Doctor Patient Communication in Health Care Service Delivery: A Case of Tribhuvan University Teaching Hospital, Kathmandu

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DEDICATION

This work is dedicated to my respected parents, Shanker P. Kattel and Ishwori Kattel who have raised me to be the person I am today. I thank them for the love, guidance, and support that they have always given me.

ABSTRACT

The health care delivery system in many countries, including Nepal is changing. There has been a growth of profit driven medicine, managed care, and increasingly technological focus. Despite sophisticated technologies for medical diagnosis and treatment, communication remains the primary means by which the doctor and patient exchange health information. This study comprises of four main objectives. The first objective of this thesis is to determine the status of doctor patient communication in medical setting. The second objective is to verify whether patient's demographic variables impacts communication. The third objected is to find out whether patients are active in interacting with doctors and lastly the fourth and final objective is to determine whether hospital's structure and procedure effected communication with patients. Barnlund's Transactional Model of Communication (1970) and Models of health care by Ferlie and Shortel (2001) has been taken as the theoretical basis of this research to evaluate doctor patient communication from three perspectives: The patient, the doctor and the hospital.

Seven doctors and 30 patients participated in the study. Mixed method research approach was undertaken for this research. Both doctors and patients were handed out a questionnaire survey consisting of both open-ended and closed-ended questions. Data collection also included non-participatory observation in medical out patient department and inpatient medical department. Structured interview was carried out with five administrative personnel. Content analysis was conducted for observational notes, field notes and responses to opened-ended questionnaires by doctors. In addition, secondary sources were used to strengthen the research.

SPSS 17 was used to gather frequency, percentage and cross tabulation of the survey. The result showed that majority of the patients was illiterate and came from villages. It also depicted patients responding on a positive tone regarding their communication with doctors i.e. communication was simple and easily understandable; they gave sufficient time for consultation. However doctors omitted to mention consequence of the treatment methods (diagnosis, side effect of medicine, health outcome) and only

42% demanded further information. More then half of the patients were satisfied with the care and had no complaints. Observation during medical consultation showed patients were passive in question asking and doctors took control in the decision making about patient's treatment. Doctors adapted a paternalistic approach and believed that socio-demographic of patient's impacted communication. This was also supplemented by patient's low literacy and low health education that influenced doctors to take the lead in patient's health care. Furthermore, Hospital lacked rules, regulation and procedure to support doctor patient communication which prohibited doctors in adapting a patient centric approach.

Good doctor patient communication has not received much attention in the study of health care service delivery in Nepal. Quality medical care depends on effective communication between patients and health professionals. Misunderstanding can occur in any medical setting but can be further compounded by lack of compliance by patients, dissatisfaction, and negative health outcome and increase risk of malpractices. The result was consistent with patient's age, gender, occupation and education and that patient's low literacy and health awareness inhibited them to take control of their health. Doctors low communication skill and lack of support form hospital managements was another factor for them to focus on the biomedical perspective of health. Understanding about doctor patient communication is still not taken as an important part in treatment practice. This is due to both parties, on one hand, doctor's lack of time and understanding of patient's behavior and work pressure where as on the other hand patients low awareness level, technological problems, and status gap between doctor and patients.

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ABBRIVIATIONS

CC	Calgary- Cambridge Observation guide
I.C.U	Intensive care unit
IOM	Institute of medicine
JICA	Japan International Cooperation Agency
MBBS	Bachelor of Medicine and Bachelor of Surgery
MD	Doctor of Medicine
OPD	Out Patient Department
O.T	Occupational therapy
TUTH	Tribhuvan University, Teaching Hospital

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CHAPTER-1
INTRODUCTION

1.1 BACKGROUND:

The goal of any health care organization, from emergency treatment centers to traditional hospitals, is to provide quality care to its patients. What is considered quality care can be ascertained in a number of ways from a number of perspectives. For doctors, it may be the number of remissions or successful treatments of patients. For nurses, it may be the feeling that they provided care that improved the quality of their patient's lives. For patients and their families, quality may include efficient, timely, affordable, and equitable care as well as positive interpersonal relationship with the doctors. Patients, who like their doctors, feel that they are listened to, are treated kindly, and generally perceive the interpersonal dynamics as positive, tend to be more satisfied with their medical care. Doctor patient communication is an important element in health care. The communications are not merely a ubiquitous feature of the health care system; they also provide the primary means for the diagnosis and treatment of disease, the management of illness, and the prevention of many health problems (Wasserman RC., Inui TS., 1983). Ultimately, doctor patient communication forms the basis of a doctor patient relationship.

The health care delivery system in many countries, including Nepal is changing. There has been a growth of profit driven medicine, managed care, and increasingly technological focus. Despite sophisticated technologies for medical diagnosis and treatment, communication remains the primary means by which the doctor and patient exchange health information. For the doctor, information is crucial for formulating diagnoses and prescribing treatment; for the patient, information fosters an understanding of one's health status which in turn may reduce uncertainty, alleviate concerns, and improve health (Stewart, MA., 1995).

The focus of this study is the communication status between doctors and patients. It is confined to the Out Patient Department (OPD) of medicine and medical ward in Tribhuvan University, Teaching Hospital (TUTH), which is considered the best

hospital among government hospitals for treatment and facilities. Patients seeking service at TUTH represents all 75 districts having ethnic, cultural, regional, language and religion diversity. The medical OPD signifies those that come for one time service or follow up service which enables the researcher to understand patients health behavior and communicative pattern, where as the In-Patient Medical Ward, the biggest unit in the hospital, represents those that are in critical condition which enables the researcher to examine the communication pattern between the doctor and patient regarding the severity of the disease and its treatment.

1.2 STATEMENT OF THE PROBLEM

In Nepalese culture, doctor patient interaction is dominated by the doctor and a culture of "not questioning the doctor" (Mugrditchian, SD., Khanum, S., 2006). Because of social and educational barriers, doctors feel there is no point in attempting to explain tests and test results to patients as they would not understand anyway (Prakash, O., 2003 cited in Mugrditchian, S.D., Khanum, S., 2006). Level of communication is placed in the hand of the physician where they are the communicator and patients are the listeners. Doctors were once seen as god-like in Nepalese society, the popular belief that they can treat and cure any condition. Hence, patients used to leave their full confidence of their health outcome to them. However, over the past decade, doctors are often criticized for not providing adequate considerations to the patients feeling or desires regarding the illness or conditions being treated. The patients on the other hand, often assume a doctor may know things about his/her condition when he or she actually does not. These are complex problems that arise when the communication gap between doctors and patients is wide. Moreover, patients or family members often sign consent forms without really understanding what they are consenting to. Such one-way communication and decision making disempowers patients who, as a result, rarely participate in their own care. Poor communication is linked with less accurate diagnoses, suboptimal patient compliance, over-treatment, under treatment and "mistreatment" (World Health Organization, 1993). Furthermore, an increasingly well educated population has begun to demand medical authority and the doctor patient relationship is becoming and issue of rights approach. (Mugrditchian, S.D., Khanum, S., 2006).

Research that has been done in Least Developed Countries has indicated that health counseling and doctor patient communication is consistently weak (Nicholas, Highby & Hatzell 1991, cited in Roter, D., et al, 1998) in the efficacy of health care delivery systems (Loevinsohn 1990 cited in Roter, D., et al, 1998). Most of the communication focuses on the delivery of message and not interpersonal communication. In most cases, even when doctors know what substantive messages to communicate to their patients, they do not have the interpersonal process skills to communicate with them most effectively (Nicholas et al. 1991 cited in Roter, D., et al, 1998).

Health service delivery today is not just affected by the accessibility, equitable allocation of resources, empowerment and inclusion in Nepal. It is also severely affected by doctor patient relationship. And communication lies at the heart of doctor patient relationship (Kane et al, 1967 stated in Anderson FH., 1976). Effective communication is the clarity of understanding between patients and doctors. Ineffective communication with patients, may deliver delayed, incorrect, or improper medical care by the physician. Similarly, patients who do not properly express their conditions may make the doctors prescribe medicine that do not match with the sickness. Hence, level of communication of both doctor and patient has to be precise and to the point.

In Nepal, there had been a growing tendency by people to vent their anger on doctors and hospitals if family members died during treatment. As a result people have been increasingly suffering for the loss of their loved ones and their expectation and trust from doctors have been slowly declining. Hence, patients are becoming more aware of their doctor's communications effectiveness, or the lack of it, these days, and it is for this reason that patients are finding it easier to criticize or question their doctor's behavior and judgments (Appleman, 1975 stated in Anderson FH., 1976).

1.3 OBJECTIVES OF THE STUDY

The study in particular aims at answering the following questions:

1. What are the factors that contribute to establish doctor patient communication?
2. Are patients able to communicate properly with doctors?

The main objective of this study is to examine doctor patient communication to ensure better quality of health service delivery. Specific objectives of this research are:

- To determine the status of communication.
- To determine what effect demographic variables of patients have upon communication in the doctor patient relationship.
- To determine whether the organizational structure and procedure effects doctors communication with patients.
- To examine if patients play an active role in interacting with doctors.

1.4 SIGNIFICANCE OF THE STUDY

This study is significant in many ways. Nepalese health system is more focused on the biomedical model where interventions to control diseases are still the key delivery pattern for public services. This is further supported by the medical curriculum in the country. The study addresses poor communication status which has resulted in hurdles and gaps to doctor patient relationship. In order to overcome such circumstances, this study gives importance on the nation's medical education system to focus on communication skills training to health professionals in order to adopt a more patient centered care. In Nepal, communicable diseases are still a major cause of preventable deaths while non communicable disease has emerged as major killers. Health information and communication are important, powerful tools for the adoption of the healthy behaviors necessary to prevent and control communicable and non-communicable diseases. Human behavior is a major factor in health outcomes, and health investments, to be successful, must focus on behavior in addition to provision of health services and facilities. People must understand the need to adopt or change health behaviors, and this can come about through effective doctor patient communication. The study is therefore intended for policy makers, funders/sponsors, advocacy organizations, practitioners, and others in providing and evaluating interventions and awareness level of individuals on health literacy and communication between doctor and patient to improve health care service delivery.

1.5 LIMITATION OF THE STUDY

The research done in the area of the doctor patient communication specific to the Nepalese health care system is deficient. Hence, much of the theoretical background information concerning the doctor patient communication is based upon findings in the United States and Europe. However, the fundamental data can be applied in regard to the Nepalese health care system. Moreover, among the handful of public hospitals and clinics in Kathmandu, this study only represents doctor patient communication regarding one hospital and one unit in the hospital. The findings of this study may not be able to generalize through out the other units in the hospital nor other hospitals throughout Nepal. Even though doctor patient communication is a useful tool to improve the health service delivery, this study does not look upon the effectiveness of health improvement due to doctor patient communication. Lastly, the fourth model of Ferlie and Shortel (2001) health care system has been omitted in this research due to the lack of time and the vastness of the model itself.

1.6 ORGANIZATION OF THE STUDY

The thesis is organized as follows. It consists of six chapters:

Chapter one, "Introduction" comprises the purpose of the study, statement of the problem, research questions and objectives of the study. It also includes significance of the study, limitation of the study and organization of the study. ***Second chapter, "Literature Review",*** portrays the purpose of communication in medical setting. It briefly explains the research outcomes of doctor patient communication. It also includes the theoretical background for this study, which uses Barnlund's Transactional Model of Communication (1970) and Ferlie and Shortel (2001) health care system model to identify the dependent and independent variables along with its indicators. ***The Third chapter*** discusses the data that provide the basis for the thesis and the methods used to analyze them. It also outlines the data collection methods, participants involved and data analysis methods. ***Chapter four*** describes the organizational structure of T.U, Teaching Hospital and whether its structure supports doctor patient communication. ***Chapter five*** presents the data collected from the field and ***the last chapter*** is dedicated to the summary and discussion.

CHAPTER-2
LITERATURE REVIEW

2.1 INTRODUCTION:

The major objective of this research is to analyze doctor patient communication for ensuring better quality of health care service. The primary goal of any health care delivery system is to provide the best possible care to its patients. In this modern era, where it is the right of every patient to demand best possible care in hospitals, it is also the duty of every staff member of the hospital to deliver his optimum efforts to the entire satisfaction of the patient. The core axis around which the whole health care system revolves is the relationship between patients and doctors. Without an intact doctor patient relationship, no health system can work. Moreover, this relationship is tied by communication. Doctors need information from patients to determine an accurate diagnosis and effective treatment plan, and patients need information about their medical problem and the rationale and procedures for its treatment. So, for any health care system to work properly, communication between doctors and patients needs to be effective and precise.

Vast literature has shown that effective communication in medical treatment leads to improved health, functional and emotional status, compliance with medical treatment, clinician satisfaction, and reduced medical malpractice risk (Wong YS, Lee A., 2006). It is also believed to be essential for exchanging information so that both parties understand each other and the nature of the situation, develop a therapeutic relationship which fosters mutual honesty and trust, and make treatment decisions that are in the best interest of and acceptable to the patient (Allen SM., et al., 2001.)

