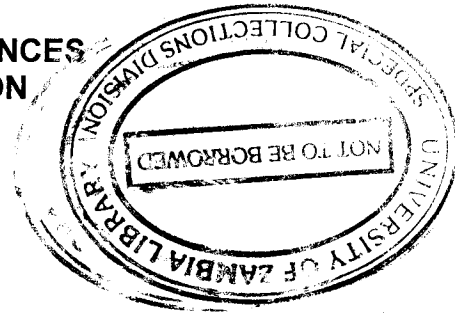


**SCHOOL OF HUMANITIES AND SOCIAL SCIENCES  
DEPARTMENT OF MASS COMMUNICATION**



**LANGUAGE DISCORDANCE AND LEVELS OF SATISFACTION BETWEEN  
DOCTORS AND PATIENTS IN A MEDICAL ENCOUNTER**

**BY**

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**2009**

## DECLARATION

I hereby declare that this report has not been submitted for a Degree in this or any other University.

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## Abstract

This study was necessitated by a paucity of research into the communication that takes place in doctor-patient interactions in Zambia; noting that patients have in the past complained that doctors communicate with them in a language they do not understand very well or at all and so were dissatisfied with the consultation. The study sought to answer the following research questions:

1. What languages are commonly spoken and understood by patients and doctors?
2. To what extent are patients satisfied with doctor-patient communication in terms of the language used?
3. To what extent are doctors satisfied with doctor-patient communication in terms of the language used?
4. What strategies can be used to mitigate barriers to doctor-patient communication?

*Methods:* A cross sectional, mixed study design involving 139 patients and 68 doctors who were randomly selected formed part of this study. Two structured questionnaires, two focus groups and fifteen in depth interviews were used to collect the data. Quantitative data and qualitative data were analysed using two computer programs SPSS version 14 and N vivo version 2.2 respectively.

*Results:* The findings showed that: (i) Patients most of the times communicated to their doctors not in English which is the official language but in any of the local languages suitable to the situation. They preferred to communicate in Chinyanja most of the time though Chibemba was rapidly becoming the language of choice. However, most of the patients understood Chinyanja, Chibemba and English very well. As for doctors, they had a preference to speak in English and Chibemba to their patients rather than any other language and yet they understood Chinyanja more than Chibemba. Patients and doctors were satisfied with their understanding of what was communicated in a language they were able to understand. (iii) Both doctors and patients saw the need to mitigate barriers in doctor patient communication but doctors were rather uncomfortable when it came to strategies to empower patients. Doctors seemed to be uncomfortable for instance allowing patients to be provided with videotapes to view as a way of educating themselves on some topics.

*Conclusions and recommendations:* This study has concluded that small-scale satisfaction surveys like this one do not measure the desired satisfaction adequately in a scientific sense, and cannot be used as robust and reliable measure for service evaluation. But when used as formative case studies they can identify problems in service provision that may require remedial action. Clinicians and managers should avoid interpreting these findings as 'league table' results but use them to demonstrate that they are working collaboratively to respond to the communication concerns of patients and doctors alike.



## **Dedication**

In memory of Emma Chanda Chisanga my wonderful mother who was responsible for my academic successes.

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## **CHAPTER ONE- INTRODUCTION**

**"Communication is not 'add on' - it is at the heart of patient care."<sup>1</sup>**

### **1.0 Introduction**

The above quotation sets the theme of this study which is "Doctor Patient Communication and Patient Satisfaction". Good clinician-patient communication is often emphasized not because it is related to health outcomes but because communication skills coupled with a compatible language between doctors and patients are related to higher patient satisfaction scores, less malpractice litigation, lower rates of voluntary termination from Health Plan membership, and increased clinician satisfaction (Stein et al., 1998).

When a patient visits a clinic or a hospital he or she needs to explain what is wrong with him or her. For a doctor to understand what the patient is saying, it is the duty of the patient to describe how he is feeling in a language which the doctor easily understands. It is also the duty of a medical doctor or a medical student to interview such a patient by asking questions. This helps to diagnose a particular problem. The approach to the patient is that a doctor should appreciate that his objective in clinical examination is to obtain complete information about the present and the past illnesses and the environmental background which will enable him make an accurate diagnosis (Parkins and Pegrum, 1974:1). There have been a number of cases related to poor treatment of patients due to wrong diagnosis. A misdiagnosis may lead to fatal results. Therefore, students should appreciate the importance of history and examination even before they graduate so that they will be able to provide quality medical services to their patients. A clear understanding or communication between a doctor and patient will result in doctor-patient satisfaction. This is so



because a close relationship often develops and the student must be aware of the effect of this on both the patient and himself or herself. Hicks, (2008) revealed that talking to your doctor clearly and understanding what they are saying to you in return is the basis of every successful doctor-patient relationship.

Some studies indicate that 80% of the information, for the doctor to make a correct diagnosis comes from what you say. The remaining pieces of the puzzle are found when one is examined and from tests. This verbal information known as your history is important and is obtained in two ways: one's answers to their questions, what one says without being prompted (Hicks, 2008). Often it is a little piece of information that one feels is irrelevant that cracks the diagnosis. Patients are encouraged to give their doctor as much information as they can. If there is anything one thinks doctors need to know, – e.g. that that one is taking supplements, over the counter medication, for example, then the patient should say so. Doctors are human too and may forget to ask certain things.

It is assumed that patients and doctors are speaking the same language, but often this is not the case. Doctors tend to use technical language, three-letter acronyms and words that mean one thing to them are something completely different to you (Hicks, 2008). General practitioners or doctors often use abbreviations that are universally understood by doctors but may mean something else entirely in normal language. Patients who exercise their right to see their medical records are advised to have someone interpret them, to avoid confusion or worry.

Lloyd and Bor (2004) explain that a patient brings to the doctor their problems, usually in the form of symptoms or complaints, their anxieties about their problems and their concerns about other aspects of their life. They also have expectations about how a doctor will deal with them as a patient. The interview between patient and doctor is the cornerstone of the problem-solving process.

The doctor's role is to gain as accurate a picture as possible of the patient's problems. This information must be processed in such a way (usually in the form of making a diagnosis) that will enable the doctor, ideally in collaboration with the patient, to develop a plan for managing the problem. How is this done?

1. Establish a rapport with the patient using the skills outlined below.
2. Help the patient to tell their story, including their underlying concerns, as completely as possible.
3. The structure of a medical history (Lloyd and Bor (2004:28):
  - Basic information about the patient
  - Description of presenting a problem
  - History of presenting a problem
  - Review of body systems
  - Past medical history
  - Family history
  - Social history
4. Process the information acquired, supplemented by the results of the examination and appropriate investigations. This stage involves the knowledge of clinical medicine and decision-making processes that develop with experience.
5. Explain to the patient what may be wrong and how they might be helped. To do this successfully demands good communication skills and involving the patient in their management.

According to Hicks (2008) communication is the basis of good healthcare and doctors are now trying hard to make sure they use patient-friendly language. Communication in health care may be as old as Hippocrates but it has only recently received attention in its own right. That is not to say that great doctors such as Hippocrates, Maimonides, Boerhaave or Virchow did not mention the doctor-patient relationship. On the contrary, they stressed that it was of the utmost importance. Several theoretical perspectives shaped the early studies of

doctor-patient communication. From a sociological perspective, the concept of 'power' was a central issue. The 'medical model elaborated by Parsons (1951) and Freidson (1972) define a hierarchical relationship between doctor and patient. This relationship was criticized by many, including Thomas Szasz (1972), Ivan Illich (1975) and followers of the Frankfurter Schule, to name just a few of the most well-known theoreticians, who claimed that it did not address patient satisfaction with communication. The evidence that patients are more satisfied and more likely to comply with treatment when doctors allow them to express their concerns and ideas in the consultation is powerful. This is so if done in a language they both understand (Sakett et al., 1975; Stiles et al., 1975; Roter and Hall 1987; Heaton, 1981; Stewart et al., 1995).

It has been established that doctor-patient communication is of great importance to primary health care. Communication is the tool of information exchange, necessary to solve health problems, and to create the therapeutic relationship, required to manage health problems and gain confidence. Communication can meet the patients' need to 'know and understand' as well as to 'be known and understood' (Bensing, 1991; Roter and Hall, 1987). Studies on doctor-patient communication have shown that the communication styles of doctors have an impact on outcome measures like patient satisfaction and compliance (Inui et al, 1982; Bertakis, 1991; Salmon et al., 1994). The achievement of satisfaction may be influenced by many factors not excluding language.

The impact of language characteristics on communication in Zambia is unknown, and we do not know how cultural linguistic differences influence doctor-patient communication and satisfaction. In the West, what has been established is what the patients consider worth talking about with their doctors and the doctors' communicative behaviour is likely to depend on society's prevailing language norms (Hofstede, 1991; Payer 1991; Melker et al., 1997). Studies have found that patients or clients who articulate their needs, concerns,

and symptoms in a compatible language with their doctors during consultations are more likely to supply the information doctors need to make an accurate diagnosis, select effective treatment, and offer appropriate advice. Patients who ask for information, for clarification, and for providers' opinions may get a better understanding of their situation and, therefore, are able to make well-informed decisions. As a result, they may have more confidence in and a greater commitment to the investigation and treatment plan (Roter, 1977; Greenfield, et al., 1985; 1988, Kaplan, 1989; Ong et al., 1995; Cegala et al., 2000). Moreover, patients who receive more information from their providers, more social and positive talk, and more facilitation of partnership in their communication are more satisfied, have higher levels of recall and understanding, and are more compliant (Roter et al., 1998).

However, this communication is not all that smooth because there are barriers. Communication barriers can adversely affect health services access, health outcomes, and patient satisfaction (Flores, 2005:62:255-99) quoted by Francesca Get al (2007:312). One example of a communication barrier between doctors and patient compliance with a drug regimen which depends on many factors. Researchers point to complexity, duration, and behavioural change associated with the drug, as well as to the patient's family stability and history of compliance (Wartman, S. A et al (1983:886). But two influences that have not received adequate attention are patient satisfaction and the quality of communication between physician and patient.

## **1.2 Statement of the Problem**

The problems that necessitated this study are multitudinous and the following stand out. The first one is related to the consultation process. Consultation is at the heart of primary care and is largely realised through language. However, research into the communication that takes place in doctor-patient interaction in primary and secondary care settings has had little to say on language issues.

Reviews of doctor-patient communication (Roter, 1989; Simpson, 1991; Stewart, 1995) are overwhelmingly weighted towards studies in which language features are either not analysed or analysed in a linguistically naive fashion (Mishler, 1984). The second one has to do with patients complaints. In Zambia, most complaints by patients and the public about doctors deal with problems of communication and not with clinical competency. The commonest complaint is that doctors communicate to patients in a language they do not understand and as such patients and doctors do not listen to each other. The problem with doctor patient communication in Zambia is rooted in misunderstandings on account of language. The third one is related to lack of empirical data on patient and doctor communication with satisfaction levels in Zambia. The problem of doctor-patient communication and satisfaction is an understudied/ under researched. The fourth one is that research on doctor-patient communication has rarely included the language variable and its impact on patients' satisfaction.

This being the case, it is undeniable that there exists a gap between the recognized importance of communication and patient satisfaction and a study in this area is worth doing.

### **1.3 Research Objectives**

Given the statement of the problem, the objectives of this study were:

1. To identify languages commonly understood by patients at the University Teaching Hospital (UTH)?
2. To explore patient's satisfaction with doctor-patient communication at the hospital
3. To explore doctor's satisfaction with doctor-patient communication
4. To identify strategies that can be used to mitigate barriers to doctor-patient communication

## **1.4 Research Questions**

The statement of the problem outlines five main problems and given these problems, this study wished to answer the following questions.

1. What languages are commonly spoken and understood by patients and doctors at the UTH?
2. To what extent are patients satisfied with doctor-patient communication in terms of language used at the hospital?
3. To what extent are doctors satisfied with doctor-patient communication in terms of language used?
4. What strategies can be used to mitigate barriers to doctor-patient communication?

## **1.5 Justification of the research**

This study is justified for a number of reasons. This is a pioneering study and as such the results are likely to stimulate the need to review the medical curriculum to include the teaching of medical communication skills. In addition, the findings may highlight the necessity for further research to initiate performance audit and patient advocacy. Finally, the methodology used in this study may be used to direct further inquiry.

## **CHAPTER TWO - LITERATURE REVIEW**

This chapter reviews the literature related to doctor patient communication and satisfaction. Since communication and satisfaction studies in medicine and public health are yet to gain momentum in this part of the world, most of the literature discussed here is based upon, and informed by researches conducted in the West and some parts of Asia. This literature review provides the reader with an overview of major academic works concerning communication and satisfaction. It is not a comprehensive review of the available literature, and it is not a meta-analysis (a synthesis of research results using various statistical methods to retrieve, select, and combine results from previous studies).

An electronic search on keywords published only in peer reviewed articles in data bases to which the University of Zambia subscribes was performed to compile the main body of literature that has been reviewed. Other than these journal articles, an electronic multi-campus network of library holdings was used to identify books. Particular note was taken of references that were frequently cited in bibliographies and appeared to be classics. References were selected that reflected the models' original formulations and origins, and changes that have been made to the theories over time. In some instances, content within references was repetitive. When this occurred, the most comprehensive sources were selected for analysis. In general, the literature review has been arranged and classified according to their focus on one of the following themes:

1. Background Information on Zambian Languages
2. Communication in Medical Settings
3. Communication Theories
4. Types of Interaction Models
5. Patient Outcomes (Satisfaction Types)
6. Communication Mitigation

These themes serve as a heuristic device, a convenient way of organizing the work in building answers to the research questions.

The emphasis of this literature review takes a social science orientation rooted in medical communication. Nevertheless, examples outside this area especially medical sociology are provided to show that the analytic framework offered can easily be applied from a wide range of disciplines. The literature has revealed that in many medical communication studies that investigate satisfaction, lay beliefs about communication in relation to the doctor and patient relationship are often juxtaposed with linguistic science bordering on discourse analysis.

