefully, all the patients agreed that the doctors listened carefully. However, the first patient clarified that the doctor listened if the situation warranted listening otherwise they just presumed and prescribed. One female patient elaborated that the doctors at MMC listened because at one point, she stopped visiting MMC due to the cost but her visits to a leading city hospital were unsatisfactory. She said that though the cost at the two facilities was

similar, "in the city hospital I would go in and before I finish my first sentence, the doctor has already told me what I am suffering from and prescribed for me medicine". Another patient said she knew the doctors listened from their stance and posture.

In relation to whether they felt the doctor communicated with them clearly, the patients agreed that the communication was clear and one patient said that the doctor communicated clearly and even consulted the Internet as the patient waited. Another patient said the doctor communicated clearly and explained how to use medication.

When asked whether the doctor took their questions kindly, all answered in the affirmative. Two of them said the doctor explained everything until they understood clearly. One said what the doctor did not take kindly was the patient making conclusions for the doctor instead of explaining and letting the doctor conclude.

In relation to whether they followed the doctor's instructions faithfully, one stressed that he followed the instructions "judiciously " while another one said she always followed instructions because "sitaki kukufa" (I do not want to die). Two of the patients however admitted they sometimes disregarded instructions especially on how to take prescribed medicine.

In response to whether the patients found it easier to communicate with a continuing doctor or a new one, they all preferred a continuing doctor. One patient said the continuing doctor already had his background and in most instances, trust already existed while the new doctor needed time to create understanding between the two. These findings were similar to those from the questionnaires.

Objective 2: To determine barriers to effective doctor-patient communication.

On the question of time spent waiting to see the doctor, as earlier stated, the findings revealed that most patients were happy with the short wait and cited long

69

waiting times as a barrier to communication.

In relation to whether age was a hindrance, two patients agreed, with one saying "being interviewed or seeking advice from an older doctor may hinder communication as they might judge me or not take me seriously". She added that younger doctors shared her world views, language and concerns. Other patients preferred middle-aged doctors due to their experience while one patient felt the older ones were more patient and did not rush the consultation. He said some young doctors rushed because they were profit oriented and wanted to see many patients. The findings from the questionnaires also indicated age as one of the barriers.

In relation to whether gender affected doctor-patient communication, findings revealed that most patients preferred male doctors. They said male doctors were more understanding and better listeners than female ones. Although one male patient found it hard to discuss some issues with female doctors, another said he preferred female doctors anytime because the way females were socialized made them receptive and they exercised higher confidentiality.

On the issue of whether culture played a role in doctor-patient communication, some of the patients thought it did. One patient said culture could make it hard to communicate with the doctor as it stopped patients from disclosing certain things to doctors of the opposite gender. Certain cultures forbade the mention of some body parts. One said, "in the African setting, there are some things you are not allowed to say loudly especially sexual things". Another patient brought in a new aspect saying that some female problems were not easy to disclose to a male unless it was your brother.

In response to what hindered doctor-patient communication, one patient brought in the issue of the doctor's race saying she had issues with Indian doctors

70

because she had been told they cheated in exams and she also found their tones condescending. This is a perceptual barrier because the patient was reporting hearsay. Another patient said confrontation between doctor and patient could hinder communication.

Objective 3: To establish ways of improving doctor-patient communication

When asked how doctor-patient communication could be improved, two patients said the patient should be given space to talk while the doctor listened keenly. Other patients said the atmosphere should be made conducive by discouraging people from walking into the room. When the patient is comfortable, they trust the doctor and self-disclose more. Another patient called for training in cultural diversity to improve communication.

When asked for any other comment, some patients advocated facilitation to consult the doctor by other means and not necessarily the face to face encounter especially on small matters. This is in line with findings from the doctors' in-depth interview where one doctor talked of the rise of telemedicine and use of online services.

In summary, the findings from the questionnaires and the in-depth interviews tallied. Generally, most of the patients were pleased with the communication at MMC. A few were however dissatisfied and this could be due to their personality.

Research Findings

Various research findings were obtained after analysis and presentation of the data. These findings were in relation to the research topics and the research objectives which the researcher set out to study. According to the study, 89% of the patients were satisfied with the way the doctor communicated with them. The remaining 11%

71

were either neutral or did not like the way the doctor communicated with them. This dissatisfaction could be due to various factors such as the personality of the patient or the already identified barriers to communication.

The research also found that there was a need to improve the communication skills training currently offered to doctors at medical school. It emerged that though some communication skills' training was currently offered, it was inadequate.

The research indicated that doctors spent very little time with the patients as 84% of the patients said they spent up to 30 minutes on average with the doctor. The patients were however content with this time. The other 16% either took over an hour or did not indicate the time they took. For someone to take that long there must be a special procedure being performed.

The findings further indicated that the men took longer with the doctor than the women. More men than women spent more than half an hour with the doctor. This contradicts the literature (Arora & McHorney, 2000; Champion, 2007) that because women disclose more emotional issues, they end up giving and also receiving more information than men.