This research specifically aims to analyze the usefulness of communication in doctor patient relationship. The focus of this chapter is to develop a conceptual framework by highlighting both dependent and independent variables. Literature review is first conducted to portray the importance of communication in health care. Then, ***Barnlund's Transactional Model of Communication (1970)*** and ***Ferlie and Shortell (2001) models in health care system*** has been taken to evaluate doctor patient

communication. This chapter is divided into two parts. The first part is the concept and context of communication. The second part deals with the theoretical framework along with variables of this study.

2.2 COMMUNICATION IN HEALTH CARE

As per the Oxford English Dictionary, the word communication comes from the Latin "communicare" which means mutual interchange and "communico" means to share. Communication is the interactive process between two people whereby one person is able to express what he/she means in a clear and unambiguous way and the other person is able to understand the meaning of the message fully and properly. In other words, one person expresses and the other understands. The responsibility for communication lies with both people – the one expressing must express as clearly as he or she possibly can and the other person must either understand or let the person who is expressing know he or she doesn't understand.

There are two ways in which we communicate: verbally and non-verbally.

- Verbal communication includes the words we use, our tone of voice, inflection, volume, emphasis and timing.
- Non-verbal communication includes our body language, gestures, posture, facial expression and eye contact, etc.

Communication is central to understanding human behavior. It is also specifically an important component in shaping human behavior to adapt and accept different health conditions. It also fortifies the relationship between doctors and patients.

2.3 PURPOSE OF COMMUNICATION IN MEDICAL SETTING:

Communication in heath care serves multiple purposes. It is foremost to solve problems. Patient's problems can be identified more easily with clear and precise interaction between doctor and patient. Once the problems are identified, through communication, patient better understand their problem even though it may or may not be resolved. This ultimately results in a significant fall in anxiety (Amir A., Yunus M., 1999). It is through communication patient's distress and the vulnerability to

anxiety and depression are lessened. Patients' anxiety and dissatisfaction is related to uncertainty, lack of information, explanation and feedback from doctors (ibid).

Communication is a vehicle for navigating the stressful circumstances that accompany acute medical illnesses. It is a tool to provide information. Through interpersonal communication, doctor and patients provide and exchange information needed for medical treatment. Patients are able to convey their feelings and emotions about their illness and socio-economic background. It is a method to generate, access, and exchange relevant health information for making important treatment decisions, for adjusting to changing health conditions, and for coordinating health-preserving activities. It is a mutual understanding of the patient's expectations of the doctors and the doctors' expectations of the patient. In addition, effective communication enables doctors to pass on relevant health information to motivate and persuade patients to pursue healthier lifestyles.

The most important aspect of communication is to form and maintain relationships. The interpersonal relationship that doctor and patient develop is defined by the way they interact with one another. These relationships guide individual responses to communications. The intimacy of emotions and the private sharing of information built on the foundation of mutual responsibilities that include - respect, open and honest communication, trust and compassion binds doctor and patient relationship. This healing relationship often includes friends and family members, patient advocates and other health care professionals. The relationship works best when physicians acknowledge the roles of these individuals and fully integrate them into the care of the patient. Patients increasingly see themselves as consumers of health care and look to their physicians for better, more efficient and more effective service. (Hopkins, J., 2003).

Effective communication maintains open discussion and a positive relationship even when there is uncertainty about the medical outcome. It provides reassurance. It is a powerful resource for healing and a source of comfort in situations where healing does not occur. When clear and confident statements are provided about patient's medical treatment, diagnosis or the failure to find the disease makes the patients cope with uncertain situation as they become mentally prepared to deal with arising

problems. Poor communication is commonly cited as a reason for patients behaving unexpectedly (such as not complying with treatment or expressing unfounded anxieties, in extreme cases physical harm to doctors).

Communication takes an important role especially in health care delivery as the lives of patients are at stake. Communication lies on a thin line between doctor and patient. A weak communication will ultimately bring a therapeutic process to worsen making the patient become more ill, or on an extreme level, will cause a loss of life. Effective communication between doctors and patients or patients' family members is the backbone of a good health care delivery system.

2.4 RESEARCH ON THE OUTCOME OF DOCTOR PATIENT COMMUNICATION

A number of studies provide substantial evidence on the relation between communication and outcome measures like satisfaction of both doctor and patient, compliance and health improvement (Curtain (1987), DiMatteo (1994), and Ong (1995), cited in Wong YS, Lee A., (2006).

2.4.1 Satisfaction:

Effective doctor patient communication is shown to be highly correlated with patient satisfaction with health care services. The key elements of patient satisfaction includes doctors to be friendly, concerned, and sympathetic and to take time and trouble for questions and explanations (Korsch, BM., Gozzi EK., Francis, V., 1968). Doctor's medical competence and his/her ability to balance between the patient's perceived needs and expectations (ibid) are strongly connected to patient satisfaction. Physicians' informativeness, interpersonal sensitivity, and (to a lesser degree) partnership-building are the main concern by patients where physician's informativeness reveled stronger patient satisfaction (Street, RL., 1991). Although system aspects such as cost(s), access, availability and waiting times are also related to patient satisfaction, they have always been identified as being less important than the doctor patient interaction (William SJ, Calnan M., 1991). Patients tend to be more

satisfied with their medical care when they communicate with doctors (Bertakis KD, Roter D, Putnam SM. 1991).

2.4.2 Compliance:

A second important finding is the relation between communication and compliance. Communication has been identified as the most important factor in determining patients' adherence to treatment (Zolnierek, H., Kelly, B. DiMatteo, MR, 2009). Low compliance with prescribed medical interventions is an important problem in medical practice and it is associated with substantial medical cost including increased hospital admissions and unnecessary expenditure on medication (ibid). It also creates an ongoing frustration to health care providers (Melnikow, 1994 cited in Wong YS, Lee A., 2006).

Effective communication enables doctors to pass on relevant health information, and to motivate patients to pursue healthier lifestyles, enhancing the doctor's role in health promotion and disease prevention (WHO, 1993). Many scholars have pointed out that satisfaction and compliance are interrelated (Korsch et al. (1968) and Francis (1969), Hulka et al. (1976) and Wilson, (1973) cited in Wartman, SA, et al (1983). Receiving an explanation of the symptom cause, likely duration, and lack of unmet expectations were found to be the key predictors of patient satisfaction and compliance to medical treatment (Wong YS, Lee A., 2006). In order to obtain compliance the doctor must assure that the patient understands and remembers what has to be done. Patients who have not been provided with the opportunity to express their concern or who do not receive the information they expected, are less satisfied and show less compliance (Korsch et al., 1968).

That is why clear, concise and explicit instructions are associated with higher compliance. Also essential for adherence is finding common ground for treatment goals and regimens. Discordance between doctors' and patients' expectations may decrease it (ibid). The patient's role in the decision process has been found essential for compliance, though not all the patients want the same role in decisions about treatment. A discussion during consultation about shared responsibility is positively associated with adherence.

2.4.3 Health improvements

Effective communication exerts a positive influence not only on the emotional health of the patient but also on symptom resolution, functional and physiologic status and pain control (Stewart MA., McWinney, IR., Buck, CW., (1979), Stewart, MA., (1995)). Doctors' asking questions about patients' illness experience, understanding the problem, showing feelings and concern, expectation of the therapy and perception of how the problem affects function and letting the patient fully express him or herself is associated with positive health outcomes (Stewart, MA.,1995).

Randomized clinical trials show an effect of such communication on the reduction of anxiety and psychological distress, pain relief, better functional status and symptom resolution (Roter et al, 1995 cited in Wong YS, Lee A., 2006, Amir A., Yunus M., 1999). Many studies (Ballard-Reisch, 1990; Roter & Hall, 1991; Stewart, 1984; Szasz & Hollander, 1956 cited in Bradley, G., et a., 2001) have shown a connection between patient-centeredness and health outcomes. Furthermore, in terms of reduction of utilization of health services, it was shown that patients who perceived that their visits had been patient centered received fewer diagnostic tests and referrals in the subsequent months (Wong YS, Lee A., 2006).

2.4.4 Provider outcomes

Although much emphasis has been put on the importance of effective communication and good doctor patient relationship in affecting patient health outcomes and satisfaction, physician satisfaction has also been associated with good doctor patient communication (Wong YS, Lee A., 2006, Kurtz, SM.,2002). A study conducted by Suchman, AL, et al., (1993) in rating the satisfaction of 124 physicians in 550 primary care visits identified that physicians were satisfied when they have a good doctor patient relationship, efficient data collection process, with the appropriateness of the use of time and with the cooperative, non-demanding nature of the patient (Suchman, AL., et al., 1993). In another study conducted by Grembowski, D., 2005 in the outpatient division of a teaching hospital showed that physician's satisfaction with their professional life was associated with greater patient trust and confidence (Grembowski, D., et al., 2005 cited in Wong YS, Lee A., 2006, Kurtz, SM.,2002).

2.4.5 Reduces Medical Malpractice Risk

Researchers have found that after a medical error, the factors that put physicians at risk of being sued are not the quality of medical, not chart documentation care (Entman et al. 1994 cited in Liebman, CB., Hyman, CS., 2005), and not technical negligence (Harvard Medical Practice Study 1990 cited in Liebman, CB., Hyman, CS., 2005), but ineffective communication with patients (Lester et al. 1993, Levinson et al. 1997 cited in Liebman, CB., Hyman, CS., 2005).

Hickson's survey of the reasons parents sued physicians after a prenatal injury to a child emphasized ineffective communication. He found that 33% sued because they were advised to do so by a third party, often another health care provider; 24% felt the doctor was not completely honest or had lied to them; 24% needed money for the child's future care; 20% couldn't get anyone to tell them what had happened; and 19% wanted revenge or to protect others from harm. Many of those suing felt their physician would not listen (13%), would not talk openly (32%), attempted to mislead them (48%), and did not warn them of potential long-term neuro-developmental problems (70%) (Hickson et al. 1992 cited in Liebman, CB., Hyman, CS., 2005). Patient dissatisfaction and poor communication are seen as the major cause of malpractice claims.

2.5 THEORETICAL CONTEXT

Many fields emphasize the importance of communication theory as a basis for understanding human behavior. Communication perspective in this study involves how communication activity contributes to the improvement in the health care service delivery. *Barnlund's Transactional Model of Communication (1970)* has identified that communication is a process that is -

- Continuous (communication is not a static activity)
- Dynamic (communication is ever changing)
- Circular (cyclical dialog between encoder and decoder)
- Unrepeatable (every communication event is unique)
- Irreversible (once a message is transmitted and received the message cannot be erased)

- Complex (communication involves language, culture, power, relationship factors etc.) (Barnland (1970) cited in West, R., Turner, LH., 2008).

In this model, senders and receivers are both responsible for the effect and effectiveness of communication (West, R., Turner, LH., 2008: 17) . Human communication is viewed as a simultaneous and interdependent process, in which the sender serves as the receiver and the receiver serves as the sender. Both have dual communicative functions, outputting and inputting messages, whether it's spoken or written. It is usually goal-directed in the sense that there is some outcome or message to be negotiated. The word transactional indicates that the communication process is cooperative (ibid). Furthermore, in the transactional encounter, a shared meaning is built using both verbal and non-verbal behaviors and simultaneously sending and receiving meanings or messages. The shared meaning is shaped by an individual's experience which refers to a person's culture, past experience, personal history, and heredity, and how these elements influence the communication process. Hence, communication between two individual is not only the result of an exchange of information between sender and receiver, but also depend on how such information in conveyed based on an individual identity. There is a high chance of misunderstanding that can occur in relationships when people are either unaware or don't attend to the transactional communication process. (Wood, 1998 cited in ibid). As stated by Woods:

"The dynamic quality of communication keeps it open to revision. If someone misunderstands our words or nonverbal behavior, we can say or do something to clarify our meaning. If we don't understand another person's communication, we can look puzzled to show our confusion or ask questions to discover what the other person meant" (ibid).

The transactional model focuses on the communicator's background and their mutual involvement in creating meaning by demonstrating the simultaneous sending and receiving of messages.