## **2.1 Background Information on Zambian Languages**

According to Ohannessian and Kashoki, (1978: 10) the majority of the present Bantu language groups in Zambia, particularly in the northern, eastern, and western parts of the country, migrated from the southern part of Democratic Republic Congo (DRC). The others not from the Congo appear to have originated either from the north in East Africa (e.g. Mambwe and Inamwanga) or from the south (e.g. the Ngoni of the Eastern province) or from the east (e.g. the Tumbuka). The migration into Zambia of the Bantu peoples probably began early in the Iron Age, during the first few centuries A.D. According to D. W. Phillipson (1972:9-10), at about the beginning of the second millennium A.D. the first settlement of the later Iron Age people appeared; they seem, archaeologically speaking, to be the direct ancestors of many sections of the present Zambian population. On the Copperbelt and around Lusaka the later Iron Age was established by the 12<sup>th</sup> century and a similar date seems probable over most of the eastern half of Zambia. It was among these people that immigrant groups later established states and kingdoms whose history is preserved in the traditions of Zambian peoples (Ohannessian and Kashoki, (1978: 10).



According to Siachitema (1986: 24) Zambia's languages belong to one group, the Bantu family of languages. They are called bantu languages because the languages share a number of common features. According to Roberts 1976(68) it was argued that on linguistic grounds that the Luba and Bemba languages were older than any other Bantu languages in eastern, central and southern Africa, and therefore the main phase of the Bantu dispersal must have originated where Luba and Bemba were spoken. This theory, however, has been challenged by recent research. What now seems clear is that a dispersal would have taken place long after the original Bantu settlement, it would have happened no more than a thousand years ago.

### **2.1.1 Languages used in Lusaka**

Patterns of Language use in Lusaka are as complex as the city's ethnic diversity. However, there are five major languages used in Lusaka namely, Nyanja, Bemba, Tonga, and Lozi and English. All the mentioned languages and other mother tongues are spoken in different situations and with varying degrees of frequency in the urban community. In terms of lingua franca however, English, Nyanja and Bemba have for a while competed with each other for status. Siachitema (1986: 25) notes that neither language has a close connection with the immediate rural surroundings which is inhabited by groups of people speaking Tonga-related dialects of Soli, Sala and Lenje. The provinces where both Nyanja and Bemba are spoken as mother tongues are geographically removed from Lusaka, their presence being part of the colonial and political history of the country. Noting that Chinyanja and Chibemba are used frequently, below is a brief profile of use and origin.

### **2.1.2 Nyanja: Origins and use in Lusaka**

According to Pike, J. G. quoted by Siachitema (1986:25) the term Nyanja refers to one of eight groups of people whose origins can be traced to a common ancestry. These groups of people are presently settled in Malawi, the Eastern

part of Zambia and Mozambique. They speak dialects of the same language Chewa, whose standard written form is referred to as Nyanja. Pike (1968: 39) observes that the designation Nyanja, "has risen largely by accident, either Chewa or Malawi would have been more appropriate. The so-called Nyanja speakers are descendants of a tribe or federation of tribes of this name."

The status of Nyanja a local language Franca for Lusaka dwellers, dates back to the colonial period when it was encouraged by the colonial administrators as the language of the federal police and army, much in the same way as Swahili was in East Africa.

### **2.1.3 Chibemba Origins and use in Lusaka**

Immediately after independence, Nyanja's position in Lusaka was threatened by Bemba, which is originally traced from Kasama. Bemba's presence in the city came about because of its association with the Copperbelt mines and the latter's significant role in the politics of Independence. The Copperbelt mines were the biggest single employment Agent for Africans in pre-Independent Zambia. Its labour force was drawn from all over Zambia as well as from neighbouring countries. In all political activities, Bemba, which was a lingua franca in the mines and spoken as a mother tongue, together with Lamba, in the surrounding areas of the Copperbelt, played a major role as the language of resistance and political independence. Political rallies were conducted in it and a number of prominent politicians of the day spoke it as a mother tongue. The political scene soon moved to Lusaka which, as the centre of colonial administration had a special political significance. Consequently Bemba, as the language of the politics of independence, consolidated its position in Lusaka thereby seriously undermining that of Nyanja which had up to then been the lingua franca for the capital (Siachitema, 1986). From the audience survey carried by Ohannesian and Kashoki 1978 (32) tentative evidence indicates that Bemba and Nyanja, followed by Tonga and Lozi, and to a lesser degree Luvale, Kaonde and Lunda, function as vehicles of wider communication in the country.

#### **2.1.4 The Role of English in Zambia**

The English language, introduced as a result of the country's colonial past, is Zambia's major official language. All Government business, the running of the country's economy and the educational system, are conducted in it. At the attainment of independence, English was declared the sole medium of instruction from the first grade including pre-school to university and colleges.

English is the principal lingua franca in terms of its use throughout the country (Ohannessian and Kashoki 1978 (31)). But this is not quite the same thing as saying that it is spoken by more people than, say Bemba. Ohannessian and Kashoki 1978 (31) further indicate from their survey that the languages claimed (by listeners to the radio) to be the most understood in the country as a whole are Bemba and Nyanja in that order. We can infer from this that English is behind these two Zambian languages at least in terms of the degree to which it is understood in the country. Ohannessian and Kashoki conclude that in terms of wider communication within the country, Bemba and Nyanja are at the moment the languages people claim to use on a wider scale than English. They are followed by English and then Tonga and Lozi in that order. Lunda, Luvale and Kaonde do not appear to be as important as the other five official languages in terms of national communication (Ohannessian and Kashoki 1978 (32)). However, this was reversed by the 1976 Educational Reforms which recommended a return to the old system whereby English was taught as a subject from the first grade onwards (Siachitema, 1986: 30). English shares its official status with seven other Zambian languages namely, Bemba, Nyanja, Lozi, Tonga, Lunda, Luvale and Kaonde. The seven languages also play a role in the educational system. They are taught as subjects in schools. Only the four major ones, Bemba, Nyanja, Lozi and Tonga are taught up to O-levels. The English language, while being the mother tongue of several millions of people, and while being associated with certain particular countries such as England or the United States of America, English is spoken by millions of non-native speakers throughout the world, and in that sense it has truly become an

international lingua franca (Ohannessian and Kashoki 1978(30). It is the official language of Zambia.

### **2.1.5 Language Policy**

According to Simwinga (2006:15) a language policy is an official statement regarding the use of language in a given situation, stipulating who should use what language where, with whom and when. This is in line with Calvet (1998:114) who defines language policy as “the conscious choices made in the domain of relationship between language and social life as a whole and more particularly between language and national life. Therefore, official languages used in Zambia for communication are Lozi, Tonga, Nyanja, Kaonde, Bemba, Lunda and Luvale. However, this assumption is strongly contested by some medical consultants interviewed at the University Teaching Hospital (16/12/2008) during in-depth interviews. A consultant indicated that the assertion that the seven languages referred to above are among the official languages used is not supported and Gazetted in the Zambian Laws what is gazetted is the English language. Knowing how to speak or understand any of the above seven languages out of the seventy-three including English would help someone to communicate with others without many problems in communication.

### **2.2 Communication in Medical Setting**

The interaction between physician and patient has come under increasing research scrutiny. In the last thirty-five years, there have been attempts mainly in the West and some parts of Asia to revolutionise the doctor- patient relationship from that of paternalism to that of patient centeredness or autonomy. This is because of a long tradition where paternalist doctors have been dominating medical interaction by using subtle ways of controlling communication (Smith, 1999:299-302; Schaeffer, 2001) and essentially this dominance does not agree with modern medical practice. As interaction is evolving, there are fundamental social cultural differences to take into account.

These differences among others include: language race, ethnicity and (Ong *et al*, 1995:912-913).

Many studies that have attempted to present patient experiences in the doctor-patient relationship have tended to concentrate on the doctor's technical competencies of care (and the related characteristics like the patient's age, sex, social class, family size and illness behaviour) and have ignored language as a critical factor. In the United States and Britain, for instance, doctors have dominated the interaction process a great deal and patients become disenchanted with the doctor's dominance (Kaplan *et al*, 1989:110-117; Fitzpatrick, 1991:1129; Light, 1991:3; Mechanic, 1991:1). Over the years, this dominance has receded because of developments in designing interaction models that have been used to meet the needs of patients. For example, models focusing on shared decision-making like the Evidence-Based Patient Care (EBPC) reflect a growing trend in health care towards patient empowerment and greater patient choice and these could only be achieved when the interlocutors are using a compatible language. Such models have been linked with better patient outcomes. This has been fostered by the increasing patient access to information about treatments and the consumerist trends in modern society (Ballard, 1993:66-80; Reiser, 1993:1012-1017; Elwyne, *et al* 1999:477-482). In the United Kingdom, current National Health Service (NHS) initiatives advocate "active partnerships" between health professionals and patients and the improvement of information to help patients choose between options (NHS Executive, 1996). Nowadays, most theorists acknowledge that unilateral decision-making by doctors is unacceptable (except in certain situations, for example, when a patient is comatose or in urgent need of life-saving action). The old paternalistic models of doctor-patient communication have been rejected by policy makers and medical academics are now in favour of more equitable and collaborative relationships characterized by informed choice.

### **2.2.1 Purposes of Medical Communication**

Interaction in the medical life world serves so many purposes. The notable ones are set forth below.

#### ***Exchange of Information***

The main purpose of medical communication is promoting the exchange of information between the doctor and the patient. Both parties can see information as a resource brought to the verbal interactions. The exchange of information consists of information giving and information-seeking (Roter *et al* 1987:437-439; Maguire and Pitceathly, 2002; 697-701).

From a medical point of view, doctors need information to establish the right diagnosis and treatment plan. From the patient's point of view, one could see that there are two needs that are expected to be met when visiting the doctor and these are: the need to know and understand (to know what is the matter, where the pain comes from) and the need to feel known and understood (to know the doctor accepts him and takes him seriously). In order to fulfil doctors' and patients' needs, both alternate between information giving and information-seeking. Patients have to impart information about their symptoms; doctors need to actively seek out relevant information. Once the diagnosis and treatment plan has been established, doctors have to efficiently impart this information to their patients. Therefore, the patients' need to know and understand might lead to additional information seeking about what has just been told (Ong *et al* 1995; 904). Patients who rate communication with their physicians as 'excellent' are four times more likely to believe they have received excellent advice than those who do not (Sotile, Mary O. (2006). And patients who like the way their physician communicates with them are more likely to comply with their doctor's recommendations and less likely to sue for medical malpractice in the event of a negative outcome (Moise H, 1999).

Sotile (2006) when commenting on effective doctor-patient communication outlines the following practical suggestions for enhancing doctor-patient communication as gleaned from a number of excellent guides by Conlee, C.J. et al (1993):

### 1. Show Empathy and Respect

Empathy is conveyed when you behave in ways that let your patients know that you care about what they are experiencing. Even a simple statement such as “ I am sorry that your are having these problems” goes a long way in conveying empathy below are some of the examples according to Shapiro J. (2002):

- Practice putting yourself in the patient’s shoes.
- Assuming the stance of “servant”, and remember that showing that showing the patient compassion and understanding is an important part of your job as a physician.
- Look for reasons behind a patient’s problematic behaviour
- Pay close attention to nonverbal cues about how the patient is feeling.

A few commonsense courtesies convey to patients that you respect them as people. Before beginning a medical examination introduce yourself and everyone else in the room and orient the patient to what you are about to do. Question patients thoroughly, letting them know that you are concerned about their medical symptoms and their general well-being. When time allows ask about problems of daily living, relationships, and feelings. Often, a simple “How are you doing otherwise” will suffice.

Conducting an interview between a doctor and a patient (Adapted from (Lloyd and Bor 2004:14).

## **Beginning the interview**

- greet the patient by name ("Good morning Mr. Zulu") and shake hands, if it is appropriate.
- ask the patient to sit down
- introduce yourself ("I am Dr. Mangani Zulu")
- explain the purpose of the interview ("I would like to find out about your present problem")
- say how much time is available
- explain the need to take notes and ask if this is acceptable

## **The main part of the interview**

- maintain a positive atmosphere, warm manner, good eye contact
- use open questions at the beginning
- listen carefully
- be alert and responsive to verbal and non-verbal cues
- facilitate the patient both verbally ("Tell me more") and non-verbally (using posture and head nods)



During the interview, there should be moments when both the patient and the doctor ought to be expressive to cover not only biomedical issues but the discussion should embrace psychosocial issues.

When a patient visits a hospital, he or she has a number of expectations of a physician such as: a comfortable setting, being greeted, by name and a handshake, being shown where to sit, the interviewers introducing themselves and explaining the procedure, an easy first question and the interviewer appearing interested in your remarks. Unfortunately, interviewers may neglect some or all these strategies, and doctors are no exception. An unsatisfactory beginning is likely to lead to unsatisfactory consultation (*Lloyd, Margaret, Robert Bor, 2004*).

### ***Medical decision-making***

Another purpose of medical communication is to enable doctors and patients to make decisions about treatment. It appears logical that in order to make such decisions, patients need information. This information can only adequately be received from a patient centred doctor. The relationship between medical decision-making and patients' informational needs has received much attention. For example, Blanchard *et al* (1988,b: 694-699) have indicated that patients suffering from various chronic diseases express a strong desire for medical information so that they can make a stand on the matter. However, the same patients also replaced responsibility for medical decision-making by their doctor for reconfirmation and not by them. As noted earlier, the desire for information about diagnosis, prognosis and treatment is especially great among patients who suffer from a life-threatening disease (Ong *et al* 1995; 904). Several other studies point in the direction of relative independence between the need for information and shared decision-making (Buckman, 2002:672). For example, (Ong *et al* 1995; 905) cite Blanchard *et al* (1998) who claim that cancer patients have a greater desire for information than cancer patients. Ong *et al* (1995; 905) also claim that Blanchard *et al* (1998) found that majority (92%) of hospitalised

adult cancer patients preferred all possible information to be given (either good or bad) but only 69% preferred to participate in treatment-related decisions as long as they had adequate information beforehand.

### **2.3 Problems in Communication – A Zambian perspective**

According to Chintu (1998:15) the impression most young doctors have is “I (doctor) knows what is best for you (the patient)”. This must change and the doctor must constantly communicate with his patients according to Chintu (1998). It is a known fact that the patient and the doctor have differing languages. Commenting on the patients’ rights to information Chintu (Ibid, 15) emphasises that when a patient consults a medical doctor, the patient does not lose the right to factual and as current knowledge as the doctor knows. Chintu (Ibid,15) further indicates that the patient socially and legally is an autonomous individual and for him or her to make a rational decision of what should be done about his or her illness, he or she must be given all the information about his or her disease and the management there of. Information may be given to a patient but the patient may not understand the information particularly if it is given laden with medical jargon. The information must be given in a language that the patient understands. Chintu (1998:16) reports that it has been observed that those patients with low socio-economic status are usually illiterate and therefore, written information may not be understood leading to poor compliance or comprehension of the intended message.