Research revealed that when older women from Nyanza were accompanied by their grown sons, they let the sons talk for them. This unique finding perplexed the researcher as this behavior was expected from the Muslim community with their strictly defined gender roles and not Nyanza where the women are relatively emancipated.

A further baffling finding on culture was when a patient said that as a lady, African culture discouraged her from discussing sexual matters with men unless the man was her brother. This is a unique observation and the researcher wondered whether this could be due to the respondent's socioeconomic class and educational

72

level. Further research is however needed on this.

The study further revealed that socioeconomic status played a significant role in doctor-patient communication. Some patients, especially those with low education, attributed all physical and psychological problems to supernatural powers. Socioeconomic status was also a problem with some members of the upper class displaying an attitude of "do you know who I am?" while others from affluent areas rejected diagnosis which they felt did not tally with their residential or social situations. For example, a doctor at MMC said some parents from Runda refused to accept that their children could have worms.

The study underscored the importance of continuity of care. It emerged that knowledge of the continuing patient's background and the prior interaction made conversation easy. This is because the already existing trust led to high self-disclosure. The findings also revealed that patients with higher education used the Internet more for medical information. Conversely, patients with the lowest education tended to get most of their medical information from the doctor.

The study indicated that patients thought that the greatest barrier to doctor-patient communication was the use of technical terms and jargon at 21.55%, followed by poor articulation of illness by patients at 17.88 % and short consultation time at 16.53%. The research also revealed that patients were increasingly keen to communicate with their doctors in other ways apart from the face-to-face encounter. This was seen in the increased use of telemedicine and other online services. The patients looked at the context set by the doctor before they disclosed details of their illness. Therefore, doctors and patients should strive to improve their communication in order to enjoy improved medical outcomes.

Summary

Chapter four provided quantitative findings from the research that was conducted. The chapter has also presented the findings from the in-depth interviews with the doctors and patients. The following chapter discusses the research findings in light of the study objectives. It also presents the conclusions of the study and the recommendations drawn from the study.

74

CHAPTER FIVE: DISCUSSIONS, CONCLUSIONS AND RECOMMENDATIONS

This study set out to evaluate doctor-patient communication at MMC at Nation Centre in Nairobi. This chapter focuses on the conclusions and recommendations derived from analysis of the data obtained from the study. The conclusions and recommendations are derived from the research objectives which were the foundation of this research.

Relationship between the Findings and Objectives

The first objective sought to evaluate the factors that affected doctor-patient communication. Communication forms the basis of all decisions and interventions in the medical encounter (Beisecker & Beisecker, 1990) and has various elements. If communication is effective, medical outcomes would improve.

One of the major elements of communication is effective listening. Eighty-four percent of the respondents agreed that the doctors listened to their explanations. The 16% who were dissatisfied could have been victims of the communication barriers previously identified. These findings support the proposition by Beck et al. (2002) that active listening encourages doctor-patient communication.

The context in which communication takes place impacts doctor-patient communication. The context refers to both the physical facilities and the setting. All the doctors interviewed said they greeted the patients and introduced themselves. This helped to break the ice and create a respectful atmosphere for effective communication to take place. This finding concurs with Ray (2005) that doctors show respect by introducing themselves and greeting the patient. It further corroborates the findings of the study at Muhimbili National Hospital by Muhondwa et al. (2006) that for a satisfactory rating, patients need to be treated well at the reception and medical

75

records even before they meet the doctor.

Another aspect of the context is the physical facilities where ninety percent of the respondents who participated in the study agreed that the consultation room was pleasant. Favorable physical amenities create a healing environment (Vellakal et al., 2010). Street et al. (1995) also contended that conditions in the physical set-up like privacy for undressing and examination, noise level, colors used in the décor and provision of amenities like drinking water, washrooms, reading materials and television positively affects doctor patient communication.

Additionally, trust is a vital element of doctor-patient interaction. In this study, almost 50% of the respondents said they did not seek alternative medical opinions but trusted what the doctor told them. These findings supported Berrios-Rivera's (2006) argument that trust which is vital for successful doctor-patient interaction results from continuity of care. The longer people interact, the deeper and wider their level of self-disclosure according to SPT. Trust leads to satisfaction with care, adherence to treatment and consequent better health outcomes. The other 50% who sought alternative opinions comprised the educated young patients who used the Internet a lot for other businesses thus ended up using it to access medical information too. This group also comprised the people in the lower social stratum who sought advice from others or visited traditional medicine men.

The doctor's communication style is crucial and affects doctor-patient communication. These styles range from doctor-centered, where the doctor focuses on the illness and makes all the decisions to patient-centered, to where the doctor views the patient as a person and involves them in decision making. In this study, 89% of the patients agreed that they were satisfied with the way the doctor communicated with them. Bradley et al. (2001) stated that doctors should use a participatory style

76

and share power and decision making with patients. This concurs with Ruiz-Moral's (2009) conclusion that mutual sharing of information and joint decision making between the doctor and patients leads to improved medical outcomes.