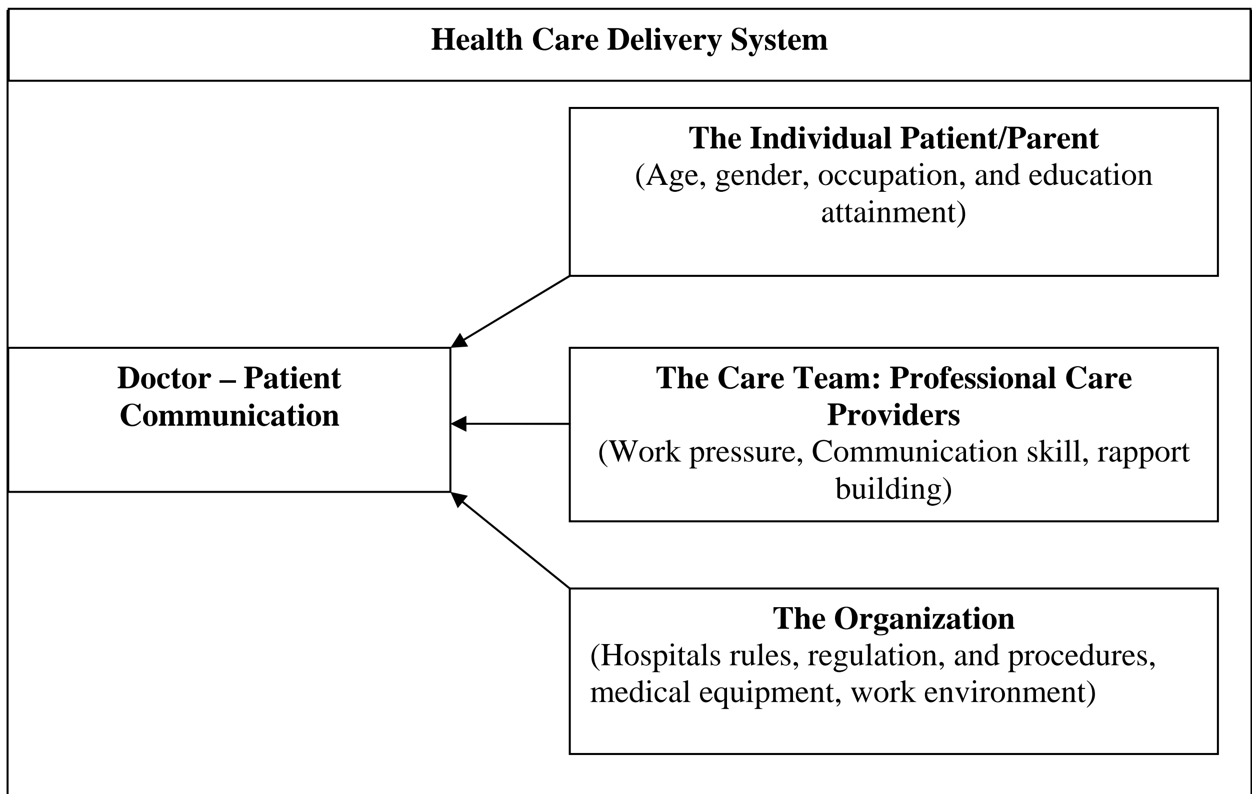
This study is further complimented by the *four model of health care by Ferlie and Shortel (2001)* to evaluate doctor patient communication in Health care Delivery system. The system is divided into the following four models:

1. The individual patient;
2. The care team, which includes professional care providers (e.g., doctors)
3. The organization (e.g., hospital) that supports the development and work of care teams by providing infrastructure and complementary resources; and
4. The larger health care system or environment in which individual organizations are embedded (e.g., payment regimes)

The fourth model of this theory has been omitted in this research due to the lack of time and the vastness of the model itself. Communication is effected by many factors. Doctor patient relationship is basically shaped by interaction/ communication between the two individuals. Communication deficit on the part of the patient, the doctor, or the lack of support from a health care institution can cause a major impact on the health outcome of patients which in return affects the health care delivery. This study measures the different factors that may affect communication pattern in the patient, doctor, and the hospital. Table 1 shows the analytical framework for this study.

Analytical Framework

Table 1: Analytical Framework



2.5.1 THE INDIVIDUAL PATIENT

The first model of the health care system reflects an emphasis on "consumer-driven" health care where the focus is on individual patient needs and preference. The availability of information reflects an increasing expectation that patients will drive changes in the system for improved quality, efficiency, and effectiveness (Reid, P., Compton, W., Grossman,J., Fanjiang, G., Editors, 2005). The fragmented delivery system, combined with the growing burden of chronic disease and the need for continuous care, have forced many patients to assume an active role in the design, coordination, and implementation of their care (ibid). However, most people who do not have access to the information, tools, and other resources are highly depended on the information disseminated by health care professionals and organization. Decision making differs between patients and their family member. Some prefer to delegate the decision making process to a trusted clinician/counselor in the care system; others want to be full partners in decision making.

In order for patients to communicate informed needs and preferences, participate effectively in decision making, and coordinate, or at least monitor the coordination, of their care, they must have access to the same information streams in patient-accessible form as their doctors. From the patient's perspective, improving the timeliness, convenience, effectiveness, and efficiency of care will require that the patient be interconnected to the health care system.

The communication context, in which the doctor patient communication takes place, is shaped by socio-economic factors (e.g., age, gender, occupation, education, etc.).

2.5.1.1 Indicators of Patients role in doctor – patient communication

a. Age:

Studies have found that age shapes how doctor communicates with patients, how they listen to patients, and the degree to which they believe and interpret what patients say to them (Govender, V., Penn-Kekana, L., 2007).

b. Gender:

Male and female patients differed in their communicative style. A study conducted by Thorson and Johansson (2004) showed that women patients of low income and status

were described as “shy”, “hesitant” with “limited knowledge in health care seeking matters” and often “not following their doctor’s prescription mainly because of a need to double-check with their husband, family and neighbors” and men in comparison were described as “daring and open”, “willing to follow directions and prescriptions and, being the primary breadwinners, also to have more access to money and to have a decision-making power of their own, independent of the rest of the family” (Thorson and Johansson (2004: 40) cited in Govender, V., Penn-Kekana, L., 2007). The results of studies about gender of patients are less consistent. According to some studies women are more likely than men to express their feelings and talk about psychosocial issues (ibid).

c. Occupation:

The occupational status reflects education and income status of patients and adds benefits that can accrue from certain jobs, like prestige, privileges, social and technical skills and power. Patients from lower social classes receive significantly less positive socio-emotional utterances, a more directive and a less participatory consulting style characterized by e.g. less involvement in treatment decisions; a higher percentage of biomedical talk and physicians' question asking; lower patient control over communication; less diagnostic and treatment information, more physical examination (Willems S., De Maesschalck S., Deveugele M., Derese A., De Maeseneer J., 2005). Moreover, these patients’ communication and actions (e.g. less question asking, less opinion giving, less affective expressiveness, less preference for decision making) elicit a less involving behavior from the doctor, with less partnership building utterances, which discourages the patient to adopt a more active communication style (Street R., 1991).

d. Education attainment:

Educational level is used as a measure because differences in education correspond with different access to information and with different levels of benefiting from new knowledge. Patients with a higher educational level have more skills and confidence in talking to their doctors and tend to provide more information, ask more questions and speak longer than other patients (Willems S., De Maesschalck S., Deveugele M., Derese A., De Maeseneer J., 2005). Educated patients seem to be more expressive and opinionated and receive more diagnostic and health information than less educated

people (ibid). They strongly believe in patient involvement and have more knowledge about health issues and medical technology. More educated patients communicate more actively (they ask more questions, are more opinionated) and show more affective expressiveness, eliciting more information from their physician. Because patients with a higher education experience a smaller cultural distance (due to a similar background) between them and the doctor, they might have fewer difficulties when interacting with the doctor (Street R., 1991).

Hence, more educated, higher income, older, and female or male patients may receive more information because they have communicative styles that elicit information from doctors. They are more assertive, express more concerns, ask more questions, and conceivably acquire more information from doctors than do less educated patients.

2.5.2 HEALTH PROFESSIONAL:

The second level of the health care system consists of doctors, nurses and family members who are collectively known as the care team. The care team is the basic building block of a "clinical microsystem," defined as "the smallest replicable unit within an organization (or across multiple organizations) that is replicable in the sense that it contains within itself the necessary human, financial, and technological resources to do its work" (Quinn, 1992 cited in Reid, P., Compton, W., Grossman,J., Fanjiang, G., Editors, 2005). This study focuses mainly on doctors in the health care system. Communication takes an important role for doctors as they have to interact with nurses and family members in the delivery of care to a patient or population of patients. They are the primary care givers in the care team. The work of a doctor (s) is to maintain the trust of the patient. They have on-demand access to critical clinical and administrative information, as well as information management, communication, decision-support, and educational tools to synthesize, analyze, and make the best use of that information. The cost of medical care depends critically on doctors. They order the tests, prescribe the drugs, and decide when patients are admitted to hospitals and when they are released. Lack of communication causes the cost of medical care for patients to increase. The role of the doctor is to provide a patient centered care. To deliver patient-centered care (i.e., care based on the patient's needs and preferences), the physician must be equipped and educated to serve as trusted advisor, educator,

and counselor, as well as medical expert, and must know how to encourage the patient’s participation in the design and delivery of care.

2.5.2.1 Indicators of doctors role in doctor – patient communication

a. Rapport Building:

Rapport building mainly consists of utterances of the categories ‘verbal attention’, ‘showing concern’ and ‘reassurance’. For example warm greeting, eye contact, a brief nonmedical interaction, or checking on an important life event. Doctors who listen to patient concern and expectation and gives support are able to maintain good doctor patient relationship. Non- verbal communication is relevant in medical interviews because therapeutic communication with the patient includes the establishment of rapport that is the basis of the doctor-patient relationship which is an emotional relationship established by the extra-verbal and nonverbal communication of emotion. The physician must learn to use nonverbal communication himself/herself because some ideas can be effectively communicated only by that means (Plaja, AN., Cohen, LM., Samora, J., 1968).

The Calgary-Cambridge Observation guide:

The Calgary- Cambridge Observation guide (CC) (Kurtz and Silverman, 1996; Kurtz et al, 1998; Silverman et al, 1998 citied in Kurtz, SM.,2002) is one of the most prominent guides for improving communication by medical students, interns and doctors with patients. The CC guide has been used in many countries and at all levels of medical education, from first year medical students to practicing physicians and in virtually all the specialties (ibid).

The structure in the CC guide reflects the tasks that are undertaken in any medical interview: initiating the interview, giving information, relationship building, and explanation and planning, and closing the interview. These tasks follow in sequential order. It is an important step to initiate doctor patient relationship and build rapport with patients.

Table 2: The Framework of the Calgary Cambridge Guide

Initiating the Session
- establishing initial rapport
- identifying the reason(s) for the patient's attendance

Gathering Information
- exploration of problems
- understanding the patient's perspective
- providing structure to the consultation
- Building the Relationship
- developing rapport
- involving the patient

Explanation and Planning
- providing the correct amount and type of information
- aiding accurate recall and understanding
- achieving a shared understanding: incorporating the patient's perspective
- planning: shared decision making
- options in explanation and planning
    - if discussing opinion and significance of problems
    - if negotiating mutual plan of action
    - if discussing investigations and procedures

Closing the session

Source: Kurtz, S., 2002. "Doctor-Patient Communication: Principles and Practices". The Canadian Journal of Neurological Sciences; 29: Suppl. 2 – S23-S29.

These elements emphasize caring and trust to create a relationship in which doctors and patients share ideas and decision making about the visit agenda, the nature and meaning of disease and illness, and treatment options.

b. Physicians Communication Skill:

Charles, Whelan and Gafni (1999) have illustrated different models that identify different communication styles by doctors in medical treatment decision making: Paternalistic model, Shared model, and Informed model. Table 3 shows the different models of doctor patient relationship.

Table 3: Models of doctor patient relationship

Analytical stages		Paternalistic model	Shared Model	Informed model
Information exchange	Flow	One way (largely)	Two way	One way (largely)
	Direction	Doctor ↓ patient	Doctor ↑ ↓ patient	Doctor ↓ patient
	Type	Medical	Medical and personal	Medical
	Minimum amount	Legal requirement	Anything relevant for decision making	Anything relevant for decision making
Deliberation		Doctor alone or with other doctors	Doctor and patient (plus potential others)	Patient (plus potential others)
Who decides what treatment to implement?		Doctors	Doctor and patient	Patient

Source: Charles, C., Whelan, T., Gafni, 1999. "What do we mean by partnership in making decisions about treatment?" BMJ, Volume 319:780-782

In the paternalistic view, the doctor presents the patient with selected information that encourages the patient to consent to the intervention the doctor considers best. The doctor authoritatively informs the patient when the intervention will be initiated. He/She acts as the patient's guardian, articulating and implementing what is best for the patient. As such, the doctor has obligations, to place the patient's interest above his or her own and soliciting the views of others when lacking adequate knowledge. This model does not elicit the patients personal information or involve him or her in the decision making process. Mutual partnership does not exist in this model. The doctors take the dominant role in a consultation with a patient, often playing little attention to the patient's concerns and understanding of their illness. This paternalistic approach is still common in many cultures and assumes that patients and doctors have the same goals, that doctors can judge patient preferences, that only the doctor has the expertise necessary to determine what should be done, and that it is simple and appropriate to spare patients the worry of decision making or even to deceive them in order to engender faith, reassurance and hope.