Commenting on cultural aspects as a source of concern in doctor-patient communication Chintu (1998:17) observes that modern medical training is Western and does not take into account that there are differences in every society. In certain situations, the patient will first speak to someone else either a relative or a Chief. These are areas which need exploration to make use of some of the cultural norms which do not harm the patient or put the doctor in conflict with what the doctor considers to be normal. Eleftheriadou, (1994) quoted by Lloyd and Bor (2004:85) explains that cross-cultural doctor and

patient communication poses different problems from those encountered when working with patients from the same cultural group. Patients who come from a different culture find themselves not only in a new and unfamiliar country, but also in an unfamiliar hospital environment. The hospital may represent a different set of cultural values and expectations, as well as a different language. Facing illness in a foreign environment can make the whole experience especially when no one speaks the patient's language extremely alienating. For example a, doctor in Western province who only knows English and Chibemba will experience a lot of problems when encountering those who speak Chilozi only. Lloyd and Bor (2004:85) illustrate this point further.

Imagine that you are physically unwell and don't know what is wrong. You know that you need to consult a doctor and you go to the nearest hospital. You walk into an unfamiliar building and don't know where you should go; all the signs are in another language. You hear this language being spoken and do not understand it, but you know you must make contact with someone urgently. How would you feel? What would you do?

The illustration above suggests that cross-cultural encounters are not only difficult for patients; they can make demands on the doctor, too. For example, during a medical consultation, you may have to consider racial and cultural factors unfamiliar to you, factors that can take time and patience to understand. Furthermore, you may be unsure of what is cultural and what are your patient's ideas and expectations.

The following cases will help one to consider the difficulties that may arise in communicating with people from different cultures. A doctor who participated in the study and explained some of the difficulties doctors face in some African countries said that a foreign doctor told an adult patient that he should undress and pull out his manhood because it was leaking and needed examination. The patient felt offended because the doctor was younger than the patient and the language used in some broken Chibemba was very crude. The result of this

poor communication ended in language barrier and misunderstandings between the doctor and the patient.

Another case was illustrated by Lloyd and Bor (2004) which went as follows: Mrs. Shah, an Asian woman attending a hospital clinic was referred to the outpatient clinic by her General Practitioner. She arrived with her husband, and the nurse called her to see the doctor. Her husband got up to go with her, but the nurse told him this is not necessary. Mr. Shah was angry and insisted on talking to the doctor himself. The doctor could see that they were dressed in traditional clothes, and that their spoken English was poor, but he wondered why Mr. Shah was so angry and why he wanted to accompany his wife. He often felt uncomfortable dealing patients from different cultures.

Therefore, in every medical encounter doctors need to understand the patient's culture in order to begin communicating effectively. According to Lloyd and Bor (2004) culture is ideas, values, beliefs, customs and behaviours based on different people's upbringing and personal experiences. When communicating with patients from different backgrounds, cultural differences are highlighted further by language, dress, gender issues, family relationships and attitudes to illness amongst many other factors. Simbyakula (1998:42) commenting on consent to medical procedures reveals that the lower levels of literacy in developing countries means that medical practitioners in such countries have an even greater challenge than their colleagues in developed countries in trying to ensure that there is shared decision-making with their patients.

## **2.4 Communication Theories**

There are a number of theories which have been used to study communication behaviour in inter-communication but none have been specifically applied to the medical encounter. The uncertainty reduction theory appears to be relevant and it is discussed in details below.

### **2.4.1 Uncertainty reduction theory**

Uncertainty Reduction Theory (URT) was introduced in 1975 in a paper entitled *Some Exploration in Initial Interaction and beyond: toward a Developmental Theory of Interpersonal Communication*. This theory, a collaborative effort of Charles R. Berger and Richard J. Calabrese, (1975) sought to predict and explain relational development (or lack thereof) between strangers. Uncertainty reduction theory was initially presented as a series of axioms (universal truths which do not require proof and theorems (propositions assumed to be true) which describe the relationships between uncertainty and several communication factors. URT was developed to describe the interrelationships between seven important factors in any didactic exchange: verbal communication, nonverbal expressiveness, information-seeking behaviour, intimacy, reciprocity, similarity, and liking.

The scope of the theory is narrowed down to rest on the premise that strangers, upon meeting, go through certain steps and checkpoints in order to reduce uncertainty about each other and form an idea of whether one likes or dislikes the other. To study this phenomenon, the interaction is viewed as going through several stages. Berger and Calabrese also introduce axioms and theorems regarding initial interaction behaviours.

#### *Stages of Relational Development*

Berger and Calabrese (1978) separate the initial interaction of strangers into three stages, the entry stage, the personal stage, and the exit stage. Each category includes interactional behaviours which serve as indicators of liking and disliking.

The entry stage of relational development is characterized by the use of behavioural norms. The contents of the exchanges are often demographic and

transactional. Common initial questions are: Where are you from? Or, Do you have any pets? The level of involvement will increase as the strangers move into the second stage (Berger and Calabrese, 1975: 99-100).

The second stage, or personal phase, is when strangers begin to explore the attitudes and beliefs of the other. Typically, this stage is entered after the strangers have had several entry stage interactions. One will probe the other for indications of their values, morals and personal issues. Emotional involvement tends to increase as disclosures are made (Berger and Calabrese, 1975:100).

The final stage of interactional development is the exit phase. Here, the former strangers decided if they want to continue to develop a relationship. Any plans for the future are made. If there is not mutual liking, either can choose not to pursue a relationship (Berger and Calabrese, 1975:100).

Understanding the cycle of relational development is key to studying how people seek to reduce uncertainty about others.

### Axioms and Theorems

Berger and Calabrese used several studies as a guide to develop the foundations of Uncertainty Reduction Theory. Research and theory development were steeped in the post-positivist tradition, using scientific methodology and deductive reasoning to reach their conclusions (Miller, 1976). The results of the studies form the foundation of the theory, seven axioms and 21 theorems. The following are the axioms set forth by Berger and Calabrese in their paper:

Axiom 1: Strangers enter an interaction with high levels of uncertainty about the other. However, as they begin to talk to one another, the level of uncertainty decreases. In turn, as the uncertainty decreases, the interacting individuals will talk more.

Axiom 2: As nonverbal expressive communication increases, uncertainty levels decrease, and vice versa.

Axiom 3: High levels of uncertainty prompt strangers to ask more questions of the other. As uncertainty decreases, so does the posing of questions.

Axiom 4: High levels of uncertainty in a relationship lead to less sharing and emotional intimacy. Low levels of uncertainty allow for more sharing and emotional intimacy.

Axiom 5: High levels of uncertainty lead to more symmetrical question exchanges in interaction. As uncertainty decreases, so does the need for an equal exchange of talk.

Axiom 6: Personal similarity will decrease uncertainty about another, while dissimilarity will produce higher levels of uncertainty.

Axiom 7: An increase in uncertainty will lead to a decrease in liking. A decrease in uncertainty will lead to an increase in liking.

Berger and Calabrese (1975) formulated the following theorems deductively from their axioms:

Theorem 1: The amount of talking and nonverbal communicative expressions are positively related.

Theorem 2: The amount of communication and its intimacy level is positively related.

Theorem 3: Time spent in interaction and questions posed are inversely related.

Theorem 4: Time spent communicating and instance of symmetric exchanges are inversely related.

Theorem 5: The amount of communication and liking are positively related.

Theorem 6: The amount of communication and personal similarity are positively related.

Theorem 7: Nonverbal expressions and intimacy level of conversation are positively related.

Theorem 8: Nonverbal expressions and information seeking are inversely related.

Theorem 9: Nonverbal expressions and instance of symmetrical exchange are inversely related.

Theorem 10: Nonverbal expressions and liking are positively related.

Theorem 11: Nonverbal expressions and similarity are positively related.

Theorem 12: The level of communication intimacy and information seeking are inversely related.

Theorem 13: The level of communication intimacy and instance of symmetrical exchange are inversely related.

Theorem 14: The level of communication intimacy and liking are positively related.

Theorem 15: The level of communication intimacy and similarity are positively related.

Theorem 16: Posing questions and symmetrical exchanges are positively related.

Theorem 17: Posing questions and liking are negatively related.

Theorem 18: Posing questions and similarity are negatively related.

Theorem 19: Instance of symmetrical exchange and liking are negatively related. Theorem 20: Instance of symmetrical exchange and similarity are negatively related.

Theorem 21: Similarity and liking are positively related.

*Viewed as a whole, the processes of getting to know someone, as well as if there is liking between the two, can be predicted by examining the interactive phenomena through Uncertainty Reduction Theory's tenets (Berger and Calabrese, 1975:101-109).*



Eleven years after Uncertainty Reduction Theory was introduced, Berger (1986) published *Uncertain Outcome Values in Predicted Relationships: Uncertainty Reduction Theory Then and Now*. His aim was to defend his theory in new contexts and modify it, as necessary. Berger later proposed three types of information seeking behaviour, passive (watching the interactant for clues in reactions to stimuli), active (posing questions to other individuals about the interactant), and interactive (posing direct questions to the interactant) (Miller, 1978). Later research by Berger and Bradac (1982) indicated that disclosures by interactants may lead them to be judged as more or less attractive. The judgment will determine whether the judge will continue to reduce their uncertainties or end the relationship. Berger (1986) also acknowledges the works of Gudykunst, et al. (1985) and Parks and Adelman (1983) to extend Uncertainty Reduction Theory to the realm of more established relationships. Planalp and Honeycutt (1985) studied the introduction of new uncertainty to existing relationships. Their findings indicate that uncertainty in long-term relationships usually impacts negatively on the relationship. A conceptual model of this theory looks like this:

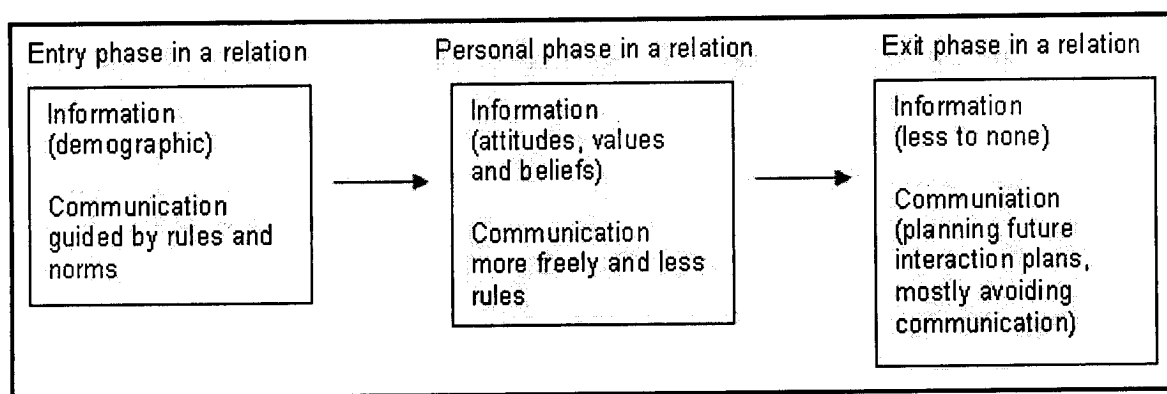


Figure 2.1 Conceptual Model of Reduction Uncertainty Theory

## ***Contemporary Use***

Uncertainty Reduction Theory has been applied to new relationships in recent years. Although it continues to be widely respected as a tool to explain and predict initial interaction events, it is now also employed to study intercultural interaction (Gudykunst et al, 1985), organizational socialization (Lester, 1986), and as a function of media (Katz and Blumer, 1974). Gudykunst argues that is important to test theory in new paradigms, thus adding to its fortitude (Gudykunst, 1985: 204) and that is why it has been included in this study.

## **2.5 Types of Interaction Models**

Whenever researchers wish to understand medical communication, they tend to use ...communication. Below are the various models that have been used to try to understand the doctor - patient communication behaviours. However, there are limitations to these models in the sense that they were conceived in situations where the interlocutors used one common language. Emanuel and Emanuel (REF) typologies are presented first as their models have formed the blueprint upon which conventional models have been crafted. After their presentation, then conventional models come later.

### **2.5.1 Emanuel and Emanuel typologies**

Falkum and Forde (2001:248) present four typologies by Emanuel E.J., and Emanuel , L.L. of the nature of patient -physician communication with patients, and these models are:

#### **2.5.1.1 The Paternalistic Model**

This is that model were the doctor has high control of the interaction. The physician can decide what is in the patient's interest without or almost without patient participation. If there is a conflict between a patient's autonomy and the

paternalistic doctor emphasizes health without hesitation. Even though the paternalistic model seems to have lost ground in most western countries, it might be justified in emergencies when the time to get informed consent or to involve a patient in decision making would obviously jeopardize or irreversibly harm the patient's health. However, practitioners who are advocates of the paternalistic model are rarely seen. This could be an expression of the cultural shift towards a greater patient autonomy that has taken place in the West (Falkum and Forde (2001:248). The theory is relevant to the study model because it appeared to the student from the outside what doctors may have been inducted during training which is an authoritarian model of dealing with patients.

#### **2.5.1.2 The Informative or Consumer Model**

According to Falkum and Forde (2001:248) this model is located at the other extreme of the patient / physician power scale. It is centred on the patient. In this model the patient decides autonomously which medical intervention should be made regardless of the physician's values or opinions. The doctor's task is to simply provide the patient with all the relevant information, which is the means for the patient to exercise control. The theory is relevant because it gives the researcher another way to examine how the doctor patient relationship could be.

#### **2.5.1.3 The Interpretive Model**

This model's aim is to elucidate the embedded, unclear patient needs and values. It helps patients determine which interventions are most likely to realize the needs and values. The doctor acts in the role of a counsellor or advisor who helps to increase self-understanding and thereby the autonomy of the patient. This model emphasizes the emotional aspect of the clinical encounter. There is a risk that the interpretive doctor may become a paternalist in disguise (Falkum

and Forde (2001:248). This model provides the researcher with yet another useful way to look at the relationship between doctors and patients.