The second objective was intended to determine barriers to effective communication between doctors and patients. In relation to the research findings, though various barriers existed, some seemed to be more dominant and of more significance to the interaction's success. Findings revealed that 21.4% of the respondents said that the use of technical terms and jargon was the major factor affecting doctor-patient communication. This was followed by 17.8% who said it was poor articulation of illness by patients, 16.5% who said short consultation time and 9.7% who said negative verbal and nonverbal cues by the doctor. Close to nine percent of the respondents said gender differences, 8.4% said age differences while the remaining 17% identified factors such as length of interaction, lack of salutation and differences in cultural perspectives. All these factors affect communication and no matter how small the count, their presence can cause ineffective communication.

The study revealed that though most patients spent less than half an hour with the doctor, they viewed this as a positive attribute. Though the researcher wondered if this time was enough to foster effective was communication, time depends on the specific case being seen hence there is no ideal length of time. Since the patients were generally satisfied, the quantity of time could be low while the quality was high. Weiner et al. (2005) stated that insufficient consultation time could be due to incentive to generate lots of money by seeing as many patients as possible. This might not avail adequate time for proper progress of relational closeness as explained in URT and SPT.

The effect of length of interaction or continuity of care cannot be ignored. This

is an ongoing relationship between patients and their care givers that covers multiple

illnesses and also provides preventive care (Saultz, 2003). In Kenya, just like in most

parts of the world, the concept of having a primary care giver who takes care of one

from the cradle to the grave is lacking. Furthermore, every time someone falls sick,

they are likely to visit different medical facilities. Even where they visit the same

facility, they are likely to see different doctors every time. Because there is no

communication between these doctors, there is an unfortunate loss of continuity of

care (Weiner et al., 2005).

Abdulahi et al. (2007) revealed that lack of continuity of care hinders effective

doctor-patient communication as every time a patient meets a new doctor, they have

to reduce uncertainty. As earlier explained, in URT, longer interaction elicits more

information-seeking and strengthens self-disclosure. Those who stick with one

primary doctor over a long period tend to be more satisfied, adhere to their medical

regimen more and lead healthier lifestyles (Abdulahi et al., 2007).

Another factor that came up as a barrier is the patient's perception that he/she

knew what he/she was ailing from. Findings revealed that younger educated patients

used the Internet and this exposure led them to demand more participation in their

care because they had more information on which to base their decisions. These

demands can antagonize the doctor who might then deny the patient the best care

(Levinson et al., 1993). Doctors could guide the patients to the credible websites and

blogs which carry accurate information.

The research also revealed that, out of the of the respondents who were

satisfied with the way the doctors communicated with them, 29% would seek

alternative medical opinions while out of the those who were not satisfied with the

way the doctors communicate with them, 49% would seek alternative medical

78

opinions. These other opinions were sought from the Internet, magazines, other doctors, friends and family. Therefore, it can be deduced that the level of satisfaction with the doctor determined whether the respondents sought alternative medical opinions. This affirms the study by Levinson et al. (1993), in which they concluded that the quality of communication between doctor and patient was vital to medical outcomes and satisfaction of both parties.

Language differences between the doctor and the patient can also hamper doctor-patient communication. In Kenya, with 42 languages and even more dialects, chances are high that the doctor and patient will speak different languages. The doctors said that patients, usually the old, who were not proficient in English or Kiswahili, relied on their chaperones to translate. This is unsatisfactory as Jacobs et al. (2006) said that when physicians rely on translators, chances of the information being distorted are high. Though this problem cannot be wholly eradicated, hospitals can reduce this problem by employing translators of the languages in the immediate environments to assist patients with language difficulties.

The third objective was to establish ways of improving doctor-patient communication. Better communication between the doctor and the patient leads to improved medical outcomes. Most doctors and patients in the study cited the need for improved doctor communication skills. Currently, there are many cases of doctors being sued for negligence and malpractice yet the problem tends to be ineffective communication and not lack of professional competence. Sussman et al. (2010) said that simple communication strategies can overcome communication barriers. This study concurs with Kidd et al. (2005) who advocated incorporation of communication skills in the embryonic stages of clinical studies by making the clinicians work alongside social scientists.

79

Just the way communication practitioners segment their audience before addressing their specific needs, doctors should also be trained in audience analysis. Doctors need to know who the person coming to them is. They need to understand their cultural and social backgrounds and also be cognizant of all their needs and concerns. Though this will demand a lot from the doctors, it will improve the IPC process.

Communication can also be improved by being sensitive to cultural diversity. In Kenya, the increased presence of foreigners coupled with urban migration has created a cultural melting pot. This calls for cultural sensitivity in healthcare to cater for all groups (Wilde, 2007; Tucker et al., 2003).

Patients are more exposed to technology and when they are dissatisfied with outcomes resulting from ineffective communication, they seek medical solutions from other sources like the Internet (Wilde, 2007). Because not all Internet information is accurate, this can cause danger to the patients. For the Internet to improve communication between the doctor and patient, the information needs to be accurate, accessible, timely and effective.