The objective of the Informed Model is for patient to gather all relevant information from the doctors. It is up to the patient to select medical interventions he or she wants and for the doctor to execute the selected interventions. The doctor is the leader and communication is one way, from doctor to patient. The doctor informs the patient of his or her state of illness, the nature of possible diagnostic and therapeutic interventions, the nature and probability of risks and benefits associated with the interventions, and any uncertainties of knowledge. The amount and type of information communicated includes sufficient information to enable the patient to make an informed treatment decision.

In contrast to the informed model, shared model, also known as patient centered model, takes into account doctor patient communication in all stages of decision making process. In this model, there is a two way exchange of information, both doctor and patient reveal treatment preferences and agree on a decision to implement. The physician role is to delineate information on the patient's clinical situation and then help elucidate the types of values embodied in the available options.

c. Work Load/ Pressure:

Physicians are central to health care organizing and patient care (Mechanic, 2003; Roter, 2000 cited in Barbour, JB., Lammers, JC. 2007). Any negative effects on them - stress, burnout, depression and anxiety - comes with adverse impact such as: worsening of doctor patient communication, diminished productivity, lower quality of care, turnover in physician practices, and overall dissatisfaction (Linzer, M., et al., 2002). Dissatisfied physicians are more likely to report less open relations with patients, less responsiveness to patients, and less attention to the psychosocial aspects of care linking to high turnover and loss of productivity (Williams & Skinner, 2003 cited in Barbour, JB., Lammers, JC. 2007).

A recent study has showed that doctors work load and pressure leads to an increase in hospital mortality (Tarnow-Mordi WO, Hau C, Warden A, Shearer AJ., 2000 cited in ibid). High doctor patient ratio and low hospital facilities per population is another cause of increased work pressure among doctors that contribute to poor doctor patient relationship (Kazmi, R., Amjad, S., Khan, D., 2008).

2.5.3 THE ORGANIZATION:

The third level of the health care system is the organization (e.g., hospital, clinic, nursing home) that provides infrastructure and other complementary resources to support the work and development of care teams. The organization is a critical lever of change in the health care system as it "provides an overall climate and culture for change through its various decision-making systems, operating systems, and human resource practices" (Ferlie and Shortell, 2001). The organization encompasses the decision-making systems, information systems, operating systems, and processes (financial, administrative, human resource, and clinical) to coordinate the activities of multiple care teams and supporting units and manage the allocation and flow of human, material, and financial resources and information in support of care teams (ibid).

Health care organizations differ between Public and private. Public Health Care organization operate in a complex environment, are more bureaucratic and slower to change compared to private health organization. Historically they are usually monopolistic which influences their bureaucratic identity and culture. They operate within public service constrains, e.g. public and administrative law, which impact on their planning, financing, and human resource management practices (DeBurca, S., 2002). Health care organization faces many challenges. They are under pressure from patients, government entities, and other stakeholders to contain cost while improving the quality of patient care and accomplish more work with fewer people to keep revenues ahead of rising costs. Another challenge is to manage clinicians, the majority of whom function as "independent agents." Less than 40 percent of all hospital-based doctors are employed as full-time staff by the hospitals where they practice, a reflection of the deeply ingrained culture of professional autonomy in medicine and the deeply held belief of care professionals that their ultimate responsibility is to individual patients (Reid, P., Compton, W., Grossman,J., Fanjiang, G., Editors, 2005). These circumstances have posed significant challenges to the authority of health care management in many organizations, often creating discord and mistrust between health care professionals and health care management.

2.5.3.1 Indicators of organizational structure in doctor – patient communication

In Health care Organization, doctor patient communication can be effected by the institution rules regulation and procedures, the availability of medical equipment and its work environment.

a. Hospital rules, regulation and procedures:

Hospital rules, regulations and procedures play an important role in supporting communication between doctor and patient. One of the factors that strains communications is for doctors to be disease oriented rather then responsive to individual complaints (Unger, JP et al., 2002). This is due to the fact that biomedical model which was widely disseminated during the colonial period is still practiced in developing countries where interventions to control disease are still the key delivery pattern for public services (ibid). Hospital rules regulations and procedure determine weather patient centered care is supported allowing effective communication between doctor and patient in health care decision making.

b. Availability of Medical Equipment

No health care system can function without adequate medical equipment. When medical devices are often broken, missing spare parts, out of date or poorly maintained, Hospitals cannot run efficiently. This leads to uncomfortable circumstances for doctors to communicate with patients when medical equipments are not available. As a result patients are often being referred to private hospital where medical cost becomes expensive. There are also serious risks to patients if the equipment needed for their treatment is not available or if their treatment depends on devices that have not been properly maintained.

c. Work Environment: -

A successful work environment will consist of management support from all levels of the institution, positive team relationship with co-workers which includes doctors, nurses, other health professionals that fosters respect and open communication, safety for both health professionals and patient, and standard polices. Fatigue, stress, dissatisfaction with workforce, and lack of safety limits doctors to properly communicate with patient.

CONCLUSION:-

Communication is a two-way process whereby information is channeled and imparted by a sender to a receiver via some medium. The receiver decodes the message and gives the sender a feedback. An exchange and progression of thought, feelings or ideas takes place towards a mutually accepted goal or information. In health care service delivery where two ways communication process takes place between doctor and patients in exchange for thoughts, feelings and ideas for information gathering and solving problems is considered on of the most important aspect for improved health and wellbeing, compliance and satisfaction of patients. It reduces the aspect of mal-practice and increases physician satisfaction. However, communication between doctor and patient is not as simple as it sounds. There are a lot of complications that takes place. It could be triggered by patients themselves, the doctors, the organization or the environment in which the health care system operates. These factors determine whether a doctor patient relationship is sound and effective. This thesis has been designed to understand the status of communication between doctors and patient by understanding the level of communication undertaken by patients and doctors and the level of support the health care organization is contributing to enhance communication. Doctor patient communication is the dependent variable and patient, doctor and the organization are the independent variable of this study.

The following chapter will deal with the methodological approach used in this research in order to give empirical ground to the analytical framework.

CHAPTER -3
METHODOLOGY

3.1 INTRODUCTION

The major objective of this chapter is to present the methodology used in this thesis. Both primary and secondary data collection methods are discussed in detail. Primary sources of data collections are interviews, observations and questionnaire where as secondary source of data collections are books, online articles, and online publications.

3.2 MIXED RESEARCH APPROACH

Every scientific study follows a certain research approach; it is either qualitative, quantitative or mixed in nature. Qualitative research emphasizes the "study of things in their natural settings, attempting to make sense of, or to interpret, (an event or experience) in terms of the meanings people bring to them." (Denzin, NK., Lincoln YS., 2000:3). Typically qualitative study designs use research questions and semi-structured methods such as open-ended and in-depth interviews, ethnographic field notes, focus groups, open-ended questions on surveys, and participant observation. Quantitative research, on the other hand, emphasizes "the measurement and analysis of causal relationships between variables, not processes" (Denzin, NK., Lincoln YS., 2000:8). Quantitative study design states a hypothesis and collects data through highly structured methods such as questionnaires, surveys, and structured observation and uses closed-ended format for questions and interviews.

Using both qualitative and quantitative elements in research is known as mixed method research. Mixed methods research is formally defined here as " the class of research where the researcher mixes or combines quantitative and qualitative research techniques, methods, approaches, concepts or language into a single study" (Johnson, RB., Onwuegbuzie, AJ., 2004). Its goal is not to replace either of these approaches but rather to draw from the strengths and minimize the weaknesses of both in single research studies and across studies (ibid).

Rossman and Wilson (1991) summarized the advantages of Combining, or linking, quantitative and qualitative data collection methods within studies in three broad reasons:

- To enable confirmation or corroboration of each other via triangulation (the use of multiple observers, methods, interpretative points of view and levels and forms of empirical materials in the construction of interpretations);
- To elaborate or develop analysis, providing richer detail; and
- To initiate new lines of thinking through attention to surprises or paradoxes, providing fresh insight. (Rossman and Wilson (1991) cited in Vitale, DC., Armenakis, AA., Field, HS., 2008)

3.3 FIELD WORK

The researcher in the field cannot rely either on their memory, or necessarily on their electronic equipment to capture all the relevant details of what is being observed. It is essential that observations and interviews be captured in clear, detailed, and descriptive notes. The most important goal of such notes is “to record as thoroughly as possible what is happening in the observed context” (Lynch, 1996:116). It should also contain the researcher’s own reflections, impressions and interpretation, and as the study progresses and insights beginning analysed (Patton, 1990 cited in Miles, MB., Huberman, AM., 1994:66). Field notes are just one source of data and may not in fact feature largely in analyses but nonetheless they serve to focus the researcher at the time of recording and can be used to check interpretations or impressions which emerge during analysis. Field notes in this study has helped keep track of more administrative information’s such as appointment times, and delays, length of appointment, number of patient waiting and communication patterns of both doctors, patients, and patients family member.

The field work was carried out from mid - March to mid-May 2010. The initial unit of research as per the thesis proposal, Kanti Children Hospital was replaced by TU, Teaching hospital due to obstacles from the former unit for data collection. As a result the participants for research changed from being parents of patients to patients and their family members. During the field study, TU, Teaching hospital which is

considered the best hospital among the government hospitals for treatment and facilities was under strike by doctors due to political conflict. They had called for a shutdown of the hospital. As a result, data collection was postponed until the services were available again.

3.4 DATA COLLECTION METHOD

Both primary and secondary data were examined for this research. Prior to going in the field to gather primary data, secondary data was thoroughly reviewed. Secondary data is basically focusing on the content analysis of the research. Content analysis for this thesis included published journals, articles, and books. Primary data on the other hand was collect through Questionnaire based interviews, interview and observation.

3.4.1 Open and closed ended Questionnaire based interview :

General type of questionnaire can be either structured or unstructured questionnaire. Structured questionnaire are those questionnaire in which they are definite, concrete and pre-determined questions and are presented with exactly the same wording and in the same order to all respondents (Kothari, CR., 2004:101). Unstructured questionnaire, on the other hand, are questionnaire that the interviewer formulates, changes, and adapts to meet the respondent's intelligence, understanding or belief. This type of questionnaire does not offer a limited, pre-set range of answers for a respondent to choose, but instead the interviewer has to carefully and attentively note down respondents own word to the extent as possible (ibid). This research has used both structured and unstructured questionnaire to get the best answers.

3.4.1.1 Patients:

A close-ended questionnaire was used for patients or their nearest family member. They were required to select from the questionnaire, the most important criteria or problem between them and their doctor. It was basically intended to obtain specific information from patients. In addition to the closed list of categories, there was also an option "Other" for respondents to explain their own answers. Before using such method, a pretest was conducted using open-ended questions at the initial stage of

questionnaire design in order to identify adequate answer categories for the close-ended questions.

The sampling was purposeful, strategic and judgmental. Patients were not in a position to respond to the questionnaire based interview due to their health condition. So, based on the researcher's judgment, a family member that is present and active in communicating with the doctor was selected for questionnaire based interview. A total of 30 family members of the patients were selected. The major strategy of sampling was to cover all potential people related to the research work and those who could be easily available. The participants were cooperative to participate after they were fully informed about the purpose and aims of the study.

From the survey, 90% of the patients came from various districts and places outside the capital. As, TUTH is a tertiary referral center, patients visit the hospital only when health post and district medical centers are not able to properly diagnose the patient. Below is the nature of respondents based on their age, gender, occupation and education.

Age: Majority of the patients in medical ward in TUTH were of age 41 years (43%) and above while 33 % were aged between 15 to 25 years. 13 percent of patients were aged btween 26 to 35 and only 10 % were aged between 36 to 40.

Gender: There were a high percent of female patients (67% percent). Fifty percent belonged to the age group of 41years and above compared to only 30% of male patients.

Occupation: Thirty seven percent of the respondents were farm workers, while 33 % of the respondents were housewives. Thirteen percent of the respondents who were unemployed were students (age bracket 15-25 years) and only 13.3 % of the respondents had a job (age bracket 36 -40 years). Majority of farmers (55%) and housewives (60%) fell in the age bracket of 41 years and older.

Education: Of the total 30 patients, 53 % of the respondents had no education. The majority of uneducated respondents fell in the age level of 41 years or above. Whereas only 27% of the respondents had completed secondary level education, 10%

of the respondents had completed higher secondary level education and 10% had completed Bachelor degree or higher. In terms of gender, 50% of female and 60% of male respondents have no education. It was also noted that occupation is related to the education of respondents. A bulk of those who are housewives (38%) and farmers (50%) are illiterate and few of them (37%) have completed secondary level education. Respondents who are employed have low paying jobs such as clerks and laborers. Their education level is either none, secondary level or higher secondary level. Thirteen percent of the respondents who are unemployed are students and 3 % of respondents are self-employed; i.e. the patient is an owner of a shop. Hence lower the education, lower is the occupation level.