#### **2.5.1.4 The Deliberative Model**

In this model, the doctor's aim is to help the patient determine the best health related values that can be realized in the clinical situation. The doctor provides factual information, elucidates values embodied in the different options, and clearly indicates why certain health related values are more important than others. In this way the doctor acts like a teacher aiming at the student's moral self-development through dialogue and deliberation. Falkum and Forde (2001:248) argue that Emanuel and his co-author envisaged this model to be the shared paradigmatic reference because of the following:

1. It embodies the ideal of patient autonomy as moral self-development. The deliberative doctor is the most caring in that he integrates knowledge, teaching, understanding and action.
2. Attempts to persuade are clearly different from the paternalistic models' impositions.
3. Doctors' values are relevant to the patients' and doctors inform patients of their choices. Doctors should also promote health related value

In the deliberative model, the researcher was informed about how to follow the doctors as a teacher or friend, by engaging the patient in dialogue on what course of action would be best.

#### **2.5.2 Evidence Based Medicine (EBM)**

This model is basically positivist and uses a biomedical perspective in patient care. The model is not very inclusive of the patient because it is typically biomedical. Clinical interventions are recommended on the strength of evidence for their effectiveness derived mostly from randomised-controlled trials and

systematic reviews. Davidoff *et al* (1995:1085-1086) and Bensing (2000:17-25) identify six basic tenets of this model and these are:

1. Clinical decisions are based on the best available scientific evidence.
2. The patient's clinical problem determines the evidence to be sought.
3. Identifying the best evidence involves use of epidemiological and biostatistical ways of thinking only.
4. Conclusions are based on the available evidence and are useful only if they are put into action for individual patients or for population health care decisions.
5. Performance is constantly evaluated.
6. The patient's individual needs, preferences, and emotional statuses are easily neglected as relevant factors in decision-making.

Following from the above, EBM is commonly criticised for being doctor-centred, in that it focuses on the doctor's interpretation of evidence and diminishes the importance of human relationships and the role of the patient in the consultation. However, it can be argued that the term 'evidence-based' is becoming outdated as consensus grows that EBM should acknowledge multiple dimensions of evidence including practical evidence based on individuals' interpretation of experience. There is a demand for a new definition of EBM that includes evidence produced outside science (Ford *et al* 2002:179-185).

This model allowed the researcher to understand how doctors were able to explain findings from the investigations they took.

### **2.5.3 Evidence Based Patient Choice (EBPC)**

EBPC is one of several models in existence which advocates providing patients with the necessary information to enable them to become involved in decisions about their care. The move towards increasing patient involvement is driven by a theoretical concern for respect for patient autonomy. This emphasises that patients should be in a position to choose whether to accept an intervention or not as part of their general right to determine their own lives. Specifically, EBPC recognises the fact that individuals differ both in what they value and in their propensity to take risks (Ford *et al* 2002:179-185).

EBPC is basically a humanistic, bio-psychosocial perspective, combining the ethical values of the ideal physician, with psychotherapeutic theories on facilitating patients' disclosure of real worries and negotiation theories on decision-making. This is the one model in which the doctor behaves in a manner, which facilitates patient expression so that the patient feels free to speak freely and to ask questions and in this way, medical care is tuned to the patient's preferences and needs (Bensing, 2000:17-25; Ford *et al* 2002:179-185). The patient centred model has an interactive style, which puts the doctor and the patient on an equal footing (Mead and Bower, 2002: 1087-1110). Stevenson *et al* (2000:829-835) affirm that the use of the patient centred model has helped patients' in drug compliance because of its inherent strength to grant patients complementary roles in decision-making. Therefore, in order for cognitively competent patients to have the power to make evidence-based choices, as well as being evidence-based, the medical consultation must be patient-centred. Providing patients with evidence-based knowledge should enhance their power and aid the development of an increasingly effective patient-centred health care system. This emphasizes that patients should be in a position to choose whether to accept an intervention or not as part of their general right to determine their own lives. A central ethical principle behind evidence-based patient choice is that the information is being given in order to enhance choice. Patient choice goes beyond consent and involves the patient in

the decision-making process. However, the move towards increasing patient involvement is not driven simply by a theoretical concern for respect for patient autonomy. Rather, it is recognition of the fact that individuals differ both in what they value and in their propensity to take risks. Stewart, (1984: 167-175), Elwyn *et al* (1999:477-482), Towle and Goldophin (1999:766-771), Bensing (2000:17-25) and Mead and Bower (2000:1088-1091) identify the following as characteristics of the patient centred model:

1. It encompasses a bio-psychosocial perspective whereby the meaning of the disease to the patient is interpreted particularly from the medical terms into the layman's language. This is important because the meaning of the disease for the patient may shed light on the clinical problem and vice versa.
2. Doctors understand and respond to patients' feelings, fears, and the links between the illness and patients lives.
3. Patient centred interaction is active listening that requires intense concentration on the patient's verbal and non-verbal behaviour.
4. The interviewing style in patient centeredness shows a balance between the doctor and the patient in order for the patients to express themselves.
5. Patients also have some control in the interaction process.
6. It advocates evidence based informed patient choice and shared decision-making.

Having looked at the two conventional models, one can see that they are mutually exclusive. For instance, the traditional doctor who controls the consultation with his biomedical agenda fills the upper left outer quadrangle; the modern self-conscious patient who controls the consultation with a bio-psychosocial agenda fills the lower –right quadrangle. But there is the emphatic paternalistic doctor who gives his patients a lot of room to tell their whole story, but who at the same time is firm in his decisions about the right medical treatment (upper right quadrangle), and the patient who controls the consultation with a persistent emphasis on a biomedical approach while the

doctor has a much broader view on the origin of the problems (lower left quadrant) (Bensing, 2000:22).

This model allowed the researcher to understand how doctors were able to explain findings from the investigations and physical examinations to enable patients make personalised choices.

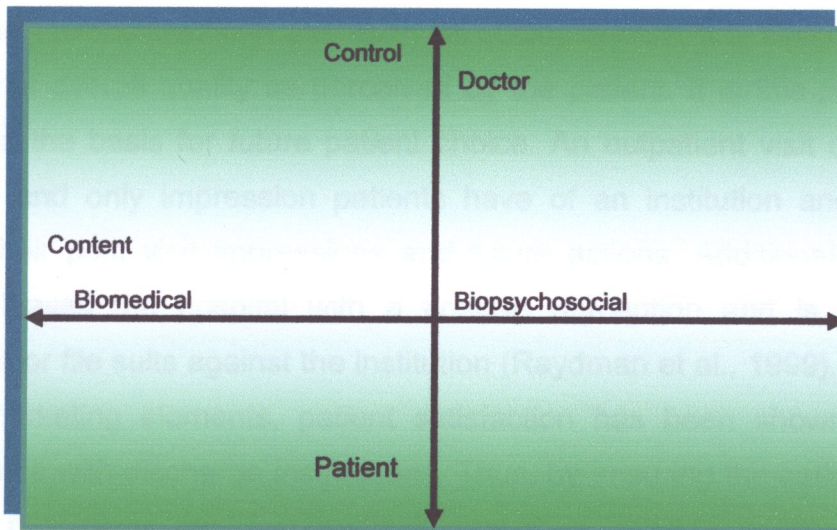


Fig.2.5.3.1 Dimensions of patient centeredness

Redrawn from Patient Education and Counselling 39 (2000): 22

## 2.6 Patient Outcomes (satisfaction types)

In the fast-paced managed care environment, relationship-building conversations can get lost in the pressure to perform. The demands of keeping abreast of the latest medical treatment can overshadow the need to practice and improve communication skills. Yet, communication is the foundation of all relationships, especially "healing" relationships, and positive physician-patient relationships are a critical part of the healing process Neuwirth (1999). Zoppi and Epstein (2002) argue that good communication is both a "way of being" and a skill that promotes positive physician-patient relationships. Neuwirth (1999)



notes that good communication is good business practice and leads to greater patient satisfaction, improved clinical outcomes, and increased patient compliance.

Patient satisfaction is considered an important goal for multiple reasons. First, patient satisfaction is an indicator of the quality of care provided (Hansagi et al., 1992; Kurata et al., 1992; Yarnold et al., 1998). Although satisfaction may not be statistically associated with the technical quality of care, it is associated with the concept of overall quality as perceived by the patient. It is this perception that becomes the basis for future patient choice. An outpatient visit often provides the first and only impression patients have of an institution and can greatly shape their post visit impressions and future actions. Additionally, a satisfied patient leaves the hospital with a positive perception and is less likely to complain or file suits against the institution (Raydman et al., 1999). In addition to these marketing elements, patient satisfaction has been shown to increase compliance with discharge instructions. Thus, by ensuring the satisfaction of the patient, physicians can favourably impact their patients' outcomes after the outpatient visit has ended. Enhancing patient satisfaction also improves the job satisfaction of the physician and other outpatient personnel. When patients leave the outpatient satisfied with the care and treatment they received, they often show this appreciation in their attitudes and expressions. It is human nature to enjoy a job in service of others when those served demonstrate their gratitude. Thus, satisfied patients may additionally serve to motivate and create a positive working atmosphere within the outpatient (Ingersoll et al., 1990; Williams, 1994).

Despite these generally accepted truisms about patient satisfaction, the satisfaction literature is limited by several factors. First, there is confusion regarding the meaning of patient satisfaction. Second, the clinical relevance of patient satisfaction information is highly dependent on the methodology used to survey the population and to analyze the survey results. Variability in study

methodology can lead to misunderstandings about the cause and effect of patient satisfaction (Young *et al.*, 2000).

A review of the recent literature illustrates that patients tend to be dissatisfied or satisfied if they get sufficient information and this may suggest that language could be one critical factor of many others. Other than the above communication models, researchers have used patient outcome models to identify situations where patients are satisfied with the type of health care provided. In the same domain, researchers have gone further to categorise the types of satisfaction. Patient outcomes, have been used in health care studies to assess the extent of the influence of the doctor's communicative behaviour. Outcome, as it is used in health care studies, can be used as an observable consequence of prior activity occurring after an encounter, or some portion of the encounter is completed (Beckman *et al* 1969:692-696). Many different patient outcomes linked to interaction have been identified in the past three and half decades. Literature shows that the outcomes can be positive and negative. A profile of the outcomes that are related with the doctor and patient centred models are presented below.

### **2.6.1 Positive outcomes of patient centeredness**

Communication researchers have become interested in the consequences of doctors' communication behaviour. Several physician behaviours depending on the model type seem to have an influence on patients' behaviour and well-being. Patient centred models have behaviours that have been found to be conducive to patients' disclosure of sensitive information especially when the doctor adopts a reassuring and empathetic interviewing style and listens to patients very attentively and sympathetically. (Cox *et al* 1981:144; Laidlaw 2001:577-579; Hobgood, 2002:1257-1259). Putnam *et al* (1998:38-47) and Maguire *et al* 1988:847) state that good interaction is aligned with good results particularly when patients are encouraged to present their concerns and this encouragement is best achieved by; (a) the use of open directive questions, (b) focusing on and clarifying psychological aspects, (c) emphatic statements, (d)

summarizing and (e) making educated guesses. Putnam *et al* (1985:74-83) noted that doctors who used inhibitory behaviours such as leading questions closed up a lot of patient detail. In the same vein, in a comprehensive review of health outcomes, Stewart (1995:1423-1433) concluded that four key dimensions of communication were related to positive patient outcomes (emotional health, symptom resolution, function and physiological health) and these were:

- The provision of clear information,
- Questions from the patient,
- Willingness to share (discuss) decisions,
- Agreement between patient and doctor about the problem and the plan.

There is compelling empirical evidence which supports the value of medical interviews which focus on the patient's needs and encourages him or her to adopt a more active role. For example, Orth *et al* (1987:387-401) showed that hypertensive patients who talked about their concerns in their own words, rather than answering closed questions, were more likely to have lower blood pressures. Kaplan *et al* (1989:447-504) has shown that a high ratio of patient versus physician talk is related to better health ratings, a reduction in days lost from work and fewer functional limitations. Further than this, satisfaction with care, adherence to treatment and plans, influence on recall and understanding of medical information, coping with the disease, quality of life, few malpractice suits and even a good state of health, have been seen to be positively related by a strong bond that is established by this patient focused approach. (Hall *et al* 1994,b: 1216-1231 Laidlaw, 2000:577-579; Oh *et al*, 2001:647-650).

There is also evidence that giving patients information about the choices open to them can sometimes lead to fewer prescriptions for specific drugs and less demand for some surgical treatments (Protheroe *et al* 2000:1380-1384).

### **2.6.2 Negative outcomes of non-patient centeredness (Doctor dominance)**

When interaction departs from the patient centred model the doctor essentially becomes the focus of the medical encounter. He is therefore dominant. He imposes his superior status on the patient while mystifying and confusing patients (Applebaum and Chambliss 1995). Doctor dominance has been expressed in so many ways by power difference in the context of the relationship with the patient/client. The doctor patient dominance is shown in five ways and these are: reluctance to give information to the client about his or her own condition; by the use of medical jargon in discussions with the patient or within the patient's hearing; by evasion of direct questions about the illness initiated by the patient; and by the doctor failing to initiate communication (Tucket *et al* 1986:1-50). Closely linked with this dominance, are the following negative outcomes: increase in lost work days, poor health ratings, poor relational bonds between the medical system and patients, law suits, poor drug compliance, lack of knowledge, poor coping mechanisms, inaccurate recall of instructions and delayed recovery (Locker and Dunt, 1978:283-292; Joos *et al* 1993:751-759).

Having stated the negative outcomes of a non-patient centred type of interaction; it would be ideal to present the characteristics of the types of dominance in these non-patient centred interactions that account for the stated phenomena by describing the types of dominance.

### **2.7 Patient Satisfaction Measurement**

Perceptions that patients have about the health care they receive are becoming increasingly important in this era of consumerism and competition. No longer is it desirable or acceptable for health care professionals to be the sole judges of the care and services provided (Merkouris *et al.*, 1999). Patients as customers are considered important sources of information for the development of new

programmes and the evaluation of existing nursing services. If patients' opinions are to be included, however, a standardized measure that allows comparisons of patients' perspectives across hospitals and across time is important (Young et al., 2000).