Conclusions from the Findings

Various factors affect doctor-patient communication. A major finding is that medical outcomes not only result from the doctor's technical competence but also depends on his or her communication skills. In Kenyan medical schools, though communication skills training is part of the syllabus, it needs to be strengthened. The study showed that doctor needs to have excellent verbal and nonverbal communication skills to enhance questioning and listening skills. The better the skills, the more the patient becomes trustful and discloses more. This leads to accurate

80

diagnosis and treatment.

Previously, patients visited doctors who examined them and decided on the course of treatment without referring to the patients at all. As the world developed and people became more conscious of their rights, patients started demanding more stakes in their own care. This research revealed that currently, patient-centric communication where both the doctor and patient mutually decide on the course of treatment is preferred. In this scenario, the patients adhered to the regimen leading to improved outcomes.

Medical care has evolved over the years and where previously the patient had to visit the doctor for consultation, other avenues are now available for this. However, the Internet is becoming increasingly significant in healthcare. Young educated patients turn to the internet for answers to their medical problems. Findings indicate that most use the Internet for preliminary inquiries to allay their fears and act as a basis for further discussions with the doctor. The medical fraternity however needs to ensure the accuracy of uploaded information to avoid misleading the users as this could have dire consequences.

The study also indicated that context played a significant role in the success of doctor-patient communication. Patients detest the practice of other people walking into the room during consultation. Privacy is a key element as it is the precursor of trust which allows patients to self-disclose candidly.

The findings reveal that at MMC, the doctors used the elements of communication to improve medical outcomes. The patients mentioned context and communication styles as elements that positively impacted on the communication. They also said MMC had closed doors and no one walked in during consultation. This evaluation of doctor-patient communication at MMC shows that the doctors used the

81

elements of communication effectively. This has led to positive medical outcomes and

MMC's rapid expansion.

The foregoing discussion thus shows that the study objectives have been met

and secondly that URT and SPT and the conceptual framework have been upheld,

although a few other variables were identified as shown in Figure 10.

Recommendations for Improving Doctor-patient Communication

This study has shown that in the doctor-patient relationship, the two should be

open and honest to ensure effective communication. This would improve the clinic

experience for both doctor and patient. Self-disclosure would ensure that the doctor

makes accurate diagnosis, counsel appropriately, give therapeutic instructions and

establish caring relationships with patients. It would also help patients make informed

choices, adhere to advice on treatment and accept life threatening conditions. The

ultimate result would be improved medical outcomes. The doctors need to be

equipped with practical communication skills to address all contexts.

Though many factors can hinder effective communication between the doctor

and the patient, both doctor and patient should ensure that they develop trust and

openly dialogue on health issues. When they do not communicate effectively, the

patient tends to seek for information and treatment from alternative sources such as

the many faith healers on television, herbal medicine and cures from the East

especially China and even the witch doctors who claim to cure all manner of sickness.

Most of these alternatives sources are not proven. There is for example, the case of

patients flocking to Loliondo in Arusha, Tanzania in search of miracle healing from a

retired clergyman (Daily Nation, Thursday April 14th, 2011). Most of the people

visiting this faith healer have lost trust in conventional medicine and are therefore

82

prey to any alternative that seems attractive.

Doctors should improve their verbal and nonverbal communication skills to engender patient trust. The doctor must therefore strive to foster trust and relieve the patient's anxiety as trust fosters self-disclosure. This can be done by building an interpersonal relationship using open-ended questions, avoiding interruptions, and providing verbal encouragement and personal warmth to elicit candid self-disclosure from the patient as explained in URT. This is more crucial particularly with patients suffering from stigmatizing or sexually transmitted diseases. Fear of the doctor's reaction can lead to self-medication resulting in inadequate treatment and the consequent development of drug- resistant strains of viruses. The WHO is currently sounding an alarm that proliferation of a new generation of antibiotic resistant bacteria is on the rise due to improper use of current antibiotics (Bartlett, 2006).

The following (Figure 10) is a revised conceptual framework emanating from further insights from the study.

83

Time₁		

CONTEXT

```
┌─────────────────────────────────────┐
│ Uncertainty reduction and Social     │
│ penetration theories talk about:     │
│   • Predict and explain              │
│     relational development           │
│     (or lack thereof)                │
│   • Explain progress of              │
│     relational closeness             │
└─────────────────────────────────────┘
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Causes   PRIVACY

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┌──────────────────────┐   ┌─────────────────────────────────┐
│ Field of             │   │ Effective doctor-patient        │
│ Experience           │   │ communication encounter through │
│                      │   │ interactive strategies like:    │
│ Communication        │   │   • Active questioning          │
│ skills training to   │   │   • Mutual self disclosure      │
│ include elements     │──▶│   • Verbal and non verbal       │
│ such as active       │Leads to │  communication             │
│ listening, self      │   │                                 │
│ disclosure, IPC,     │   └─────────────────────────────────┘
│ communication,       │
│ culture and          │
│ perception           │
└──────────────────────┘
```