3.4.1.2 Doctors:

For doctors, the bulk of the questionnaire included open-ended items to understand their perspective on communication in doctor patient relationship. The advantage of using open-ended questions includes the possibility of discovering the responses that doctors give spontaneously. The sampling was again purposive. A total of 10 questionnaires were handed out to doctors but only 7 of them participated in filling out the questionnaire. Doctors that were surveyed were resident doctors. Fifty seven percent of them were in-between the age of 20-30 and were MBBS residents; where as the remaining 42.9% of doctors were MD residents, among them one was Assistant lecturer. 86% of the respondents who participated in the survey were male resident doctors.

3.4.2 Interview:

Interviewing is one of the most common tools for naturalistic data - collection because of its interactional nature. The purpose of interviews is to find out those things which cannot be observed directly; a representation of what someone else is thinking. A structured interview (interviewer asking predetermined questions) was conducted to 4 different officers in TUTH; Account officer, Administrative officer, medical record department officer and social service officer.

3.4.3 Qualitative Observation

Qualitative observation is essentially naturalistic and occurs in the natural setting under study where the observer is unobtrusive and inconspicuous, neither manipulating nor controlling the situation (Mays, N., Pope, C., 1995). Observational research can vary widely with the researcher assuming a role that can range anywhere between the hidden, or absent observer, who watch from outside or with a passive presence, to the active participant who is involved in the setting and who acts as a member rather then a researcher (ibid). Since there was no natural role that could be assumed, it was not possible for the researcher to assume a role of participant in the context of the medical setting being observed in this study. Observation was therefore carried out in a non-participatory, unobtrusive and inconspicuous manner as possible.

For observant to observer or notice everything which occurs in a natural setting is not possible, even within the context of attempting to achieve a holistic sense of the situation. Social researchers (Glaser, 1978; Padgett, 2004; Patton, 2002 cited in Bowen, GA., 2006) recommends using what they call 'sensitizing concepts' to help make the situation manageable and to determine those aspects which becomes focus of each observation. Sensitizing concepts can provide a framework and give the analyst a "general sense of reference" (Blumer (1954) cited in Bowen, GA., 2006). Some sensitizing concepts were initially identified by the researcher to investigate communication between doctor and patient in the study. These concepts are as such: doctors work environment, direct communication, indirect communication, doctor's conversational skill, doctor's rapport building, patient's conversational skills and assertiveness by patients or his/her family member in asking questions to the doctor.

The observations were performed at the medical OPD in Tribhuvan University, Teaching Hospital and medical ward during doctor's daily rounds. A total of 8 hours of observation was conducted (6 hours in OPD, and 2 hours in doctor's daily rounds for inpatients in medical ward). The health care professionals were resident doctors including interns. Researchers kept a log of events and descriptions of the events, specially focusing on the sensitized concepts.

3.5 QUALITATIVE CONTENT ANALYSIS

Qualitative content analysis is a technique for systematic text analysis (Mayring, 2000). Content analysis can be defined as the use of a replicable and valid method for making specific inferences from text (Krippendorff (2004). It can be used either alone or in conjunction with other methods. All sorts of recorded communication can be used, as for example field notes of observations, medical records, transcripts from interviews and documents such as books (Krippendorff, 2004). The goal of qualitative content analysis is to reduce the material into the smallest parts, textual units. The rules of analysis are that the material is to be analyzed step by step and to organize the material into content analytical units.

Observational notes, field notes and responses to opened – ended questionnaires by doctors are measured using content analysis. The researcher has tried to find common ground for the observed interaction, leading to more general conclusions. Content analysis is gauged by doctor's reaction to communication in health care and conditions that hampers doctor patient communication.

3.6 SECONDARY SOURCES

Secondary sources are also a major source of data for this research. Secondary data means data that are already available i.e., they refer to the data which have already been collected and analyzed (Kothari, CR., 2004:101). In this study, they are used mainly to review existing literature regarding previous studies on doctor patient communication and its effect in health care delivery system. These secondary sources of data included official publications, previous studies and reports, newspapers and journals. Furthermore, various online journals have been investigated such as British Medical Journal (BMJ), Pubmed central, Health Education, Medical Care, Jestor, Sage publication, Family Health Journal, Pediatrics, Journal of General Internal medicine, Google Books, …etc.

3.7 DATA ANALYSIS:

The data were processed with the help of SPSS 17 package. The Data collected along with the information obtained through observation and interviews were used to

provide an overview of the condition of communication. Frequency, percentage and cross- tabulation was conducted to analyze the data. Furthermore, triangulation method has been used to make information reliable, valid and accurate.

3.8 CONCLUSION

The aim of this chapter is to discuss the methods used in this study. A mixede research approach was chosen to carry out this research. This research used both open and closed ended questionnaire, interview, content analysis, and qualitative observation to increase the validity and accuracy of the results.

CHAPTER-4
HEALTH CARE ORGANIZATION - TU, TEACHING HOSPITAL

4. INTRODUCTION:

Quality health care system depends on good communication. For instance, health outcomes are strongly influenced by how well health care professionals communicate with individual patients and patient communities about disease prevention, symptoms, treatment plans and options, risks and benefits, medication instructions, and other relevant topics. Another aspect that also strongly influence health outcome is when hospitals or any health organization identify effective health care communication as an essential element of public health and a core component of health care quality. A health organization plays a major role in either supporting communication through its organizational structure or policies and procedure. This chapter specifically aims to depict whether TUTH as a health care delivery and teaching institution supports communication between doctor and patients.

4.1 BACKGROUND OF TU., TEACHING HOSPITAL

Many of the medical institutions in Nepal are registered under Nepal Medical Council. One of them is the Institute of Medicine (IOM) under which T.U. Teaching Hospital falls into. The Institute of Medicine (IOM) was established in 1972 under Tribhuvan University and has the mandate and the responsibility of training all categories of health manpower needed in the country. TUTH was established only in 1983 with the support of JICA, as an integral part of the Institute of Medicine. TUTH was established to fulfill three main roles: to provide a teaching base for the Institute of Medicine for all types of academic programs (basic, graduate and postgraduate), to provide tertiary level of health services to the patients and to act as the main center to conduct health researches.

The hospital caters to a large number of public from various parts of the country. Prior to coming to TUTH, patients usually visit various places for treatment like Tradition faith healers, local hospital, clinics, pharmacy, and health post. The hospital is

therefore known as one of the largest tertiary referral center among government hospitals.

300 bedded hospital when established, now consist of 482 beds, out of which 44 beds are free (hospital bears all expenses) and 30 to 40 beds are reserved for research purpose. However, these beds are also used as free beds for the extremely poor. Stated below are the total number of Hospital personnel and doctors working in TUTH.

Table 1: Hospital Staff

Hospital Staff	Number *
Administrative workers	85
Utility/Clerk	432
Technicians (lab)	157
Nursing Staff	336
Total	1010

*Data received from Social Service dept of TUTH as of 2065 (2008/2009)

A total of 1010 members are currently working in the hospital. As per Shangita Malla , Social Service department head, there has been no shortage of manpower and all vacant position has been filled as of 2065 (2008/2009). Table 2 shows the total number of health professionals employed at the hospital.

Table 2: Doctors

Doctors	Number *
Professor (Senior Doctors)	28
Associate Professor	43
Lecturer	73
Teachers	19
Teaching Assistant	25
House Officers/ Interns (1 yr training for those who have completed MD or MBBS)	55
Residents	250
Total	493

* Data received from Social Service department and Accounts deptartment of TUTH

Resident doctors are the major workforce in this hospital. Their total number outweighs junior and senior doctors. Residency is a stage of graduate medical training. A resident physician in TUTH is a person who is currently undergoing a medical degree (MD, MBBS) and who practices medicine under the supervision of fully licensed physicians.

4.2 HOSPITAL RULES REGULATIONS AND PROCEDURE

TUTH operates under Tribhuvan University and its Educative Administration Rules 2050 (1993). Under Tribhuvan University rights, hospital managements, rules, regulations and procedures fall under working procedure of TUTH Act of 2053 B.S (1996). To run the hospital, different committees and sub-committees have been formed. They are –

- Hospital Management Council
- Hospital Management Council Standing Committee
- Drug Sub-Committee
- O.T. Sub- Committee
- I.C.U. Sub- Committee
- Disaster Management Committee
- Hospital Environment and Infection Control Committee
- Quality Management Committee
- Medical Audit Committee
- O.P.D. Sub- Committee
- Kitchen Sub- Committee

Each committee and sub-committee has their own purpose of existence, authority and responsibility. The director of the hospital is the head of the hospital. Any changes made on the rules, procedure and duties of the above mentioned committees must get approved by the director. It can be noticed from the above mentioned lists of committees that there lacks information and communication committee. Communication, which is a vital part of hospital management, is given no importance.

4. 3 MEDICAL EQUIPMENT:

Hospitals have become technical institution of health care. In the era of advanced technology, equipment form an integral part of the hospital environment and they are required at every step of diagnosis and treatment. The status of medical equipment in the hospital is quiet poor. The hospital is equipped with all the necessary machinery, but there is a poor monitoring and maintenance. As Ram Bikram Adhikari, a technician at TUTH points out that:

"*The maintenance service in our hospital is not felt as vital importance to good patient care and good management. Some technicians have no proper knowledge about all the equipments for repairing. They just try even when they do not know what the fault is. It could be more harmful to the equipment by this type of trial and error practice. On the other hand many health care professionals do not see the care and safety or equipment as priority*." (26th Anniversary souvenir, 2008, TUTH).

Similarly, Interview conducted on May 13th 2010 with maintenance officer of TUTH, Chanchal Kumar Joshi further points out that hospital equipments are poorly maintained that has caused patients to get frustrated as they are being referred to other private hospital for services. He points out that: -

"*The hospital mainly consists of old machinery, finding their spare parts is a tough task and most of the time we are not able to obtain it. We have an annual maintenance contract that is given to the third party for those machines that our department is not able to repair. We have a shortage of personnel, there are only 3 people who are able to fix medical equipments and fall under the category biomedical maintenance. The remaining 33 staff is plumber, carpenter, and electrician, etc, and falls under the category of General Maintenance. Administration has not been able to understand the difference between General Maintenance and Biomedical Maintenance and threat them as the same. So, they believe that they have enough technicians in this department. There is also a lack of staff training on new Technology machinery and software. There is an absence of preventive maintenance system in this hospital. Monthly maintenance check is required for medical equipments to detect any signs of early damage. However, due to the lack of support by administration and shortage of*

manpower in the field of Biomedical Maintenance, such process is not adopted. So, unexpected failure of medical equipment occurs that causes direct impact on patients".

The proper functioning of medical equipments is a vital element for a proper function of a hospital and for the health of the patients. Therefore, maintenance and care of the equipment is very important for health care delivery.

4.4 WORK ENVIRONMENT:

Understanding the work environment of the hospital establishes whether there is a comfortable atmosphere for doctors and patients to effectively communicate with each other. One of the most important factors that effect doctor working condition is their salary and benefits. Doctors working at TUTH are paid by IOM. They receive an additional 50% of their salary as benefits from TUTH. The residents, who are mainly students, also receive a salary of NRS 21, 000 (roughly USD 300) per months. Similarly, interns are provided with NRS 7,600 (roughly USD 105) per month.
Interview conducted with Shambov Bhattarai on May 13th points out that:-

"Doctors and Staff working at TUTH and its affiliated branches are provided 90% cut on any medical services. Whereas, students studying at Tribhuvan University get about 50% cut for their medical services. Doctors receive their salary from IOM. For their services at TUTH, they are provided with an extra 50% of their salary by the hospital. Similarly, staff members at TUTH are also provided 50% extra allowance apart from their monthly salary".

Residents and Interns are under the surveillance of Doctors/ Professors who work under different departments/Unit such as Nephrology unit, Pulmonology Unit, Cardiology Unit, Neurology Unit, Gastroenterology Unit, Cardiology Unit, Hematology Unit, Oncology Unit, Endocrinology Unit, and Rheumatology Unit. Each unit consists of one Unit head (professor) and two assistant professors followed by several residents and interns.

An open – ended questionnaire survey conducted for doctors on whether they believe that their work environment may effect their communication with patient depicted that crowded and congested OPD rooms and a lack of privacy when interacting with patients was the major problem on communicating with patients. Patients felt uncomfortable in openly communicating with doctor as they are surrounded by other patient impatiently waiting for their turn to get a checkup.

4.5 CONCLUSION:

Without the support of the Hospital and its management structure, doctors are likely to face communication problems. One of the major shortcomings that TU, Teaching hospital has not been able to adapt is to a patient centered communication. This is primarily due to the absence of rule, regulation and procedure that would allow patient and doctors to be aware of the rights patients have to information regarding their health. When patients become more aware about their health, they are able to make better informed decisions. Work environment and poor maintenance of medical equipment are other factors that have weakened doctor patient communication in TU, teaching hospital.

CHAPTER-5
DATA PRESENTATION AND ANALYSIS

5. INTRODUCTION

The aim of this chapter is to present the survey data and observation notes conducted in the field. There are two parts in this chapter. The first Part depicts the patient's perspective regarding doctor patient communication focusing on their age, gender, education and occupation. The second part of this chapter presents the doctor's perspective on doctor patient communication. A mixture of both the survey questionnaire and observational points are presented in this chapter.