The literature offers many definitions of patient satisfaction. Hostutler et al. (1999) described satisfaction as occurring when services are rendered in terms of customer expectations, needs, and perceptions. Thompson<sup>1</sup> and Yarnold (1995) stated that satisfaction occurred in the setting of confirmation of patient expectation(s), and dissatisfaction occurred in the setting of disconfirmation of the same expectation(s). Rhee and Bird (1996) stated that patient satisfaction was characterized by the patient's beliefs regarding future use or recommendation of the institution for future care. Other authors describe patient satisfaction as the degree of congruence between patients' expectations of care and their perceptions of the care actually received (Anderson et al., 1987).

This study is recommending using the common definition of overall patient satisfaction as being *when the patient's own expectations for treatment and care are met (or exceeded)*. Using this definition, it is critical that any survey instrument should frame a general satisfaction question by *defining* the chosen satisfaction measure. For example, "in terms of the doctor revealing to you what you are suffering from, rate your satisfaction with your overall care." As noted elsewhere in this literature review, these measures have been associated with the state of overall patient satisfaction.

### **2.7.1 Previous Measures**

An important early measure of satisfaction with care was based on "intra-interpersonal character and operations of the nurse and technical-professional

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<sup>1</sup> Thompson DA, Yarnold PR. Relating patient satisfaction to waiting time perceptions and expectations: the disconfirmation paradigm. Acad Emerg Med. 1995; 2:1057–62.

competencies" (Risser, 1975: 46). In more recent instruments investigators have modified and extended the three dimensions of Risser's original instrument to "reflect nursing behaviours expected in the acute care setting" (LaMonica et al., 1986:44). Several additional instruments measuring patient satisfaction have been developed and refined during the past four decades (Hinshaw et al., 1982; LaMonica et al., 1986; Larson and Ferketich, 1993; Oberst, 1984). However, all have limitations associated with the conceptual complexity of patient satisfaction. One of the most important issues related to patient satisfaction as a measure has to do with the potential impact of individual service expectations on patient satisfaction ratings. For patients to judge whether they are satisfied, they must compare their experiences with their expectations. Yet many patients have limited experiences to assure confidence in their expectations. Most patients have few past experiences with medical encounters and hospitalization and have no exposure to the procedures. Their personal knowledge is based on brief hospital visits or conclusions drawn from accounts of acquaintances and the media (Locker and Dunt, 1978; Oberst, 1984).

Satisfaction and dissatisfaction with care have been described by several authors (LaMonica et al., 1986; Locker & Dunt, 1978; Oberst, 1984; Wallendorf, 1979). However, whether they operate on a continuum or represent different constructs is unknown (Williams et al., 1998). Although the degree of satisfaction is commonly assumed to be linear, aspects of care that contribute to satisfaction may differ from those that generate dissatisfaction because of expectations. Patients and health workers have different priorities and expectations about care (Gustafson et al., 2001).

The state that represents patient satisfaction has been defined in many ways. Generally, the definition relates patient (customer) expectations and the extent that these expectations are met. Interestingly, the survey instruments used by different authors to measure patient satisfaction vary widely. Investigators have sought associations of clinical service delivery factors with various surrogate measures for satisfaction. In Table 2.6.1 the student lists the various measures



reported by authors of most cited studies. Often authors reported they measured “overall satisfaction,” but did not report how the term was framed within the survey instrument. Scaled (Likert) measures also differed in terms of the number of options available and whether the options were skewed or symmetric about some neutral value.

Table 2.7.1 Variation in patient satisfaction measures used in selected studies

Study	Concept/Item Designated as Representing Overall Patient Satisfaction (Measure: e.g., Visual Analog Scale [VAS] or Likert Scale [Symmetric vs Skewed]); Scale Length or Number of Categorical Points on Scale)
Baker et al. 1998	Developed using the mean score from 5 specific measures: “friendliness, respectfulness, concern for the patient as a person, spending enough time, and making the patient feel comfortable.” (skewed; 5-point scales)
Björvell and Stieg 1991	“When you now leave the ED, how do you feel?” and “If you urgently have to go somewhere because you feel sick or have been injured, what would you then think of this ED?” (both with VAS scale; 100-point)
Bursch et al. 1993	“Overall, how satisfied are you with the care you received in the ED?” (unspecified scale) Carrasquillo et al. 1999 <sup>22</sup> “Satisfaction with overall care” and “Would you return to the same ED if you had another problem that required emergency care?” (skewed; 5-point scale [only two upper categories = satisfied] and [presumed] dichotomous query, respectively)
Hall 1996	“Likelihood of recommending our ED to others” (skewed; 5-point scale)
Hansagi et al. 1992	“How satisfied were you with the medical treatment at the ED?” and “How satisfied were you with the general service/care?” (skewed; 4-point scale)
Krishel and Baraff 1993	“Overall satisfaction” and service subcategories (skewed; 5-point scale)
Lewis and Woodside 1992	“Overall satisfaction with ED visit” (skewed; 3-point scale)
Mack et al. 1995	Overall satisfaction constructed out of measurement of satisfaction with medical care, quality of interactions with staff, and state of hospital facility (each measure used skewed, 10- point scale)
Maitra and Chikhani 1992	Overall satisfaction determined through self-categorization of “satisfied” or “not satisfied” (dichotomous query)
McMillan et al. 1986	“32 service categories/attributes” related to ED care (symmetric; 5-point scale).
Rhee and Bird 1996 <sup>8</sup>	“How would you rate the overall quality of the service?” and “Would you recommend the ED to friends or relatives?” (Skewed; 5-point scale and dichotomous yes/no).
Thompson and Yarnold 1995	“Describe your experience in the ED” (skewed; 4-point scale).
Thompson et al. 1996	“After your visit, how would you describe your experience with the ED?” and “How likely would you be to recommend this ED to a friend or relative?” (Skewed; 4-point and 3-point scales, respectively).
Watson et al. 1999	Viewpoints about care in the ED.
Yarnold et al. 1998	“Overall satisfaction” (symmetric; 5-point scale, and skewed; 4-point scale).

Despite the differences in study methodologies and measurements, several recurrent themes are evident from these studies. A strong positive association between provider–patient communication and patient satisfaction exists.

### **2.7.2 The purposes of patient satisfaction measurement**

Commentators generally agree that the measurement of patient satisfaction fulfils several distinctive functions. Fitzpatrick put forward parameters and these were:

1. Understanding the patients' experiences of health care.
2. Promoting cooperation with treatment.
3. Identifying problems in health care and
4. Evaluation of health care.

### **2.8 Communication mitigation**

Research shows that when patients and doctors fully disclose their concerns, expectations, and preferences, both the doctor and the patient can assess their problems more accurately and communicate effectively (Frederickson and Bull, 1995; McCann and Weinman, 1996). Yet studies have found that patients in both developed and developing countries generally participate little in consultations (Roter, 1977; Street, 1991; Roter et al., 1998; Kim et al., 1999). Researchers have identified problems areas in medical communication and in the quest to eliminate communication problems, they have suggested strategies that may improve the communicative behaviours of both doctors and patients. The necessity to continuously improve one's ability to communicate in ways that build and sustain positive patient relationships needs to be addressed. Patients can improve the quality of their reproductive health care, for instance, by actively communicating with doctors, nurses, and other providers. Strategies that have used to overcome these problems have included the following:



### **2.8.1 Teaching Patient Participation**

To encourage patients to participate more fully in health care visits, researchers in developed countries have tested various patient education interventions for the waiting room. Patients have been given print materials to read (Frederickson and Bull, 1995; McCann and Weinman, 1996) videotapes or computer programs to view or individual coaching by a patient educator (Socha et al., 1998; Kaplan et al., 1999). A few interventions have reached patients at home or in the community with print materials (Fleissig, et al., 1999; Cegala et al., 2000), telephoned instructions (Middleton, 1995), or group educational programs (Tennstedt, 2000). Most of these interventions have focused on teaching patients specific communication skills, such as how to ask questions, disclose information about symptoms and medical concerns, and to check their understanding of the diagnosis and treatment plan. Legitimising patients' right to speak also has been a key component of some projects (Robinson and Whitfield, 1985; Tabak, 1998; Fleissig, et al., 1999).

The results of these interventions have been largely, although not entirely, positive. In some studies, brief training of patients in communication skills before they see a provider has helped them ask more questions (Thompson, et al., 1990; Socha, et al., 1998), disclose more information about their health problems (Middleton, 1995; Cegala, et al., 2000) elicit more factual information from providers (Kaplan et al., 1999; Cegala, et al., 2000), and recall treatment plans more accurately (Robinson and Whitfield, 1985; Socha et al., 1998).

### **2.8.2 Teaching communication skills to doctors**

There is plenty of good evidence that changing doctors' behaviour and communication skills can be achieved quite easily with proper teaching and that it will last. Secondly, despite the changes in the structure and practice of medicine, it is still more than just a job. Doctors have a moral and social responsibility as well as a medical one and must preserve their patients' trust.

Thirdly, communication is an interactive process. Patients also need skills and support to take part in decision-making and raise questions about quality. Efforts to improve quality increasingly incorporate patients' perspectives, and providers who know what services patients would value to meet expectations, or counsel patients in a way that expectations become more realistic. There is encouraging evidence that some of the issues addressed, for example in the Toronto consensus statement on doctor-patient communication, have already begun to change awareness (Simpson et al., 1991). The Toronto consensus statement published in 1991 clearly showed that communication problems in clinical practice are important and common. It also showed that the quality of communication is related to health outcomes for patients, but that traditional medical education is ineffective at teaching communication. New teaching methods and media have been developed since then, but current knowledge has yet to achieve broad implementation in practice (Levinson and Roter, 1993; Stuart and Lieberman, 1993; Kaplan et al., 1996; Fallowfield , 2002; Anthony et al., 2003).

Learning communication skills in times of change and uncertainty depends on an emotional openness to self and others. Medical educators should use knowledge of patients' perceptions of care to focus teaching on areas that will help trainees to meet patients' expectations. Teaching communication skills should be included at all levels of medical education and, even more importantly, should be a mandatory element of the medical school curriculum and programmes of continuing medical education. This can be achieved only with the support of all grades of doctors in all specialties (Laine et al., 1996).

## **CHAPTER THREE RESEARCH METHODOLOGY**

### **3.1 Introduction**

This is was a cross-sectional qualitative and quantitative study that took a multidimensional triangulatory approach in methodical application. After getting approval from the University of Zambia Biomedical Research Ethics, the researcher applied to the University Teaching Managing Director for permission to conduct this research. The application was referred to the Deputy Managing Director of UTH who approved it. The researcher was linked to the heads of departments across all specialties through the Matron-in-Charge UTH who later on introduced the researcher to senior nurses in the clinics.

Five 5<sup>th</sup> Year students were employed as research assistants. They were trained on how to administer structured questionnaires to doctors and patients. After the medical consultation, patients were first given a consent form to read. For those who did not understand English the research assistants explained in their local languages (Appendix V). When a patient agreed to participate they were given the questionnaire to fill in. Other instruments used were a Focus Group Discussions where 7 patients participated. In this particular case arrangement was made to interview patients who agreed to gather in a ward. In-depth Interviews were conducted with twelve doctors ranging from junior doctors across registrars to consultants.

### **3.2 Sampling and size**

In order to present the sought social reality and from which observations explanations were needed, the study employed two types of sampling and these were; i) convenience and ii) purposive sampling. The researcher did not predict which doctors and patients would be in the clinics and only those doctors and patients who were available at that particular time participated in the study. Purposively doctors and patients were selected to answer questionnaires.

Doctors answered the questionnaire soon after they had completed their morning tasks. Since this is a quantitative and qualitative study, issues of sampling could not be dealt with in the same manner since each has its own ontology and epistemology.

### **3.3 Instrument development**

Noting the emphases of patient satisfaction as enunciated in the literature review section, we proposed that a standardized measure for out-patients based on communication in a one to one medical encounter would permit consumers (patients) and sellers (doctors) to evaluate the communication care experience. In this study, the student developed and validated a measure of the degree to which patients and doctors perceived communication during the medical encounter in the OPD. The instrument was designed to meet the following criteria: (a) limit respondent burden, (b) able to be completed reliably after a brief episode of care, (c) avoid reference to care expectations, and (d) is affected minimally by socio-demographic, personality, and other factors. Swanson-Kauffman's (1988) theoretical and empirical work on core aspects of communication was selected as the theoretical framework to derive the five communication domains that we are using to assess satisfaction. Five domains of communication and satisfaction were included then in the study.

When the instrument was developed, it was evaluated for content validity, conceptual clarity, and comprehensiveness qualitatively by six medical practitioners and a medical sociologist who served as experts. After individually scoring items, the experts had a consensus meeting to discuss items in which disagreement occurred. Some items lacked clarity, some involved tasks the experts believed many patients and doctors would not experience, and others were not consistently judged important. An item was dropped or reworded to enhance clarity whenever an expert identified it as problematic based on content, clarity, or importance.

Apart from the instrument, the student conducted one FGD and four one to one interviews with the Head of Medicine, the Deputy Director and two Senior Consultants.

### **3.4 Data collection**

The researcher including his assistants was, naturally, not allowed into the consulting rooms to make observations between doctors and patients during their medical encounter.

The researcher documented data from structured questionnaires, Focus Group Discussions and In-Depth Interviews.

The researcher administered a standard structured questionnaire (SASSQ) to patients after and before the medical encounter. Where children, the deaf and dumb, as well as illiterate patients were concerned, the response of the relevant third parties present assisted in providing information for the study.

The researcher conducted intensive individual interviews with Doctors, who agreed to participate through in-depth interviews in order to explore their perspectives on a wide range of phenomena in the medical encounter, to bring out thoughts and meanings of the various communicating behaviours. Interview questions were founded on the following themes:

- Doctors use the medical language when communicating with patients.
- Greeting patients in language patients would understand.
- The doctors' satisfaction level of his understanding the patient in an effort to explore the patient's problem.
- The doctors' satisfaction level of the patient's understanding of the health problem.
- The doctors' satisfaction level of the patient's understanding of the health interventions.