Leads to

Produces

Generates

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┌────────────────────────────────────────────────┐
│ Positive medical outcomes result from:          │
│   • Frank and honest explanation of symptoms and│
│     diagnosis                                    │
│   • Clear understanding of symptoms and diagnosis│
│   • Faithful compliance with the prescribed      │
│     treatment regimen.                           │
│   • Mutual understanding                         │
└────────────────────────────────────────────────┘
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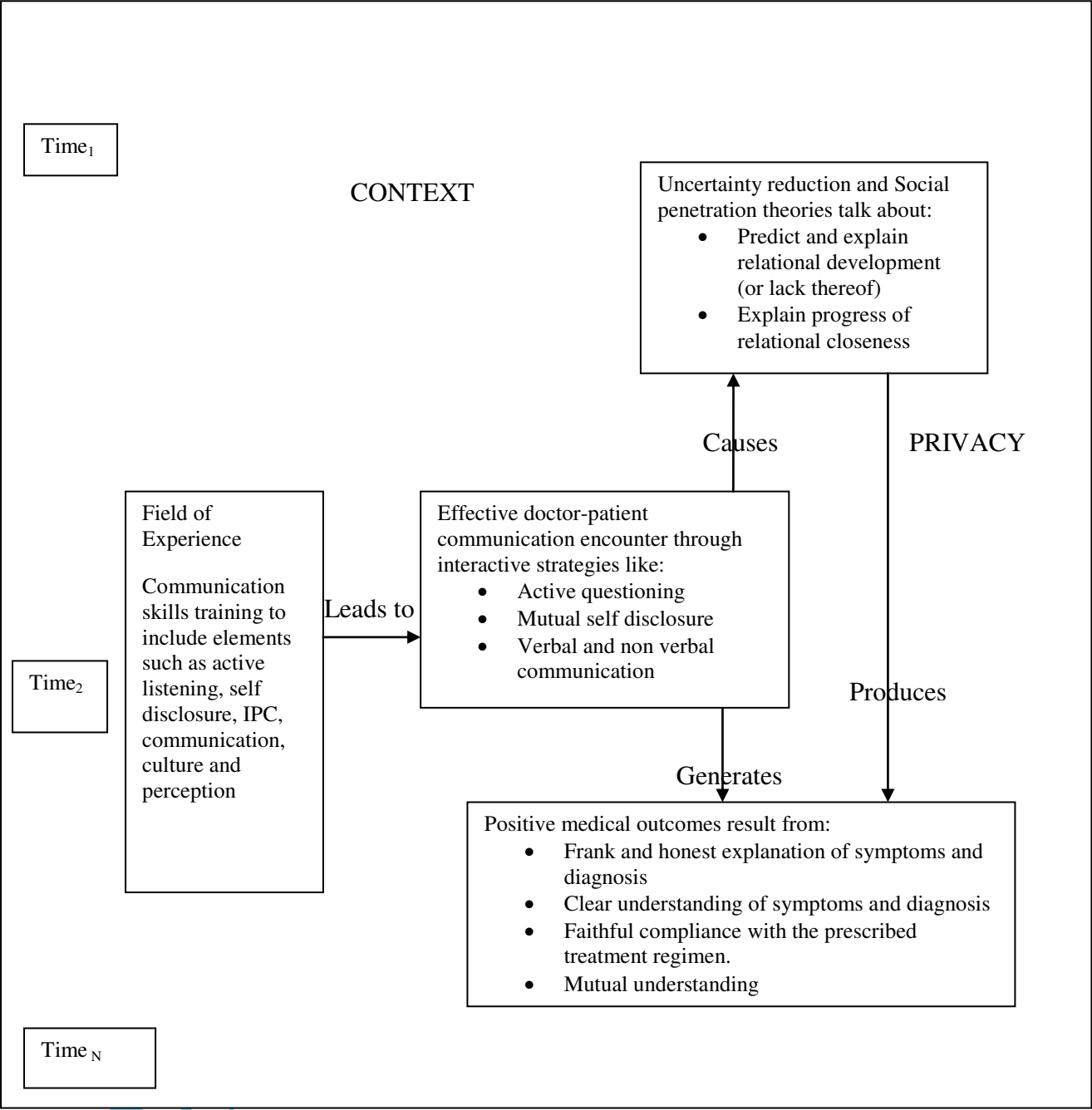| Time₂		

Time N		

Figure 10: Revised conceptual framework (Ochuodho, 2011)

Recommendations for Further Study

With regard to effective doctor-patient communication, this study's

respondents said that there was a need for further study on effect of culture on doctor-

84

patient relationship especially where the doctor and patient were of different gender.

Most patients also reported that they spent less than half an hour with the doctor. The researcher believes that consultation time can be inadequate and that more research needs to be done to find out the optimal time for a clinic encounter.

Both print and electronic media in Kenya are increasingly reporting cases of doctors being accused of negligence leading to permanent damage to patients' health and even death. Most of these cases result from breakdown of communication between the doctor and patient. There is therefore need for a study on how to overcome these communication hurdles that have dire results.