PART I

5.1 THE INDIVIDUAL PATIENT

Communication is essential to almost all aspects of health care. In this phase the patient is the expert. The patient knows why he/she has come to see the doctor, his/her worries, anxieties and attributions and his/her individual request of the doctor. The individual patient main role is to communicate its symptoms, understand the cause and affect of his/her illness and be part of the medical and treatment decision making. In this phase, the doctor listens, explores and be receptive to the patient's concerns. The data collected in this study consists of four main variables: age, gender, occupation and education. Information is collected to analyze the way patients communicate with doctors in the In-Patient medical ward in TUTH. This study also analyses patients understanding of their illness and whether they are active in their own care. The cross tabulation of data has been carried out to note the relationship of the variables with the questions posed to respondents (Table 1). Furthermore, an observational study conducted during doctor patient medical consultation in Out-Patient Department further illustrates patient's communication style with doctors.

Table 3: Results of the questionnaire based interview with patients (N= 30) based on age, gender, occupation and education.

Questions	Explanation of findings
Easy to communicate with the doctor	Ninety seven percent of the patients responded "Yes" on whether they found it easy to communicate with their doctor. Among them, 40% belonged to the age 41 years and above, 33% were in between the age 15-25 and 27% were in between the age 26-40. In terms of gender, 63% were female. As for occupation, 33% were housewives, 33% were farmers, 13% were unemployed, 13% were employed and only 3% was self-employed. As for education, 53% of the respondents were uneducated and only 43% had completed secondary level education or higher.
Communication about treatment	Seventy seven percent of patients responded "Yes" on whether they were told about their treatment process. Among them, 33% belonged to the age group 41 years or older, 27% were in between the age 26-40 and 20% were in between the age 15-25. In terms of gender, 47% were female and only 30% were male. As for occupation, 23% were housewives, 27% were farmers, 13% were unemployed, 10% were employed and only 3% were self employed. In terms of education, 40% were uneducated and only 37% had completed secondary level education or higher.
Patient Understanding about treatment	Seventy percent of patients responded "Yes" on whether they understood the process of their treatment. Among them, 30% belonged to the age group 41 years or older, 23% were in between the age 26-40 and 17% were in between the age 15-25. In terms of gender, 43% were female and only 27% were male. As for occupation, 23% were housewives, 27% were farmers, 13% were unemployed, and 7% were employed. In terms of education, 37% were uneducated and 33% had completed secondary level education or higher.
Communication about possible consequence	Seventy seven percent of patients responded "No" on whether they were told about the possible consequences of their illness. Among them, 30% belonged to the age group 41 years or older, 17% were in between the age 26-40 and 30% were in between the age 15-25. In terms of gender, 53% were female and only 23% were male. As for occupation, 23% were housewives, 33% were farmers, 10% were unemployed, 7% were employed and only 3% were self employed. In terms of education, 40% were uneducated and only 37% had completed secondary level education or higher.

Question	Explanation of findings
Demand Information	Fifty percent of the patients responded "No" when asked whether they demanded information regarding the possible consequence of their illness. Among them, 30% belonged to the age 41 years and above, 17% were in between the age 15-25 and 10% were in between 26-40. In terms of gender, 33% were female and 23% were male. As for occupation, 17% were housewives, 27% were farmers, 3% were unemployed, 7% were employed and only 3% was self-employed. As for education, 37% of the respondents were uneducated and only 20% had completed secondary level education or higher.
Time Availability with doctor	Fifty three percent of patients responded that they immediately had time with the doctor when they required. The remaining 47% responded difficulty in obtaining time with the doctor. Among the 57% of patients who received time, 23% belonged to the age 41 years and above, 17% were in between the age 15-25 and 13% were in between 26-40. In terms of gender, 30% were female and 23% were male. As for occupation, 17% were housewives, 23% were farmers, 3% were unemployed, and 10% were employed. As for education, 30% of the respondents were uneducated and only 23% had completed secondary level education or higher.
Consultation on which subject matter	Seventy seven percent of patients consulted with the doctor regarding the seriousness of the disease. The remaining 23% consulted on the outcome of the treatment process or the dosage of medicine. Among 77% of respondents, 40% belonged to the age 41 years and above, 20% were in between the age 15-25 and 17% were in between 26-40. In terms of gender, 53% were female and 23% were male. As for occupation, 30% were housewives, 23% were farmers, 10% were unemployed, and 13% were employed. As for education, 43% of the respondents were uneducated and only 33% had completed secondary level education or higher.
Doctor Listens	Ninety three percent of patients responded "Yes" when asked whether doctor listened to them. Among them, 40% belonged to the age group 41 years or older, 23% were in between the age 26-40 and 30% were in between the age 15-25. In terms of gender, 60% were female and only 33% were male. As for occupation, 33% were housewives, 33% were farmers, 13% were unemployed, 10% were employed and only 3% were self employed. In terms of education, 50% were uneducated and only 43% had completed secondary level education or higher.

Any hesitance in communicating with the doctor	Seventy percent of the patient responded that they did not hesitate when communicating with the doctor. The remaining 30% believed that the language barrier, economic barrier and status difference made them timid when communicating with the doctor. Among the 60% of respondents, 30% belonged to the age group 41 years or older, 13% were in between the age 26-40 and 27% were in between the age 15-25. In terms of gender, 53% were female and only 17% were male. As for occupation, 27% were housewives, 20% were farmers, 10% were unemployed, 10% were employed and only 3% were self employed. In terms of education, 27% were uneducated and 43% had completed secondary level education or higher.
Understanding Doctors language	Ninety three percent of patients responded “Yes” when asked whether doctor listened to them. Among them, 40% belonged to the age group 41 years or older, 23% were in between the age 26-40 and 30% were in between the age 15-25. In terms of gender, 60% were female and only 33% were male. As for occupation, 33% were housewives, 33% were farmers, 13% were unemployed, 10% were employed and only 3% were self employed. In terms of education, 50% were uneducated and only 43% had completed secondary level education or higher.
Satisfaction with allocated time	Seventy percent of patients responded “Yes” when asked whether they were satisfied with the allocated time as given by the doctors. Among them, 40% belonged to the age group 41 years or older, 13% were in between the age 26-40 and 30% were in between the age 15-25. In terms of gender, 40% were female and only 30% were male. As for occupation, 20% were housewives, 27% were farmers, 13% were unemployed, and 10% were employed. In terms of education, 33% were uneducated and only 37% had completed secondary level education or higher.
Preference in communication with Doctor	Sixty percent of patients preferred to communicate with doctors because they believed doctors knew first hand what the patients were going through. The remaining 40% of the patients believed that doctors can give them accurate information and they trusted the doctor. Among the 60% of respondents, 27% belonged to the age group 41 years or older, 13% were in between the age 26-40 and 20% were in between the age 15-25. In terms of gender, 40% were female and only 20% were male. As for occupation, 23% were housewives, 23% were farmers, 13% were unemployed, 7% were employed and 3% were self-employed. In terms of education, 37% were uneducated and only 40% had completed secondary level education or higher.

Satisfaction to care provided by doctors	Sixty percent of patients responded “Yes” when asked whether they were satisfied with the care they were provided. Among them, 27% belonged to the age group 41 years or older, 13% were in between the age 26-40 and 20% were in between the age 15-25. In terms of gender, 40% were female and 20% were male. As for occupation, 23% were housewives, 23% were farmers, 3% were unemployed, and 10% were employed. In terms of education, 37% were uneducated and only 23% had completed secondary level education or higher.

Source: Survey 2010

Based on the results of the questionnaire, patients had an overall positive attitude on the way doctors communicated with them. However, it is important to note here that 53% of the patients were illiterate and belonged to the age group 41 years and older (43%). Majority of the patients were housewives (33%) and farmers (37%). Ninety percent of the patients came from various districts and regions out side the capital where poor infrastructure, illiteracy, access barriers, and language barriers still exists. The findings were consistent between age, gender, occupation and education of patients.

When asked whether they found it easy to talk to the doctor, 96.7% of the patients regardless of their age, gender, occupation and education found it easy to communicate with the admitting doctors and stated that consultation with them had been useful. 77% of the respondents were told by their doctor about their treatment process, where as 23 % were not provided with any information. Among those respondents who were given information about their treatment process, 70% understood what they were told. However, when it came to knowing the possible consequences of the treatment or illness (diagnosis, side effect of medicine, health outcome), 77% of the patients were unaware about the consequence of their treatment process. Among them 57 % of the respondents did not demand further clarification. They were content with the limited information provided to them. Doctors are regarded as high status people and patients are not accustomed to questioning the treatment method and process. People from villages still view doctors as god like with the ability to cure their diseases. They believe that questioning their treatment methods will only elicit anger and hence doctors will secede to take care of the patient in a proper manner.

Furthermore, patients were asked whether they were able to communicate with the doctor when needed. Fifty percent of the respondents stated that doctors were immediately available. The remaining respondents believed that it was difficult to get time with the doctors. They complained that the resident doctors who are on duty are accessible but the specialists who are the main people to take care of the patients are hardly available. Seriousness of the illness was the main subject matter patients consulted on. Ninety three percent of them stated that doctors were attentive when they communicated with them and the language they used was simple and understandable without any complicated medical jargons. Patient's primary reason to communicate with the doctor is not because they trusted them, but they knew first hand what the patient was going through. Overall 60% of the patients were satisfied with the care they received. A major dissatisfaction for the remaining 40%, regardless of the age, gender, occupation and education level the respondents had, was no improvement in the condition of the patient's health, less attention by doctors, doctors not available when needed and lack of clarification about patient illness.

Observation conducted during medical consultation showed that patient's age and gender was also not seen as important criteria in determining patient communicative behavior with doctors. Patients were more concerned explaining their symptoms rather then asking questions concerning the cause, effect, and reason for a diagnosis the doctor had recommended. Furthermore, patients question asking behavior was seen as passive and was rather closed ended, limiting the doctors to provide full explanation. Table 4 shows the frequently asked questions by patients during observation.

Table 4: Frequently asked questions by patients during observation:

"What exactly is wrong with me?"
"When should I take the medicine?"
"When should I come back?"
"What tests are necessary?"
"Will I get better after taking these medicines?"

Source: Field work 2010

Patients did not typically speak long enough for physicians to insert encouraging minimal responses, as they were typically asking closed-ended questions. Similarly, with the pressed time and long queue of patients, doctors also adapted a closed – ended questionnaire format in order to take control of the conversation and to limit patients to talk. Hence, There researcher during observation did not find any patients asking any of the following important questions:

Table 5: Questions that should be included by patients during a medical consultation

1. What is the diagnosis?
2. What does the test results say?
3. What treatment will I need?
4. Does the treatment have any side effects?
5. What is the purpose of taking the medication?
6. What will the treatment do to my body, what will it achieve?
7. What can be done for the pain and discomfort I might experience?
8. What should I do or not do while having treatment?

Source: Butow, PN., Dunn, SM., Tattersall, MHN., Jones, QJ., 1994. . "Patient participation in the cancer consultation: Evaluation of a question prompt sheet". Annals of Oncology 5: 199-204.

To ensure healthy communication, patients must be willing to voice their concerns to doctors and gather much information as possible in order to take control of their health. Low education and lack of health literacy was seen as a primary factor for patients to be passive during medical consultation. Their limited health knowledge and lack of question asking skill permits them to be ignorant on different health issues. In Nepal, there are large disparities in literacy rates between urban and rural, rich and poor and ecological zones. According to the Nepal Living Standards Survey 2003-04, while the adult literacy rate for the urban area was 73 %, it was only 43% for rural area. Marked differences were found between the literacy rates of consumption/income quintiles, with the richest at 72% (male 87% and female 59%) and the poorest at only 23% (male 37% and female 12% only). The recent Nepal Labor Force Survey II (2009) revealed adult literacy rate at 55.6% (Male 70.7%, Female 43.3%) demonstrating a gender gap of 27.4% points (CBS, 2008).

A study conducted by Williams et al, showed that low literacy is one of the factors that impacts patients' participation in the medical encounter. (Williams, MV. Davis, T., Parker, RM., Weiss, BD., 2002). Patients with low literacy have less knowledge about their medical illnesses and more difficulty navigating the health care system, understanding recommended treatments, and following the instructions of doctors. (Baker DW, Parker RM, Williams MV, et al., 1996.).

PART II

5.2 HEALTH CARE PROFESSIONAL

In this section, the doctor is the expert. By means of directive questioning the doctor translates the patient's complaint into a medical frame of reference. Systems review is a part of this phase, as well as physical examination, in which clarity of instruction and sensitive courteous behavior is especially important, because the patient is often in a vulnerable position. Three independent variables (Word load, Doctor conversational Skill, and Rapport Building) is analyzed along with other barriers of communication as noted by doctors. The data below represents both the questionnaire survey and observation conducted by the researcher.