### **3.5 Data analysis**

Data were analysed by means of the SPSS statistical software package version 12. The researcher initially performed an exploratory univariate analysis to obtain frequencies of all descriptive variables and contingencies tables.

#### **Factor analysis**

In order to determine the level of satisfaction and further the reliability of the satisfaction scores, the factor structure of the satisfaction Likert items was assessed using principal components analysis. The polychoric correlation matrices of the items were used in the analysis because of the similarities in the ordinal scaled variables. The number of factors retained was determined using a screen plot using Caiell's (1978:22-24) guidelines. The initial principal components obtained were rotated using oblique rotation. This rotation was chosen because the items were linearly dependent. Those items that loaded at higher than 0.5 on one factor were retained and those below 0.5 were removed. The resulting factor scales were checked for reliability using Cronbach's alpha.

## CHAPTER FOUR- FINDINGS

### 4.0 Introduction

In this study, the student presents the research findings using the themes to stand in for the research questions<sup>2</sup>. The decision to present the findings according to themes from research questions are based on de Vaus's (2001) advice to researchers doing cross sectional research. The sound advice is that critical issues that are similar are easily organised under a research question or its themes and that in this way critical issues are unlikely to be missed. Therefore the results chapter is divided into four sections as follows: section one deals with a descriptive analysis of the respondents demographic profile; section two is related to languages that are commonly understood by patients and doctors; section three addresses the extent to which patients are satisfied with doctor-patient communication; section four is related to the extent to which are doctors satisfied with doctor-patient communication. The strategies that could be used to mitigate barriers in doctor-patient communication form part of section five.

Data for this analysis was drawn from 139 patients and 68 doctors. The results are from a cross sectional study carried out in the outpatients department in the University in the months of November 2008. All participants were volunteers and signed a written informed consent statement prior to taking part in the study. The total number of patients who were approached for the study who satisfied the inclusion criteria was 153, of which 3 declined and 10 did not complete all questions, leaving the study population sample of 139. The total number of doctors who were initially approached and satisfied the inclusion criteria was 75,

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<sup>2</sup> What languages are commonly understood by patients?  
To what extent are patients satisfied with doctor-patient communication?  
To what extent are doctors satisfied with doctor-patient communication?  
What strategies can be used to mitigate barriers to doctor-patient communication?

of which 2 declined because they were uncomfortable and 5 were on leave leaving the study population sample of 68.

#### **4.1 Descriptive demographic findings**

Within the patient population,  $n = 56$  (40.3%) were men and  $n = 83$  (59.7%) were women. On the other hand, within the doctor population,  $n = 48$  (70.6%) were men and  $n = 20$  (29.4%) were women (Table 4.1). The majority of patients  $n = 83$  (59.7%) led a married life and very few  $n = 56$  (40.3%) led a solitary life of being single, divorced or widowed. Majority of these patients  $n = 96$  (74.1%) had completed their senior secondary education with some having been to college or university as compared to those  $n = 36$  (25.9%) who are literate and have never been to school at all . As for the doctors, the majority of them had general practitioner training  $n = 63$  (92.6%) whereas  $n = 5$  (7.4%) had done post doctoral training (Table 4.1) and their practice orientations varied from paediatrics  $n = 41$  (60.3%), internal medicine  $n = 16$  (23.5%), surgery  $n = 9$  (13.2%) and gynaecology and obstetrics  $n = 2$  (2.9%).



Table 4.1.1 Patients and Doctor's demographic profile

Parameter	Frequency	Percent
<b>Patient's Sex</b>		
Male	56	40.3
Female	83	59.7
Total	139	100
<b>Doctor's Sex</b>		
Male	48	70.6
Female	20	29.4
Total	68	100
<b>Patient's Marital Status</b>		
Single	25	18.0
Separated	3	2.2
Divorced	5	3.6
Widowed	23	16.5
Married	83	59.7
Total	139	100
<b>Patient's Educational Status</b>		
I have never been to school	6	4.3
Primary level education	22	15.8
Junior secondary level	8	5.8
Senior secondary	52	37.4
College	44	31.7
University	7	5.0
Total	139	100
<b>Doctor's Professional Status</b>		
MBChB	43	63.2
MD	20	29.4
Consultant	1	1.5
Registrar	4	5.9
Total	68	100.0

Majority of the patients who were recruited had a medical problem (table 4.2)

Table 4.1.2 Profile of problem warranting visit n=139

Unit or firm seeing the patient	Frequency	Percent
Surgery	41	29.5
Medicine and Centre Of Excellence	74	53.2
Department of Obstetrics and gynaecology	24	17.3
Total	139	100.0

The patient and doctor and age profile show skewed distributions to the right with values of 0.843 and 2.33 respectively. The oldest patient was 81 whereas the youngest was 18 years. The mean patient age was 35 ( $\pm 1SD = 13$ ) years and most were younger below the median 34 (Figure 4.1). The oldest doctor

was 67 whereas the youngest was 22 years. The mean doctor age was 33 ( $\pm 1SD = 8.2$ ) years and most were younger below the median 34 (Figure 4.1.2).

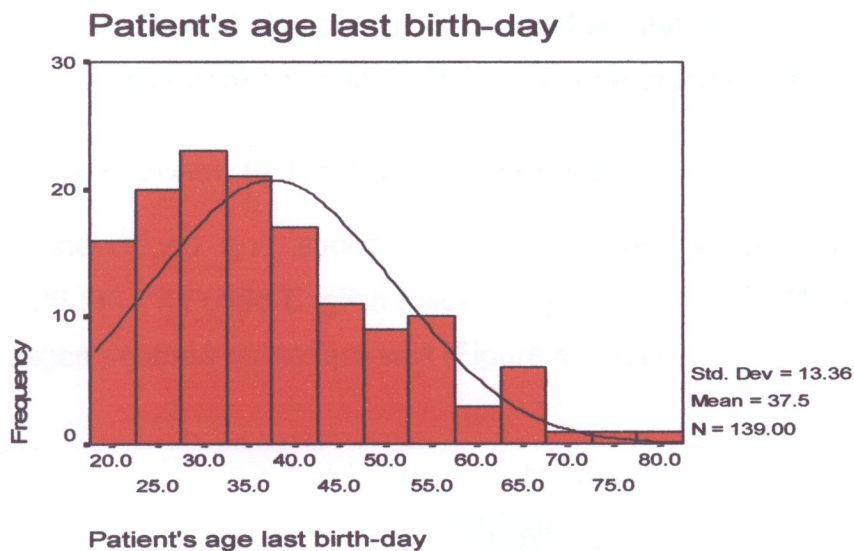


Figure 4.1.1 Patient's Age Distribution  $n= 139$

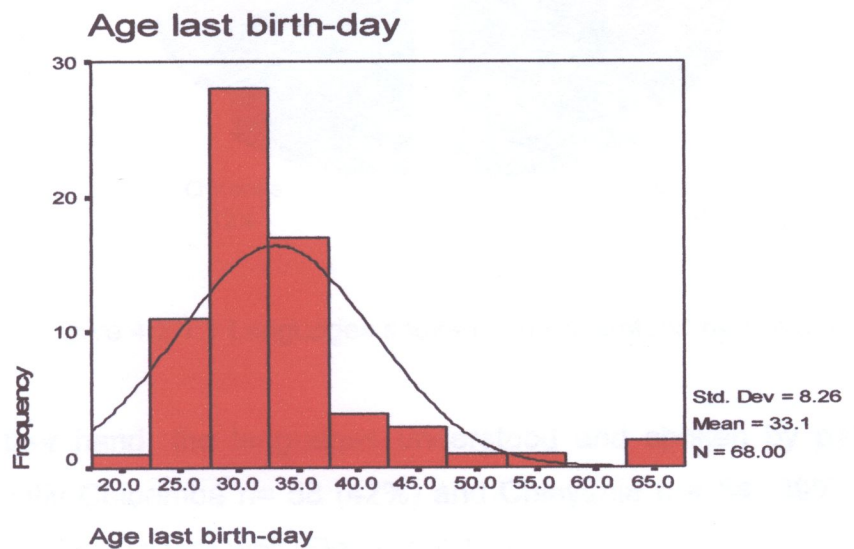


Figure 4.1.2 Doctor's Age Distribution  $n= 68$

## 4.2 Languages commonly spoken and understood by Patients and Doctors

An inquiry was made to ascertain which languages were spoken and understood among both patients and doctors. The researcher first presents the primary languages which were spoken under (4.2.1) and understood under (4.2.4).

### 4.2.1 Languages spoken by Doctors and Patients

Languages understood and spoken by doctors were varied. However, the majority  $n= 26$  (38.2%) used English followed by Chibemba  $n= 21$  (30.9%). The other languages seemed not to fare well (Figure 4.2.1.1).

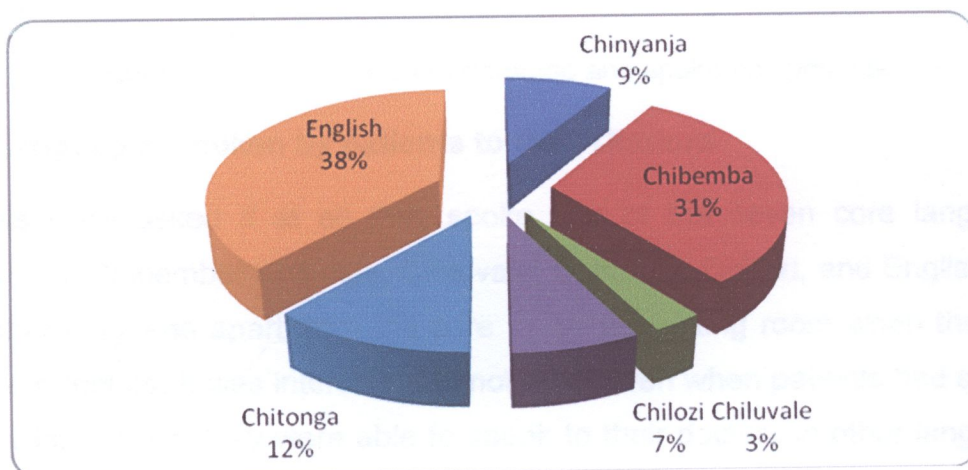


Figure 4.2.1.1 Languages spoken and understood by doctors

On the other hand, the languages understood and spoken by patients were predominantly Chibemba  $n= 58$  (42%) and Chinyanja  $n = 54$  (39%). The other languages did not to fare well (Figure 4.2.1.2).



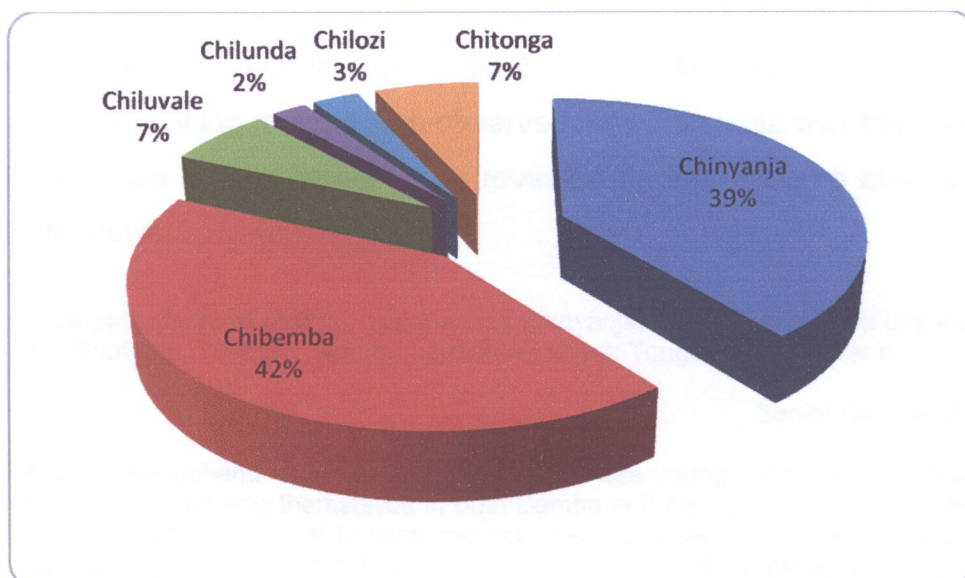


Figure 4.2.1.2 Languages understood and spoken by patients

#### 4.2.2 Languages spoken by patients to their Doctors

Patients were asked if at all they spoke any of the seven core languages (Chinyanja, Chibemba, Chilunda, Chiluvale, Chitonga, Chilozi, and English) and any other language apart from the core in the consulting room when they met with their doctors. It was interesting to note that even when patients had specific primary languages, they were able to speak to their doctors in other languages (table 2.2.4.1). It was interesting to note that patients decided to communicate to their doctors not in English the official language but in a local language as the situation determined. Nyanja had the highest score  $n= 57$  (32.4%).

Table 4.2.2.1 Language spoken to the doctor in the consulting room  $n=139$

Question type	Yes	%
Did you speak Chinyanja with your doctor today?	57	41.0
Did you speak Chibemba with your doctor today?	44	31.7
Did you speak Chiluvale with your doctor today?	0	0
Did you speak Chilunda with your doctor today?	3	2.2
Did you speak Chilozi with your doctor today?	1	.7
Did you speak Chitonga with your doctor today?	3	2.2
Did you speak English with your doctor today?	25	18.0
Did you speak any other language with your doctor today?	6	4.3
<b>Total</b>	<b>139</b>	<b>100</b>

When doctors were interviewed to establish the language that most patients used in the consulting room, it was observed that Chinyanja was the commonest and Bemba was rapidly emerging as revealed by the following quotes from in-depth interviews.

Most patients surrounding Lusaka speak Chinyanja; those from outside Lusaka like Southern, Western, Northern provinces speak Tonga, Lozi and Bemba.

Senior Consultant

Most of my patients communicate in Nyanja. I see younger ones to have the tendency to express themselves in both Bemba and Nyanja. But you see with the rapid urbanisation of Lusaka, we now see most people from the Copper belt coming to Lusaka and this changing the face of the language. I am sure you have seen this in town too. The Kaponyas and [ehh]...

Registrar

4.2.3 Languages spoken by doctors to their Patients

Doctors were asked if at all they spoke any of the seven core languages (Chinyanja, Chibemba, Chilunda, Chiluvale, Chitonga, Chilozi, and English) and any other language apart from the core in the consulting room when they met with their patients. It was interesting to note that doctors could speak other languages, but they had a preference to speak English and Chinyanja to their patients.