Dissemination of Findings

Healthcare is a vital pillar of society and at independence, the founding father of the nation Mzee Jomo Kenyatta pledged to fight poverty, ignorance and disease. Unfortunately, this has not been fully achieved and the health situation remains bleak especially with the spiraling of deadly diseases like AIDs, cancer and diabetes taking their toll on the population. It is hoped that the findings of this study would contribute towards the improvement of the country's health outcomes.

The researcher hopes to disseminate the availing copies of the study to libraries in all the local universities offering medical training. This would enable students to refer to it. As the case study, MMC would also be given a copy of the completed study.

Wider dissemination would take the form of presentation at medical information conferences. This would ultimately result in the publication of the study in a refereed journal and would help to achieve wider dissemination. Finally, a synopsis of the study would be presented to the Ministers for Medical Services and Public Health with a view to encouraging them to use any relevant portion of the study for policy

85

change and implementation.

Summary

This chapter has discussed the findings of the study in relation to the research objectives. It has also presented conclusions drawn from the research objectives, recommendations on how to enhance doctor-patient communication, recommendations for further research and ways of disseminating the findings.

Research Summary

Effective doctor-patient communication has not received much attention in the study of health care delivery in Kenya. This study has revealed that improved medical outcomes depend on effective communication between the patient and the doctor. Various types of literature related to the topic have shown the multiple impact of communication on various aspects of medical outcomes which include better health outcomes, higher compliance with therapeutic regimens for patients, higher patient and doctor satisfaction and reduced malpractice risk.

This study exposed how different elements such as self-disclosure, trust, effective listening, doctors' communication styles and the context in which the communication takes place can affect its effectiveness. It also highlighted the factors that inhibit effective communication including language, duration of consultation, poor articulation of illness by patient and lack of continuity of care, among others. The study further highlighted the importance of offering doctors training in communication skills and the use of online sources in healthcare.

On a general note, this study has shown the need for the country to establish proper rules and procedures to promote awareness of the importance of doctor-patient

86

communication. This will result in improved medical outcomes for both doctors and

patients.

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92

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APPENDICES

APPENDIX ONE: INTERVIEW SCHEDULE FOR DOCTORS

Good Morning/Afternoon Doctor ---------.

 My name is Jeddy Ochuodho. I am a postgraduate student at Daystar University. As part of the requirements for a Master of Arts Degree in Communication, I am conducting an academic research titled "An Evaluation of Doctor-Patient Communication: A Case Study of MMC at the Nation Centre in Nairobi".

The research is purely for academic purposes and all information provided will be treated with utmost confidentiality. The findings will help both doctors and patients communicate more effectively and achieve improved medical outcomes.

I would like to have your permission to record this interview. This will help me to remember everything accurately and avoid unnecessary mistakes. Therefore, please just relax and if you feel uncomfortable with any question, do not answer it.

If you would like, I can arrange to give you a copy of my research once it is completed.

 Thank you for your time and God Bless you.

1. How long have you been a doctor at MMC?

2. On average, how long do you take with one patient?

3. Kindly outline how you conduct the consultation.

4. Do your patients explain their problems clearly? Why?

5. Do you feel that they listen to you attentively? Why?

6. Do they communicate with you clearly?

7. Do you think that they follow your instructions faithfully? Why?

7. What factors do you feel hinder communication between you and the patients?

8. Is it there a difference between communicating with a new patient or a continuing patient?

9. Which patients are easier to communicate with; the younger or the older ones? Why?

10. Does education have any role in how they communicate? How?

11. Does the patient's gender affect how they communicate? How?

12. Does culture play any part in how you communicate with your patients? How?

13. Are some patients harder to communicate with than others? How?

14. How do you think this communication can be made more effective?

15. Any other comments?

Thank you very much for sparing your valuable time to answer these questions. I now also kindly request for permission to call on you again should a need arise.

Once again, thank you very much and may God bless you.

APPENDIX B: INTERVIEW SCHEDULE FOR PATIENTS

Good Morning/Afternoon   ---------.

My name is Jeddy Ochuodho. I am a postgraduate student at Daystar University. As part of the requirements for a Master of Arts Degree in Communication, I am conducting an academic research titled "An Evaluation of Doctor-Patient Communication: A Case Study of MMC at the Nation Centre in Nairobi". The research is purely for academic purposes and all information provided will be treated with utmost confidentiality. The findings will help both doctors and patients in MMC communicate more effectively and achieve positive medical outcomes.

I would like to have your permission to record this interview. This will help me to remember everything accurately and avoid unnecessary mistakes. Therefore, please just relax and if you feel uncomfortable with any question, do not answer it.

If you would like, I can arrange to give you a copy of my research once it is completed.

Thank you for your time and God Bless you.