5.2.1 COMMUNICATION STATUS OF DOCTORS:

This Part of the research presents and analyzes the data and observation conducted in the medical consultation by focusing on doctors work load, Conversational skill and Rapport building.

5.2.1.1 Work load:

Demand for primary care services has increased in many countries due to population ageing and rising patient expectations. At the same, the supply of doctors is constrained, especially in public hospital. Most of the time doctors are bound to handle more patients then expected. Table 6 shows the total number of patients for three consecutive years visiting the out patient department in TUTH.

Table 6 : Medical Record Department: OPD Statistics

Year	Total number of Patients (new and old)
2006/2007	261,543
2007/2008	296,600
2008/2009	298,133

Source: T.U Teaching Hospital, medical record department

According to officer in charge in Medical record department, Kumar K.C, interviewed on May 15th 2010, "total daily OPD patients average around 1000 to 1500". Resident student total intake of patient averages around 15 - 30 a day providing about 10 to 15 minute time or longer for each patient depending on the health condition. Resident students are the major workforce in the hospital, especially in OPD where practical learning takes place. They are on duty six days week from 8:30am to 5 pm, three days in Out Patient Department and three days for ward visit. The major problems they face in terms of doctor patient communication is stated in Table 7.

Table 7: Framework of content analysis of doctors descriptive evaluations (n= 7). Major problems of communication:

Major communication problem
Less consultation time
Lack of Health education
Lack of knowledge sharing
Medical Language
Low education level of patients
Crowded work environment in OPD
Poor Health Literacy of patients

Source: Field work 2010

Resident doctors at TUTH are constantly crowded by patients when conducting medical consultation. The noise, crowd and lack of privacy cause them to focus more on the diagnosis of the illness rather then forming a doctor patient relationship. The volume of patients is another aspect that restricts them to give enough time to properly explain patient's medical problems. Since majority of the patients coming to TUTH have low level of education, doctors complain that patient would not be able to understand if the medical process of their treatment is explained to them. Medical terminology was also seen as another factor that caused doctors to provide minimum

explanation. Doctors use of medical terms, combined with patients' limited health vocabulary, results in inadequate and even confusing communication. As a result, doctors try to avoid technical terms and try to explain the illness in a simple language. However, explanation of English medical terms in Nepali is still a big task for resident doctors.

Due to low education level of patient, health literacy of the respondents is also very low. Health Literacy is an individual's ability to read, understand and use healthcare information to make decisions and follow instructions for treatment. Literacy is widely acknowledged as benefiting the individual and the society and is associated with a number of positive outcomes for health, nutrition, and the overall well-being of both men and women (NDHS, 2006). However, low education and health literacy level of patient encourages doctors to make decisions in patient's treatment.

5.2.1.2 Conversational skill

Communication skills are important qualities in the behavior of a doctor. Charles, Whelan and Gafni's (1999) different models of communication styles by doctors in medical treatment decision making depicts doctor engaging in either one way communication from doctor to patient where doctors are the decision makers (Paternalistic model), or when doctors provide information and patient makes the decision (Informed model), and two way partnership in making medical decisions (Shared Model).

Doctors were asked about their guiding philosophy of being a doctor. Eighty percent of the respondents believed in caring for the patient including his/her physical and psychological well-being. It is noted that their statement contradicts with their communicative behavior. Based on observation, conversation takes place only when doctors initiate the conversation by asking the patient about his/her health problem. Once the patient has finished describing his/her symptoms, the doctor focuses mainly on asking closed ended questionnaire and starts making notes. This strategy of question asking limits the patient to tell their story in their own words. Medicine is then prescribed to the patient along with a date for follow up. Doctors provide no description on the type of medicine given and its side effects. There is no questioning about patients health behavior nor do they try to understand the patient socio-economic background. There is no explanation on what might have caused these

symptoms. It was also observed that there was a lack of understanding about patient's family history, personal and social history, and drug and allergy history. The following Table shows an example of a closed- ended doctor patient conversation.

Table 8 : Example of doctor – patient conversation: Resident doctor with Student patient:

Doctor: What is the problem?

Patient: My head hurts, my eyes becomes red, mostly in the evening.

Doctor: Is it cause of the light?

Patient: No, there is pain in one side of my eye and starts turning red.

Doctor: Did you check your eyes before?

Patient: Yes, took medicine

Doctor: Do you feel like vomiting?

Patient: I cough a lot, but I feel like vomiting

Doctor: Does it hurt around your shoulder?

Patient: No

Doctor: Where does it hurt the most?

Patient: Right side of my eyes

Doctor: Have you done CT scan?

Patient: No

Doctor: When your eyes are red, do you tear?

Patient: No, but when I close my eyes it hurts.

Doctor: Does it hurt when you look at light and candles?

Patient: No

Doctor: Does it hurt during the day?

Patient: No

Doctor: Does your nose close up?

Patient: No

Doctor: Do you get tired quickly?

Patient: No

(Doctor conducts medical checkup)

Doctor: First you need to conduct an eye check up, and then we will see what problem has occurred with your eyes. See me after your eye exam.

(Patient nods and exits the room)

Source: Field work 2010

The above conversation style gives the patient little choice in the way they answer and usually elicits a “yes” or “no”. Patient’s socio economic background was seen as an obstacle for communication. As identified by the doctors, patient from villages were the most difficult to communicate with, followed by female patient, older patients, uneducated patients, male and younger patients. Primary reason was that they would not be able to capture and retain all the information due to their low literacy level. Secondly, doctors do not have enough time to individually explain the treatment process, diagnosis, results of medical reports, and side effects of medicine. Fifty seven percentages of resident doctors have sometimes failed to tell the truth to a patient about his/ her condition. It is doubtful whether the patients knew about the nature and severity of their illness. Furthermore, 43 % of the doctors either mention every risk they can think of or only major risk.

Doctor feels that if patient were given information on all the risk involved in the treatment, they might get mentally disturbed. In order to assure patients, doctors minimize communicating the risk involved in patient’s treatment. However, 86 % believed that patients play an active role in obtaining information regarding their illness. There is doubt on what kind of information patient demand. Furthermore, fifty seven percent believe that patients that come to TUTH are demanding i.e., they are active in obtaining information that they consider important.

The doctor’s questioning style is information seeking, taking down the patient’s history and finding the cause and solution of the patient’s problem. Despite the fact that the doctor’s purpose in questioning is closely tied to the nature and goals of the interview, the doctor still claims power by staking the right to question. This type of doctor patient relationship is known as Paternalistic or doctor centric (Charles, C., Whelan, T., Gafni, 1999) where one-way communication exists. Doctors take the upper hand in decision making and patients are just the listeners and followers.

5.2.1.3 Rapport building

The medical interview, during which doctor-patient communication occurs, is a tool by which the physician gets to know the patient so that he/she feels like a person, not just a health problem. By taking into consideration patient's problems, understanding

him/her and the expectations that he/she has of the doctor, mutual satisfaction from healthy patient doctor relationship becomes the wanted result. Therefore, both the verbal and nonverbal processes through which a doctor obtains and shares information with a patient is called doctor patient communication. All patient doctor interactions are influenced by the expectations of the both parties because this is always a two-way process.

Success in communication largely depends not only on the doctors' clinical knowledge and technical skills, but also on the nature of the rapport that is established between doctor and patient. Seven components were considered to be fundamental to all encounters between clinician and patient (Nelson, 2008 cited in Miric, NMB., Bakie, NM., 2008) :

- Build the relationship
- Open the discussion
- Gather information
- Understand the patient's perspective
- Share information
- Reach agreement on problems and plans
- Provide closure

These points focus on overcoming barriers that can occur in communication and could enhance efficiency in doctor-patient communication, improve quality of care and time management.

During observational study, forming a doctor patient relationship was seen as deficient. Opening discussion would always start by doctors directly asking the patient his/her medical problem. The doctor and patients did not exchange any formal or informal greeting. A warm greeting, eye contact, a brief non-medical interaction, or checking on an important life event which could of build rapport in less than a minute was not present. Information was gathered primarily using closed- ended questions that limited the patient to fully communicate his/her medical problem. Despite doctors understanding of patient’s perspective of the illness, there was a lack of shared information on nature illness and treatment options. From the study it can be said that doctors omit to mention:

- *Description of the illness;*

- *The root cause or the possible cause of the illness,*
- *The type of medicine that is prescribed, its side effects, possibility of allergic reaction, if any;*
- *The explanation of the results as stated in the medical report;*
- *Different type of treatment plans that patients feel more comfortable with.*

Complicated problems can benefit from shared and informed decision making. When patients are involved in creating a plan, they are more satisfied and have better outcomes, and their doctors are less likely to generate unnecessary tests or referrals. Decision on treatment was seen one-way. Medicines were prescribed to the patients without educating them what the medicine was for or what were its side effects. Once that was complete, doctor would tell patient to come after certain days. There lacked a proper closing session. Doctor's non-verbal communication would include smiling, attentive listening, and thorough medical checkup. Only when the patients were seen assertive, doctors would respond to the queries and concern about their medical diagnosis and treatment. More often, the pressed time would limit such conversation to occur.

In questionnaire survey, doctors were asked what they would do if patients did not follow proper medical instructions. The result showed that 86 % would convince the patients and 14 % would go along patient's choice. Similarly, when asked whether effective communication will lead to greater health outcome and patient satisfaction, all respondent response was "yes".

In the following table, doctors were asked what they thought would establish a proper doctor patient communication in TUTH. Table 9 provides the responses along with the change that needs to take place in TUTH.

Table 9: Framework of content analysis of doctors descriptive evaluations (n= 7). Criteria's that will establish a proper- doctor patient communication along with the measure that TUTH needs to take.

Elements for good doctor patient communication	Theme
• *Uncrowned Environment,* • *Privacy*	• Hospital management
• *Health care education program* • *Maintain doctor-patient number*	• Health Education • Hospital management
• *Communication Skill training and knowledge,* • *Positive attitude of patient, patient party and doctor*	• Communication skill training • Education on health communication for both parties
• *Eye to eye contact* • *Willingness of patient to get recovered* • *Improve language problem*	• Rapport building • Patients assertiveness • English medical terminology in Nepali
• *Provide more time to patient* • *Maintain patient confidentiality* • *Follow up and compliance by patient*	• Hospital Management • Patients partnership
• *Talk, listen, advise and council patient*	• Adopting Patient- centric communication

Source: field work 2010

Hospital management is considered the primary barrier to effective doctor patient communication. Doctors complained about crowded environment, lack of privacy, overflow of patients, and short time for medical consultation as a hindrance to promote communication with their patients. Moreover, doctors complained that they lacked training in communication, proper rapport building and partnership building. They believed in patient centric communication but were unable to put it in practice due to other factors such as hospital management and lack of communication skill training. Lack of patient assertiveness was also believed to limit doctors to communicate with patients. Most importantly there is an absence of health education and literacy among the respondents coming in TUTH.

Comprehending the status of doctor patient relationship in TUTH, this study can relate to Barnlund Transactional Model of Communication (1970). He views

communication as continuous, dynamic, circular, irreversible and complex. Communication pattern in this study between doctors and patients is not observed as dynamic nor circular. It is mainly viewed as complex since there are many factors that hinder effective communication between doctor and patients. Also, communication was mostly one-way. Furthermore, the complexity of communication was further added by the poor hospital managements, low health literacy and passivity of patients and poor communication skill of doctor's make communication in TUTH deficient.

5.3 CONCLUSION:

Countries like USA and UK have been adapting to a more patient centered communication ever since Edith Balint defined patient centered medicine as "understanding the patient as a unique human being" (Balint, E., 1969 cited in Moore, M., 2008). This movement has grown in contrast to the traditional biomedical model of health and disease (Moore, M., 2007) by 'putting the patient at the centre of the consultation' and shifting from 'thinking and responding in terms of disease and pathology toward understanding and caring for people and their problems' (Henbest, R., Fehrsen, G., 1992). However, in countries like Nepal, shifting from a paternalistic model to a patient centered model is a far cry. Doctor patient communication is obstructed not only by the communicative style doctor uses, but also the communicative pattern, socio demographic background of patients and the lack of support by hospital management.

CHAPTER-6
SUMMARY AND DISCUSSION

6.1 SUMMARY:

This study is build mainly on four major issues; to determine the status of communication; to determine what effect demographic variables of patients have upon communication in the doctor- patient relationship; to determine whether the organizational structure and procedure effects doctor communication with patients, and lastly, to examine if patients play an active role in interacting with doctors. To emphasize these issues, doctor patient communication is taken as the dependent variable and independent variable consists of the Individual patient, the doctor and the health care organization/ hospital. For this study, individual patients are examined through four indicators: age, gender, occupation and education. Doctors are examined through their work load, communication skill and rapport building. Lastly, hospital is examined through their rules regulation and procedure, medical equipment and work environment. Empirical studies conducted on doctor patient interface, in relation to the process of communication is deficient in Nepal. In this sense, the present research initiative marks a milestone in the analysis of doctor patient communication in health care delivery system.