Table 4.2.3.1 Language spoken to the patient in the consulting room n=68

Question type	Yes
Did you speak Chinyanja with your patient today?	53
Did you speak Chibemba with your patient today?	36
Did you speak Chiluvale with your patient today?	1
Did you speak Chilunda with your patient today?	0
Did you speak Chilozi with your patient today?	2
Did you speak Chitonga with your patient today?	8
Did you speak English with your patient today?	56
Did you speak any other language with your patient today?	2

When doctors were interviewed about the language they spoke in the consulting room, they indicated a strong preference for English though they found

themselves speaking whatever language they could try to communicate with their multilingual patients. However, apart from English, they said they communicated in Chinyanja most of the times. Below the student shows the extreme variations of experiences:

If I am not conversant with a particular language, I will ask a member of staff like a nurse to interpret in the local language being used by a patient. But you see we have these problems because most of our patients are not educated. Remember that the official language of communication in this country is English and we learn medicine in English and how do you translate things like lung consolidation to convey the true message to the patient?

Medical doctor

I have been here and seen by all sorts of doctors speaking to me in this and that language. But most try to speak our local languages. But you see, the University Teaching Hospital is multi-factorial, the doctors come from all over. We have got doctors who are volunteers; we have doctors who come to Zambia on government-to-government grants. There are Russian, Chinese, Cuban, and Congolese just to mention a few. If you meet some of these, it will be difficult to communicate. In my case I try to use sign language but it is very frustrating.

Diabetic and hypertensive patient

#### **4.2.4 Languages understood by Patients**

When patients were asked about the languages that they understood, it was noted that they understood Chinyanja, Chibemba and English well. However patients seemed not to understand the other languages (in bold red).



Table 4.2.4.1 Depth of language understanding by patients n=139

Please indicate how well you understand Chinyanja		
	Frequency	Percent
Very well	84	60.4
Well	40	28.8
Just a bit	15	10.8
Not well	0	0
Not at all	0	0
Total	139	100.0
Please indicate how well you understand Chibemba		
Very well	93	66.9
Well	28	20.1
Just a bit	16	11.5
Not well	0	0
Not at all	2	1.4
Total	139	100.0
Please indicate how well you understand Chiluvale		
Very well	9	6.5
Well	7	5.0
Just a bit	13	9.4
Not well	11	7.9
Not at all	99	71.2
Total	139	100.0
Please indicate how well you understand Chilunda		
Very well	11	7.9
Well	5	3.6
Just a bit	0	0
Not well	13	9.4
Not at all	110	79.1
Total	139	100.0
Please indicate how well you understand Chilozi		
Very well	28	20.1
Well	11	7.9
Just a bit	3	2.2
Not well	10	7.2
Not at all	87	62.6
Total	139	100.0
Please indicate how well you understand Chitonga		
Very well	45	32.4
Well	2	1.4
Just a bit	35	25.2
Not well	0	0
Not at all	57	41.0
Total	139	100.0
Please indicate how well you understand English		
Very well	88	63.3
Well	34	24.5
Just a bit	7	5.0
Not well	0	0
Not at all	10	7.2
Total	139	100.0

#### **4.2.5 Languages understood by Doctors**

When doctors were asked about the languages that they understood, it was noted that they all understood English except one who did but 'just a bit'. However, doctors in addition understood Chinyanja and Chibemba (in bold blue). Doctors seemed not to understand all other languages (in bold red).



Table 4.2.5.1 Depth of language understanding by Doctors n=68

Please indicate how well you understand Chinyanja		
	Frequency	Percent
Very well	30	44.1
Well	32	47.1
Just a bit	2	2.9
Not well	2	2.9
Not at all	2	2.9
Total	68	100.0
Please indicate how well you understand Chibemba		
Very well	22	32.4
Well	26	38.2
Just a bit	10	14.7
Not well	4	5.9
Not at all	6	8.8
Total	68	100.0
Please indicate how well you understand Chiluvale		
Very well	1	1.5
Well	1	1.5
Just a bit	2	2.9
Not well	2	2.9
Not at all	62	91.2
Total	68	100.0
Please indicate how well you understand Chilunda		
Very well	1	1.5
Well	1	1.5
Just a bit	1	1.5
Not well	4	5.9
Not at all	61	89.7
Total	68	100.0
Please indicate how well you understand Chilozi		
Very well	6	8.8
Well	4	5.9
Just a bit	12	17.6
Not well	6	8.8
Not at all	40	58.8
Total	68	100.0
Please indicate how well you understand Chitonga		
Very well	12	17.6
Well	4	5.9
Just a bit	20	29.4
Not well	10	14.7
Not at all	22	32.4
Total	68	100.0
Please indicate how well you understand English		
Very well	56	82.4
Well	11	16.2
Just a bit	1	1.5
Not well	0	0
Not at all	0	0
Total	68	100

When doctors and patients were compared in terms of understanding of the seven languages, it was noted that both doctors and patients understood Chinyanja, Chibemba and English (in bold blue). Both doctors and patients had poor understanding of Chiluvale, Chilunda, Chitonga and Chilozi (in bold red). It was interesting to note that while patients seemed to understand Chitonga well and to 'just a bit'; their doctors were poor at understanding Chitonga.



Table 4.2.5.2 Depth of language understanding by both patients and doctors

Please indicate how well you understand Chinyanja		Patients		Doctors	
		f	%	f	%
Very well		84	60.4	30	44.1
Well		40	28.8	32	47.1
Just a bit		15	10.8	2	2.9
Not well		0	0	2	2.9
Not at all		0	0	2	2.9
Total		139	100.0	68	100.0
Please indicate how well you understand Chibemba					
Very well		93	66.9	22	32.4
Well		28	20.1	26	38.2
Just a bit		16	11.5	10	14.7
Not well		0	0	4	5.9
Not at all		2	1.4	6	8.8
Total		139	100.0	68	100.0
Please indicate how well you understand Chiluvale					
Very well		9	6.5	1	1.5
Well		7	5.0	1	1.5
Just a bit		13	9.4	2	2.9
Not well		11	7.9	2	2.9
Not at all		99	71.2	62	91.2
Total		139	100.0	68	100.0
Please indicate how well you understand Chilunda					
Very well		11	7.9	1	1.5
Well		5	3.6	1	1.5
Just a bit		0	0	1	1.5
Not well		13	9.4	4	5.9
Not at all		110	79.1	61	89.7
Total		139	100.0	68	100.0
Please indicate how well you understand Chilozhi					
Very well		28	20.1	6	8.8
Well		11	7.9	4	5.9
Just a bit		3	2.2	12	17.6
Not well		10	7.2	6	8.8
Not at all		87	62.6	40	58.8
Total		139	100.0	68	100.0
Please indicate how well you understand Chitonga					
Very well		45	32.4	12	17.6
Well		2	1.4	4	5.9
Just a bit		35	25.2	20	29.4
Not well		0	0	10	14.7
Not at all		57	41.0	22	32.4
Total		139	100.0	68	100.0
Please indicate how well you understand English					
Very well		88	63.3	56	82.4
Well		34	24.5	11	16.2
Just a bit		7	5.0	1	1.5
Not well		0	0	0	0
Not at all		10	7.2	0	0
Total		139	100.0	68	100.0

#### 4.2.6 Discordant languages

In this study, it was difficult to establish language discordance to see what difficulties patients and doctors had when the preferred language was different, because the researcher was not allowed to observe interaction in the clinical setting between doctors and patients. However, interviews and focus group discussions showed that language discordance was a critical factor in UTH. Patients were coming from various cultural and ethnic orientations and yet the doctor population employed spoke no indigenous languages at the outset. It was noted that doctors preferred to communicate in English to overcome switching languages since most were unable to communicate beyond two languages. Others were very adamant not to communicate in any other language claiming that English was the official language.

English is the medium of instructions. Therefore, it is not proper for me to be restricted to speak local languages.

Medical doctor

I try by all means as one attending to a patient. If I know the patient's language, I try to speak in a local language to help my patient acquire the services sought. But it is never easy here in UTH if I do not have a patient to share in Bemba or Nyanja. It is difficult to put up in such a situation.

Medical doctor

As for me I communicate in English. I do not think I have ever come across a High Court Judge, a Supreme Court Judge or a Magistrate Judge who is going to conduct the proceedings of the court in the local language of the defendant or the complainant, No! it is in English which is the official language. But you are putting this burden on the doctor to be able to speak to this patient who is seeking his or her services in the local language, yet the government does not provide an official Interpreter for him.

Registrar

It is very common to fail to communicate with patients. Some two days ago there was a certain gentleman ... he does not speak true Lozi he speaks somehow some language I do not know whether it is Luvala or something like that. We had a lot of difficulties to communicate with him. Unfortunately none of my doctors, students not even my nurses could speak that language. So the communication was one way. We had to wait for his son to come from work, when he comes back you leave a message or you talk to him to communicate to his father.

Consultant



### 4.3 Doctor satisfaction with patient communication

In the present study, we have attempted to describe, using to two types of research, the levels of satisfaction within the two samples studied. Table 4.3.1 shows that doctors were generally satisfied with the manner patients communicated to them in the selected languages in all the seven communication categories since the frequencies show more a shift to the left than to the right (more towards the positive than the negative).

Table 4.3.1 Doctor's qualitative satisfaction profile n=68

Satisfaction Type	Very satisfied	Satisfied	Not sure	Unsatisfied	Very unsatisfied
How satisfied were you with the language you used when exploring your patient's medical problem?	16 (23.5%)	47 (69.1%)	5 (7.4%)	0 (0%)	0 (0%)
How satisfied were you with the language you used during physical examination?	17 (25.0%)	46 (67.6%)	5 (7.4%)	0 (0%)	0 (0%)
How satisfied were you with the language you used when explaining the investigations that needed to be carried out on the patient?	14 (20.6%)	48 (70.6%)	5 (7.4%)	1 (0.7%)	0 (0%)
How satisfied were you with the language you used when explaining the results of the investigations carried out on the patient?	13 (19.1%)	46 (67.6%)	6 (8.8%)	3 (4.4%)	0 (0%)
How satisfied were you with the language you used when explaining the diagnosis to the patient?	15 (22.1)	46 (67.6%)	5 (7.4%)	2 (2.9%)	0 (0%)
How satisfied were you with the language you used when explaining the treatment for your patient's problem?	11 (16.2%)	50 (73.5%)	6 (8.8%)	1 (0.7%)	0 (0%)
How satisfied were you with the language you used when checking the patient understanding of issues surrounding the illness and treatment?	6 (8.8%)	38 (55.9%)	21 (30.9%)	3 (4.4%)	0 (0%)

Using the Rasch model (Rasch, 1960), that is commonly used to determine the cut off points for satisfaction and taking the midpoint "not sure" as the median when making a decision whether doctors were satisfied or not, the scores show a shift to the left with more doctors satisfied than not with the manner patients

communicated to them in the selected languages in the seven communication categories.

Within the framework of item response theory (IRT), a rating scale model (RSM) based on Andrich (1978), which is an extension of the Rasch model (Rasch, 1960), that is commonly used to determine the score range was used. The researcher used the RSM model because respondents were presented with the same response choices for all satisfaction scores so that all items have the same rating scale structure. A cursory look at our rating scale shows that all items required patients' and doctors' subjective judgments, which are very likely to vary from person to person. Acknowledging the subjective nature of the judgment, the researcher set a determination point for satisfaction and non satisfaction *a priori*.

The researcher set the decision criteria such that both doctors and patients would give responses that would vary between two extremes and the mid points. The average value of agreeing on a 5 point-scale is not the arithmetical average of 3 but is a range from 2 to 4. There is therefore an inherent bias in the use of 1-5 scales in surveys. In order to correct this standard bias the researcher decided to use the 'Top 1 – Bottom 5 model' that says: 'Respondents rating 1 were considered as satisfied. Respondents rating 2, 3 and 4 were considered as neutral' and those rating 5 were considered as not satisfied. The researcher decided to apply this stringent measure because communication cannot be treated using the rule of simple averages. Based on this grouping rule, we can more easily measure satisfaction with communication.

When type of satisfaction was scored using a 5-point Likert-Scale (Very satisfied-1, Satisfied-2, Not sure-3, Unsatisfied-4, Very unsatisfied-5) response format, it resulted in possible score ranges per individual of 8-14 for very satisfied, 15-21 for satisfied, 22-26 not sure, 27-33 unsatisfied and 34 to 40 totally unsatisfied. In essence, if one was to score quantitatively the level of



satisfaction, the mean would be the best indicator. In this study, the mean satisfaction score was 15 ( $\pm 1SD = 3.4$ ) and the mean falls in the satisfied category of 15 to 21 on the scale. The modal score was 16 (falling within the satisfied category). However, figure 4.3.1 shows a leptokurtic curve that contains more scores in the centre than a normal curve tends to have. When one calculates the satisfaction mean score, nearly all doctors  $n= 55$  (96.6%) ( $\pm 3 SD = 3.4$ ) amassed less than 21 points across the seven communication categories implying that they were generally satisfied with communication in the medical encounter (table to 4.3.3).