1.   How long have you been a patient at MMC?

2.   Why is MMC your preferred clinic?

3.   On average, how long does the doctor take with you?

4.   Do you feel the doctor handles you privately during consultation?

5.   Do you feel safe during the consultation?

6.   Do you feel he gives you adequate time to explain your problems clearly?

7.   Do you feel that he listens to you attentively?

8.   If not why do you feel he is not attentive?

9.   Does he communicate with you clearly?

10. Are you comfortable with the doctor's tone?

96

11. Does he take any question from you kindly?

12. Do you follow his instructions faithfully?

13. If not, why do you not follow them?

14. Do you have access to the internet?

15. Do you access ant medical information from the internet?

16. What are the factors that you feel can hinder communication between you and the doctor?

17. Is there a difference between communicating with a new doctor and a continuing one?

18. Which doctors are easier to communicate with; the younger or the older ones? Why?

19. Who communicates more effectively; male or female doctors? Why?

20. Does culture play any part in how you communicate with the doctor? If yes, How?

21. Are some doctors harder to communicate with than others? Why?

22. How do you think this communication can be made more effective?

23. Any other comments?

Thank you very much for sparing your valuable time to answer these questions. I also kindly request for permission to call on you again should a need arise.

Otherwise, thank you very much and may God bless you.

APPENDIX C

QUESTIONNAIRE FOR PATIENTS

Dear Respondent,

Hello. My name is Jeddy Ochuodho and I am a postgraduate student at Daystar University. I am working on the final requirement towards my Master of Arts Degree in Communication; my master's thesis. The topic I have chosen to study is "An Evaluation of Doctor-Patient communication: A Case Study of MMC at the Nation Centre in Nairobi". My research so far has revealed that not much has been done in this field in Kenya, and with your help, I would like to change that.

Kindly take a few minutes of your time to fill the attached questionnaire. The research is purely for academic purposes and all information provided will be treated with utmost confidentiality. Therefore feel free to be as honest and accurate as possible. Where choices are provided please tick as appropriate; where your response is not "option" feel free to add it in the "other (specify)" section.

Thank you in advance for your participation. If you have any questions or concerns regarding this study, please feel free to contact me on telephone number 0723 846 073 or drop me an email at jeddy.ochuodho@yahoo.com.

Yours faithfully,

Section One: Bio Data

Kindly tick in the bracket with the correct response.

1. Gender

Male   (   )   Female   (   )

2. How old are you?

Under 18 years   (   )   18- 27 Years   (   )   28-37 Years (   )

38-47 Years   (   )   48-57 Years   (   )   58-67 Years (   )

68-77 Years   (   )   78 and above   (   )

3. What is your nationality?   --

4. What is your highest academic qualification?

Primary   (   )   Secondary   (   )   Graduate   (   )

Post Graduate   (   )

5. Do you have a medical cover?

Yes   (   )   No   (   )

If yes, answer question, 6. If no, go to section two.

6. Where can you use your cover?

MMC only   (   )   Other medical facilities also   (   )

Section two.

1. How often do you visit the doctor at MMC?

Rarely   (   )   Often   (   )   Very often (   )

2. How long have you been a patient at MMC? …………………………….

3. When did you last visit any doctor before today's visit? …………………..

4. Do you visit any other health facility? ....

If yes, which one(s)…………………………………………………………

99

5. How long do you wait on average to see the doctor? ....

6. How long do you take with the doctor on average? -------------------------------

7. Do you communicate with the doctor in any other way apart from the physical

    visits?

Yes   (   )   No   (   )

If yes, go to question 8 and if no, go to question 9

8. If yes, how do you do this? ---

9. Is there any difference between communicating with a new doctor and a

    continuing one?

Yes ( )   No ( )

10. Where else do you get medical information apart from your doctor?

Internet   ( ) Magazines   ( ) Friends and relatives   ( ) Other sources (specify) ( )

11. Choose the top 3 factors that you believe negatively affect doctor-patient

    communication (Please Tick)

Factors that affect doctor-patient communication negatively	
Poor articulation of illness by the patient	Clinic setup
Use of technical terms by the doctor	Short consultation time
Different cultural perspectives between doctor and patient	Length of prior interaction between doctor and patient
Age differences between the doctor and patient	Lack of salutation by the doctor
Gender differences between doctor and patient	Others (specify)

100

12. Please tick the number that best describes your feelings about your

communication with the doctor.

Statement	Strongly Agree 1	Agree 2	Neutral 3	Disagree 4	Strongly Disagree 5
I am satisfied with the way the doctor communicates with me					
The doctor pays attention to my explanations					
The doctor greets me warmly at every visit.					
The doctor uses a friendly tone during consultation					
I feel safe during the consultation					
There is privacy during consultation					
The doctor takes my questions kindly					
The consultation room is pleasant					

13. Do you accept everything your doctor tells you?

Yes   (   )   No   (   )

If no, why? --

14. Do you follow all the instructions your doctor gives you?

Yes   (   )   No   (   )

If no, why? --

15. Do you seek alternative medical opinions?

Yes   (   )   No   (   )