The main assumption of this study is to provide some evidence for the importance of effective communication in health care delivery and to show its state of triviality in Nepal. The recognition of the importance of doctor patient relationship and communication in medicine has particular relevance for primary care physician whose discipline has long focused on the disease centered quality health care delivery. The theoretical aspect of this study concentrates on Barnlund Transactional Model of Communication (1970) and the four model of health care by Ferlie and Shortel (2001); the individual patient; the care team, which includes professional care providers (e.g., doctors); and the organization (e.g., hospital) that supports the development and work of care teams by providing infrastructure and complementary resources; and the larger health care system or environment in which individual organizations are embedded.

This study was carried out through a mixed method research approach. Information is collected through open and closed - ended questionnaire based interviews, non-participatory observation, field notes and interviews. Besides these strategies, secondary resources are used to make research more valid and reliable. The data are presented both through tabulation and description.

6.2 DOCTOR PATIENT STATUS OF COMMUNICATION:

Results from the questionnaire survey for patients shows that more then half of the respondents has a positive reaction on the way doctors communicated with them. They are satisfied with the care, the consultation, the allocated time by the doctors and the attention they received. However, it is important to note that more then half of the patients hand no education. So, satisfaction in this study cannot be compared to the satisfaction level of doctor patient communication in countries such as UK or USA because the literacy status on health awareness is much lower in Nepali patients. In addition, the overcrowding of patients in outpatients clinic provides little time for the effective doctor patient communication. Furthermore, Nepalese doctors believe that patient's socioeconomic background effects communication. The biggest limitation of this study is the absence of recorded conversation between doctors and patients to exactly figure out what hinders doctors to properly communicate with patients having different socio-economic background and why female patients are more difficult to communicate rather then male. A study conducted by Alexander Kiss (2004) showed that male patients tend to resist communicating about their psychological problems whereas women tend to talk about their physical problems and more about their psychological problems. So it is believed that doctors may try to limit patient talk and focus more on biomedical consultation. This was exactly the case for resident doctors at TUTH. Doctors are seen to be paternalistic in nature where their primary focus is on the biomedical consultation and not interpersonal communication with patients. Communication is directed one- way where doctors take the lead in all decision making with minimum patients participation. Major reasons why doctors have problems in communication with patients are basically the crowded environment, lack of privacy, less consultation time, lack of health education of patients, and medical terminology. Hence the results received from patients in terms of communication contradicted to the result received by doctors. Doctors are not viewed as information

givers and patients are not viewed as information seekers. Hence, the status of communication is seen as complex as it's based on the individual identity and culture.

6.3 SOCIO-DEMOGRAPHIC OF PATIETNS INCLUDING THEIR ASSERTIVENESS IN DOCTOR PATIENT COMMUNICAITON:

In this study, patient's socio- demographic is seen as important predictors of their willingness to participate in the medical setting. TUTH is a tertiary referral center where patients from various underdeveloped regions come and get their treatment. In this study 90% of the patients are from various districts and villages and more then half of the patient that is surveyed are poor and have no education. Low literacy level and health awareness of the patients consequently lead to patients being passive during medical consultation. Patients may also have been reluctant to ask their doctors questions or express their opinions either because of their lack of question asking skill or the "decision making role" doctors have. Consequently, there is an absence of doctor encouragement in the form of partnership building and supportive talk that dejected patient participation.

Age, gender, occupation, and education of patients are not seen as important criteria in determining patient communicative behavior with doctors due to the standardized format of the medical interview. Patient's poor question asking behavior and poor health judgments led them to be dependent on doctor's decisions.

6.4 ORGANIZATIONAL ROLE:

The concern for doctors to improve doctor patient communication is mainly by improving hospital management. The crowded environment, over flow of patients, lack of privacy is a major concern that hinders them to spend proper time with patients. Doctor's communication skill is also another aspect. Student doctors are required to study communication skill during the first two semesters of their MBBS, but there is an absence of this course in MD curriculum. The implication is that, by the time students implement their knowledge in practice those learned theories regarding communication would have been already forgotten. Hence, there is an absence in communication skill training during practical training of resident doctors that stalls doctors to adapt a more patient centered communication. Poor maintenance

of medical equipment is also seen as another factor that inhibits doctors to communicate with patients. Frequent downfall of medical equipment causes a negative impact on the relationship as doctor are required to refer patients to private hospital that charge enormous fees.

6.5 FUTURE RESEARCH

This research is primarily focused on the Out Patient Medical Department and Inpatient Medical ward. The findings cannot be generalized in departments such as Cardiology, Oncology, Endocrinology, Hematology department …etc or during patients end- of - life treatment. One of the main shortcomings of this research has been the lack of direct measurement of the variables instead of collecting data as was done (questionnaire). Perhaps some actual measurements of time spent with the doctor and communication effectiveness through the use of audiotapes videotapes would have yield some other results. Another limitation of this study is that the questionnaire was conducted for patients admitted in the medical ward and not for medical OPD patients. Patients coming for a checkup are mostly in a vulnerable and irritable situation and in a non-participatory mood. If the survey was conducted in OPD rooms as well, there is a chance the results might have been different. Furthermore, a comparison between public and private hospital would have generated different results on doctor patient communication.

6.6 CONCLUSION:

Good doctor patient communication has not received much attention in the study of health care service delivery in Nepal. Quality medical care depends on effective communication between patients and health professionals. Various literatures have showed its multiple impacts on various aspects of health outcomes which include better health outcomes, higher compliance to therapeutic regimens in patients, higher patient and clinician satisfaction and a decrease in malpractice risk. The study exposes how different elements such as patients, doctors and the hospital could affect the effectiveness of communication. The result is consistent with the view that patient's low literacy and health awareness inhibit them to take control of their health. Doctors low communication skill and lack of support form hospital managements is another

factor for them to focus on the biomedical perspective of health. More emphasis needs to be given in the countries health policy to establish proper rules, regulation and procedures to promote health literacy among patients and awareness of doctor patient communication. Doctor patient communication is a tool in health care delivery to improve patient's health awareness in order to adapt a healthier lifestyle that ultimately leads to decrease of unnecessary treatment process and medication. As a result, patients are able to trust doctors and confide their health problems.

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APPENDIX

Questionnaire for Patients at T.U., Teaching Hospital

Thesis title: - Doctor-Patient communication in Health Care Service Delivery: A Case of T.U. Teaching Hospital, Kathmandu

Part A: Socio-economic background of patients

1. Age of Patient:
   a. ☐ 15-20 yrs b. ☐ 21-25 yrs c. ☐ 26-30 yrs d.☐ 31-35 yrs

   e. ☐ 36-40 yrs f. ☐ 41 yrs or above

2. Gender of Patient: Male ☐ Female ☐

3. Language of Mother/Father/Guardian:
   a. ☐ Nepali b. ☐ Tamang c. ☐ Newari d. ☐ Maithili e. ☐ Other

4. Geographical Location of Patient: ______________________

5. Occupation of Patient:
   a. ☐ Housewife b. ☐ Farm worker c. ☐ Industrial worker
   d. ☐Semi-professional e. ☐ Professional f. ☐ Other

6. Education:
   a. ☐ Illiterate b. ☐ Primary level c. ☐ Lower secondary level
   d. ☐ Secondary level e. ☐ higher secondary level
   f. ☐ Bachelor degree or higher

Part B: Patient Information

1. Diagnosis of admission to hospital? ____________________
2. Did the admitting doctor ask you about your illness?
   a. ☐ Yes b. ☐ No

3. Did you find it easy to talk to the admitting doctor?
   a. ☐ Yes b. ☐ No

4. Did the nurse or doctor tell you about the treatment you are being given?
   a. ☐ Yes b. ☐ No

5. Did you understand what you were told about the treatment?
   a. ☐ Yes b. ☐ No

6. Did the nurse/doctor tell you about the possible consequences of your illness?
   a. ☐ Yes b. ☐ No

7. Do you understand what you were told about the possible consequences?
   a. ☐ Yes b. No

8. If no, do you demand clarification and further information about the possible consequences and treatment process?
   a. ☐ Yes b. ☐ No

9. Do you get time with the doctor when you want to communicate with him?
   a. ☐ Yes, immediately
   b. ☐ I have to wait for a one or two days
   c. ☐ It is very difficult to get time with the doctor
   d. ☐ No

10. On which condition do you consult with the doctor?

a. ☐ Medicine dosage

b. ☐ Seriousness of the disease

c. ☐ Outcome of the treatment process

d. ☐ Duration of stay in hospital

e. ☐ Other _________________

11. Do you think you get enough time with the doctor?

a. ☐ Yes b. ☐ No

12. Are you satisfied with the allocated time with the doctor?

a. ☐ Yes b. ☐ No

13. Do you think the doctor listens to what you tell him/her?

a. ☐ Yes b. ☐ No

14. To whom you prefer to communicate regarding your illness?

a. ☐ Doctor b. ☐ Nurses

15. Why do you prefer to communicate with Doctors?

a. ☐ They know first hand what I am going through

b. ☐ They can give me accurate information

c. ☐ I trust what they say

d. ☐ Other _______________

16. Has the consultation with the doctor been useful to you?

a. ☐ Yes b. ☐ No

17. Do you have any hesitance to communicate with the doctor?

a. ☐ Language barrier

b. ☐ Economic barrier

c. ☐ Caste difference

d. ☐ Gender difference

e. ☐ Status difference

f. ☐ Other _________________________

18. Do you understand the language doctor uses?

a. ☐ Yes b. ☐ No

19. During daily doctor rounds, is the regular checkup being conducted?

a. Yes b. ☐ No

20. Are you satisfied with the care you are receiving?

a. ☐ Yes b. ☐ No

21. Why are you not satisfied?

a. ☐ No medicine
b. ☐ Too few nurses
c. ☐ Doctor not available
d. ☐ Poor attention by doctors
e. ☐ My health did not improve
f. ☐ Others ______________

22. What is your grievance?

a. ☐ Short time with doctors
b. ☐ Lack of attention by doctors
c. ☐ Lack of clarification of my illness
d. ☐ Lack of positive outcome
e. ☐ Expensive medicine
f. ☐ Other _____________________

23. What is your suggestion?

a. ____
b. ____

Questionnaire for doctors – T.U. Teaching Hospital

Thesis title: - Doctor-Patient communication in Health Care Service Delivery: A Case of T.U. Teaching Hospital, Kathmandu

1. Name : ____

2. Age:
   a. ☐ 20-30yrs
   b. ☐ 31-40 yrs
   c. ☐ 41 yrs and above

3. Gender:
   a. Male ☐
   b. Female ☐

4. Language:
   a. ☐ Nepali b. ☐ Tamang c. ☐ Newari d. ☐ Maithili e. ☐ Other

5. Position / Specialty: ______________________

6. The guiding philosophy of your being a doctor is to :
   a. Preserve or restore patients physical health;
   b. Care for the patient as a person including his/her physical and psychological well- being;
   c. Serve the community;
   d. Provide service on demand;
   e. Other

7. What is the major problem in communication with patient? Please identity three major reasons.
   a. ____
   b. ____
   c. ____

8. Which groups are more reluctant to communicate with?

a. Uneducated
b. Male
c. Female
d. Patients from villages
e. Patients from the city
f. Older patients
g. Younger patients
h. If other, Please specify_________________________

9. Do patients play an active role in obtaining information regarding their illness?

a. Yes
b. No

10. Do you think patients coming to T.U. Teaching Hospital are demanding?

a. Yes
b. No

11. What do you do when patients do not follow proper medical instructions?

a. Convince the patient
b. Delay treatment and try to convince patients
c. Refer the patient to another doctor
d. Refuse to continue as patient doctor
e. Go along with patients choice
f. No answer

7. Patients have grievance that (a) Doctors are not available, and (b) Doctors do not tell the truth regarding their condition, what is your explanation?

____

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____

8. Have you ever failed to tell the truth to a patient about his/her condition?
   a. Never
   b. Seldom
   c. Sometimes
   d. Often
   e. Usually
   f. No answer

9. Do you tell the patients of every known risk involved in a treatment of his/her child that you recommend?
   a. Every risk I can think of
   b. Only major risks
   c. Only if I am asked
   d. Only if I judge it to be in patients interest to know
   e. No answer

10. What hinders you to communicate with the patient (s)? Please specify two reasons.
    a. ____
    b. ____

11. Do you believe that effective communication with patients will lead to greater health outcome and patient satisfaction?
    a. Yes
    b. No

12. Do you believe patients socio-economic background effects communication?
    a. Yes
    b. No

13. Do you think hospital has some limitation to create effective health service delivery? Please identify three main reasons.
    a. ____
    b. ____

14. Do you think your work environment may effect your communication with patients? If yes or No, Please specify.

____
____
____
____
____
____
____
____

15. What are the criteria, from your point of view, will enable to establish a proper doctor- patient communication? Please specify three main reasons.

a. ____

b. ____