If yes, from who or where? --

16. Any other comments --

101

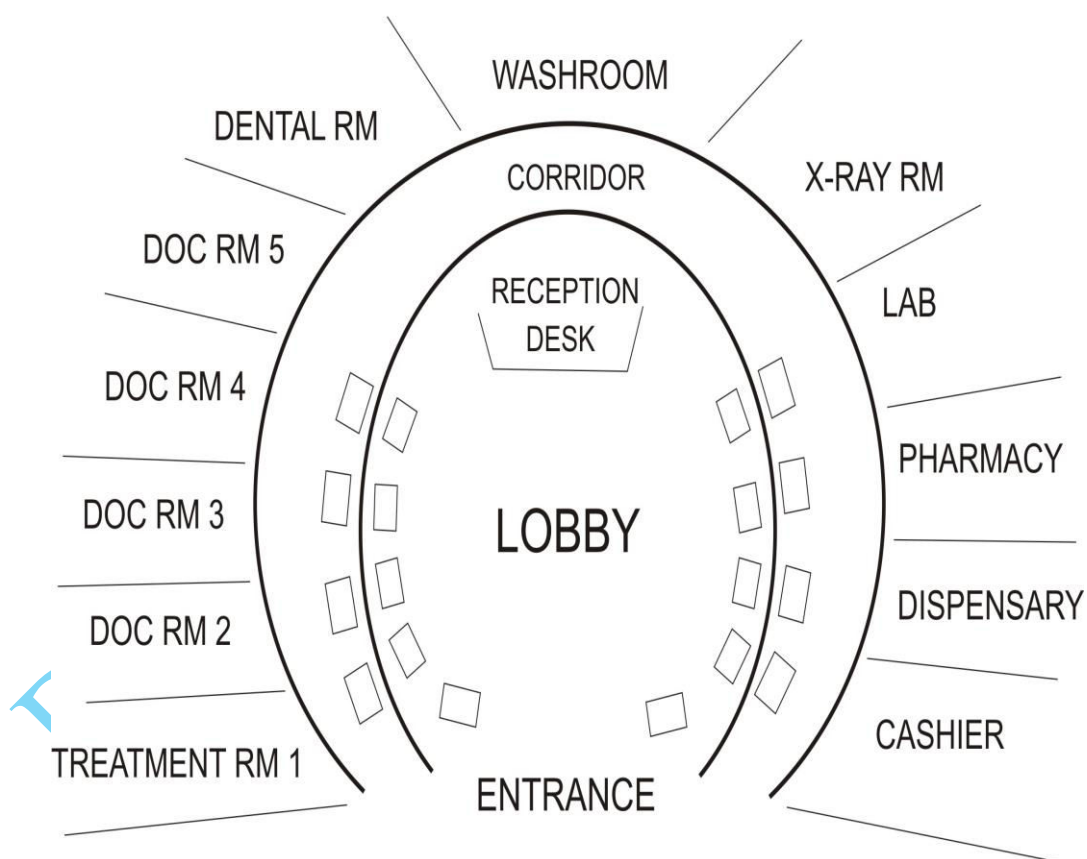Thank you for your time and may God Bless You.

APPENDIX D:

LAYOUT AND PICTURES OF MMC NATION CENTRE
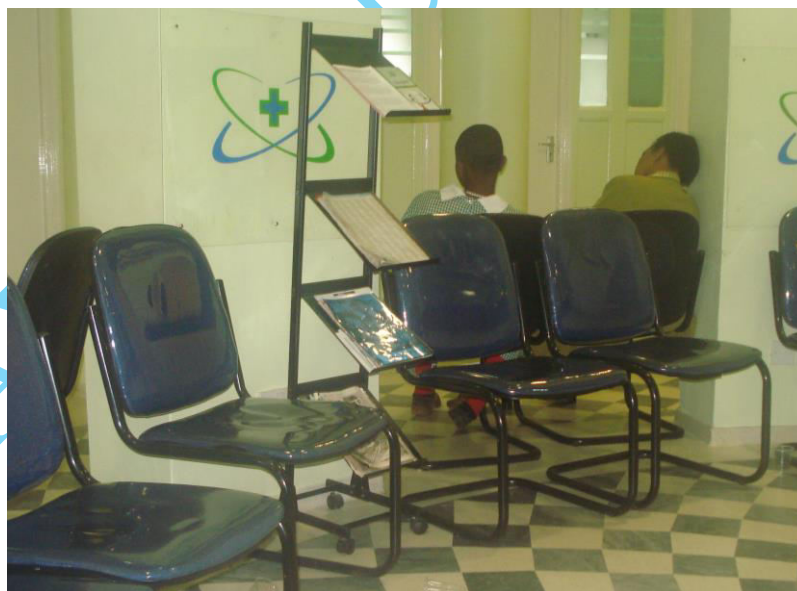
MERIDIAN MEDICAL CENTER
NATION BRANCH
PHYSICAL LAYOUT

Physical layout of MMC Nation Centre (By Sakwa, 2011)

102

Reception of MMC Nation Centre (By Sakwa, 2011)

Waiting area of MMC Nation Centre (By Sakwa, 2011)

103