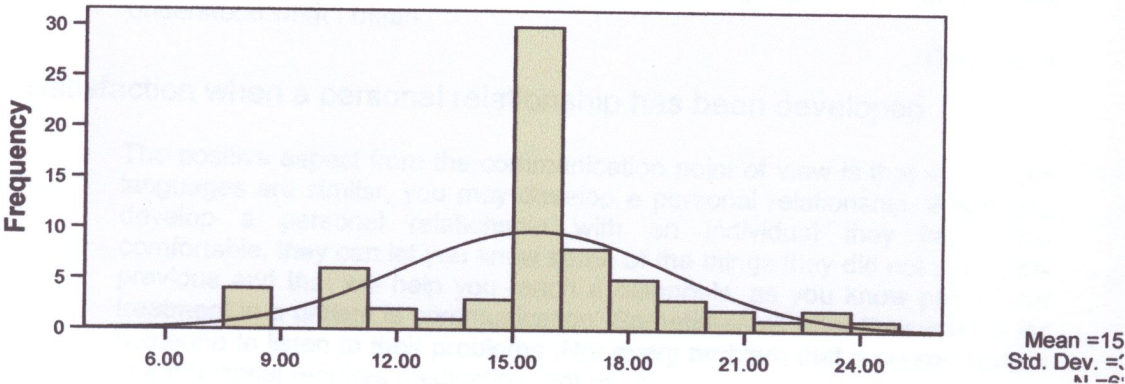


Figure 4.3.1 Doctor's Satisfaction Mean Scores

Table 4.3.2 Doctor's Quantitative Mean Satisfaction Scores n=68

Mean score	Frequency	Percent
8.00	4	5.9
10.00	5	7.4
11.00	1	1.5
12.00	2	2.9
13.00	1	1.5
14.00	3	4.4
15.00	11	16.2
16.00	19	27.9
17.00	8	11.8
18.00	5	7.4
19.00	3	4.4
20.00	2	2.9
22.00	1	1.5
23.00	2	2.9
25.00	1	1.5
Total	68	100.0

The few doctors who expressed dissatisfaction also deserve some attention. It was clear that the dissatisfaction had to do with the levels of language discordance. The excerpts below highlight the rigid factors:

#### The problem of intra and inter personal translation

No! It is, you cannot [have] complete satisfaction. [It] can only occur if the patient and you are speaking the same language. Because even if I speak to a patient in Tonga, Tonga is not my mother's language so whatever I speak to him, first of all I have to think of it [as] if I am reading something. I believe that this is the diagnosis is in English I interpret it into either my mother tongue then from there I interpret into Tonga and reverse coming back for me to write down because the patient speaks and this is what he is feeling. I have now to interpret it again and convert it to English, so I am not also satisfied because something I do not know whether this patient has understood what I mean.

Consultant

#### Satisfaction when a personal relationship has been developed

The positive aspect from the communication point of view is that when your languages are similar, you may develop a personal relationship. When you develop a personal relationship with an individual they feel more comfortable, they can let you know some of the things they did not say in the previous and that will help you reach a diagnosis, as you know part of the treatment in a patient is communication. Sometimes all what they want is for someone to listen to their problems. Not every problem that a person comes to the hospital requires medication, not at all.

Medical officer

#### Regional and cultural commonalities

And communication because if you are from Sothern Province, I am from Northern Province, we have a communication barrier, even if you are speaking in English but that is a secondary language. But I will not communicate to you in the same way or relate with you in the same way if we were both from the same ethnic group.

The negative is that if you do not speak the same language and the patient does not understand the medical terminology, you will completely misunderstand each other, that is where you find that then patient will leave the hospital sometimes will go to the public or the private media, you have seen some patients on television saying that I had gone to the hospital they just sent me back, there is nothing they are doing because the patient has not understood the problem. Because there some things where for or may be the stage the disease has reached nothing you can do about it for example a cancer which has gone beyond a certain point, you cannot treat that cancer anymore. Now because this patient has not understood that cancer has spread all over the inside of the body because he cannot see it. You know he



will not understand you and he will just say that I am having pain and they gave me pain killers. And said you go home but you have tried to explain to the patient that you have got what we call in medical language metastasis the cancer has spread all over the body and we cannot offer you any kind of treatment here which is going to cure you, so whilst you are still able to have a good quality of life you can go home make certain decisions like writing a will and things like that but the patient will not understand it.

Specialist

### **Workload and period of acquaintance**

In public practice where you are not able to see the same patient everyday that language barrier takes a long time to break and that is where openness which develops takes a long time because you do not see the patient most of the time because you are indebted with work and numbers.

Registrar

## **4.4 Patient Satisfaction with Doctor Communication**

Table 4.4.1 shows that patients were generally satisfied with the manner doctors communicated to them in the selected languages in all the seven communication categories since the frequencies show more a shift to the left than to the right.

Table 4.4.1 Patient's qualitative satisfaction profile n=139

Satisfaction Type	Very satisfied	Satisfied	Not sure	Unsatisfied	Very unsatisfied
How satisfied were you with the language the doctor used to greet you	63 (45.3%)	47 (33.8%)	7 (5.0%)	15 (10.8%)	7 (5.0%)
How satisfied were you with the language the doctor used when exploring your medical problem	60 (43.2%)	63 (45.3%)	8 (5.8%)	7 (5.0%)	1 (7%)
How satisfied were you with the language the doctor used during physical examination	63 (45.3%)	68 (48.9%)	2 (1.4%)	5 (3.6%)	1 (0.7%)
How satisfied were you with the language the doctor used when explaining the investigations that needed to be carried out on you	54 (38.8%)	55 (39.6%)	8 (5.8%)	21 (15.1%)	1 (0.7%)
How satisfied were you with the language the doctor used when explaining the results of the investigations carried out on you	64 (46.0%)	36 (25.9%)	11 (7.9%)	22 (15.8%)	6 (4.3%)
How satisfied were you with the language the doctor used when explaining the diagnosis	53 (38.1%)	58 (41.7%)	17 (12.2%)	10 (7.2%)	1 (7%)
How satisfied were you with the language the doctor used when explaining the treatment for your problem	52 (37.4%)	58 (41.7%)	17 (12.2%)	9 (6.5%)	3 (2.2%)
How satisfied were you with the language the doctor used when checking your understanding of issues surrounding the illness and treatment	39 (28.1%)	53 (38.1%)	33 (23.7%)	5 (3.6%)	9 (6.5%)

When the student applied the same decision rules (see 4.3 above) of scoring the communication categories he obtained the mean satisfaction score of 15 ( $\pm 1SD = 5.5$ ) falling in the satisfied category of 15 to 21 on the scale. The modal score was 8 (falling within the very satisfied category). When one calculates the satisfaction mean score, nearly all patients  $n= 55$  (87.8%) ( $\pm 3 SD = 5.5$ ) amassed less than 21 points across the seven communication categories implying that they were generally satisfied with communication in the medical encounter (table to 4.4.2).

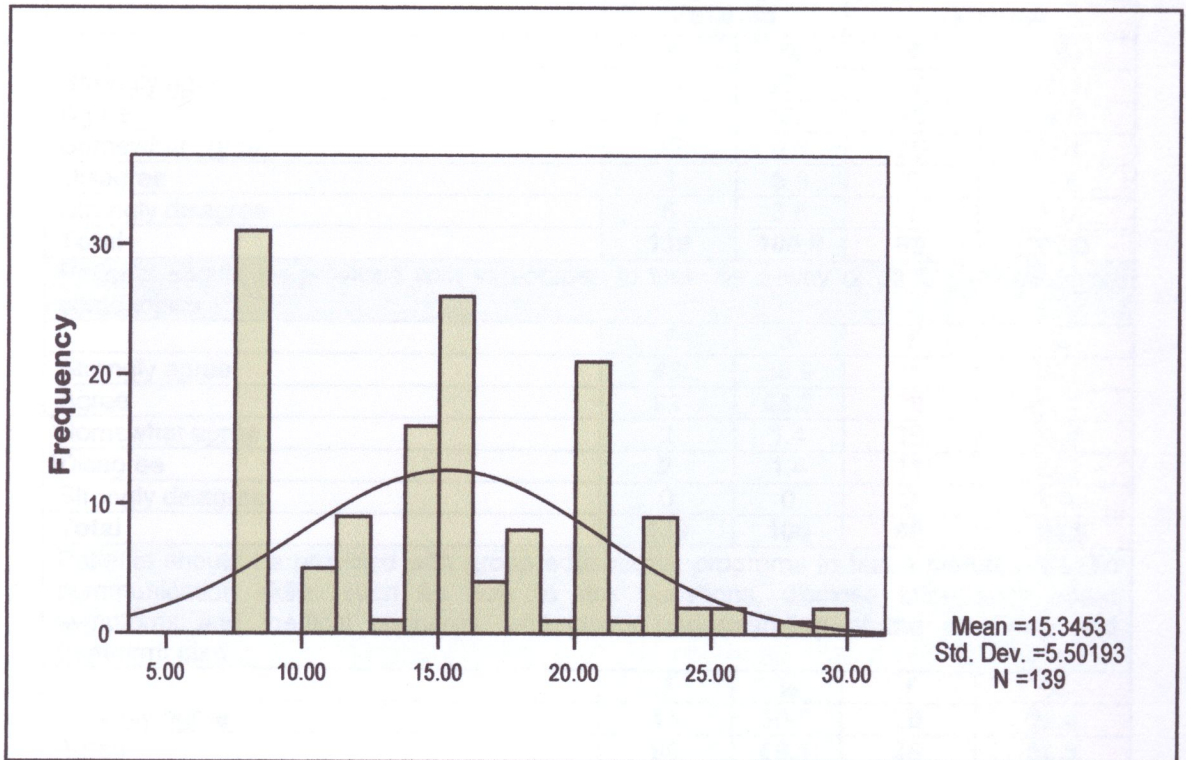
Table 4.4.2 Frequency distribution of individualised scores across all eight categories of satisfaction type.

Mean individual satisfaction score	Frequency	Percent
8.00	31	22.3
9.00	1	.7
10.00	1	.7
11.00	3	2.2
12.00	9	6.5
13.00	1	.7
14.00	16	11.5
15.00	17	12.2
16.00	9	6.5
17.00	4	2.9
18.00	8	5.8
19.00	1	.7
20.00	1	.7
21.00	20	14.4
22.00	1	.7
23.00	9	6.5
24.00	2	1.4
25.00	1	.7
26.00	1	.7
28.00	1	.7
30.00	2	1.4
Total	169	100

The distribution satisfaction score (figure 4.4.1) shows imperfect distribution.



Figure 4.4.1 Patients' Satisfaction Score



#### 4.5 Strategies that could be used to mitigate barriers in doctor-patient communication

When doctors and patients were asked about the need to mitigate barriers in doctor patient communication, it was surprising to note that doctors were rather uncomfortable when it came to strategies to empower patients. Doctors seemed to be uncomfortable only with allowing patients to be provided with videotapes to view as a way of getting educated on some topics (bold in red low score). In all other strategies, doctors and patients expressed a strong need for mitigation (table 5.1).



Table 5.1 Doctors and patients levels of agreement to mitigating communication

Patients should be provided with print materials to read on selected topics				
	Patients		Doctors	
	f	%	f	%
Strongly agree	49	35.3	27	39.7
Agree	65	46.8	15	22.1
Somewhat agree	12	8.6	20	29.4
Disagree	8	5.8	5	7.4
Strongly disagree	5	3.6	1	1.5
<b>Total</b>	<b>139</b>	<b>100.0</b>	<b>68</b>	<b>100.0</b>
Patients should be provided with videotapes to view as a way of getting educated on some topics				
	f	%	f	%
Strongly agree	43	30.9	11	16.2
Agree	92	66.2	28	41.2
Somewhat agree	2	1.4	16	23.5
Disagree	2	1.4	11	16.2
Strongly disagree	0	0	2	2.9
<b>Total</b>	<b>139</b>	<b>100</b>	<b>68</b>	<b>100.0</b>
Patients should be provided with group educational programs to teach patients specific communication skills, such as how to ask questions, disclose information about symptoms and medical concerns, and check understanding of the diagnosis and treatment plan				
	f	%	f	%
Strongly agree	43	30.9	20	29.4
Agree	96	69.1	36	52.9
Somewhat agree	0	8.6	6	8.8
Disagree	0	0	4	5.9
Strongly disagree	0	0	2	2.9
<b>Total</b>	<b>139</b>	<b>100.0</b>	<b>68</b>	<b>100.0</b>
Teaching communication skills should be included at all levels of medical education and programmes of continuing medical education				
	f	%	f	%
Strongly agree	51	36.7	20	29.4
Agree	83	59.7	40	58.8
Somewhat agree	5	3.6	8	11.8
Disagree	0	0	0	0
Strongly disagree	0	0	0	0
<b>Total</b>	<b>139</b>	<b>100.0</b>	<b>68</b>	<b>100.0</b>
Teaching communication skills should be a mandatory element of the medical school curriculum and programmes of continuing medical education				
	f	%	f	%
Strongly agree	52	37.4	25	36.8
Agree	86	61.9	31	45.6
Somewhat agree	1	.7	9	13.2
Disagree	0	0	2	2.9
Strongly disagree	0	0	1	1.5
<b>Total</b>	<b>139</b>	<b>100.0</b>	<b>68</b>	<b>100.0</b>

### 5.0 What this study shows

This cross sectional study shows the following answers to the four research questions

To the first research question: What languages are commonly spoken and understood by patients and doctors? The answer is: Patients communicated to their doctors not in English which is the official language but in a local language as the situation predetermined. They preferred to communicate in Chinyanja most of the time but Chibemba was rapidly becoming more popular. Patients understood Chinyanja, Chibemba and English very well. As for doctors, they had a preference to speak English and Chibemba to their patients than any other language and yet they understood Chinyanja more than Chibemba.

To the second research question: To what extent are patients satisfied with doctor-patient communication in terms of language used? The answer is that patients were satisfied with their understanding of what was communicated to them by doctors in a language they were able to understand.

To the third research question: To what extent are doctors satisfied with doctor-patient communication in terms of language used? The answer is that doctors were satisfied with their understanding of what was communicated to them by patients in a language they were able to understand.

To the fourth research question: What strategies can be used to mitigate barriers to doctor-patient communication? The answer is that both doctors and patients saw the need to mitigate barriers in doctor patient communication but doctors were rather uncomfortable when it came to some? strategies to empower patients. Doctors seemed to be uncomfortable with allowing patients

to be provided with videotapes to view as a way of getting educated on some topics but accepted ....

### **5.1 Synthesis of findings**

This study has shown that language is critical in communication in the medical setting, and that when the interlocutors have a common language that they can speak or understand, it yields satisfaction in both the doctors and patients. One can say that patterns of language use in Lusaka's University Teaching Hospital are not as complex as the city's ethnic diversity seems to show because three languages, namely English, Chinyanja and Chibemba are at the centre of communication.

Our study has affirmed what Siachitema (1986: 25) earlier noted, that none of the two local languages which are Chibemba and Chinyanja that are spoken in the medical encounter have any close connection with the immediate surroundings of Lusaka Province which is inhabited by groups of people speaking Soli, Lala and Lenje dialects. It is surprising that Chinyanja from the Eastern and Chibemba from the North and Luapula Provinces are spoken as though they were mother tongues in Lusaka Province and yet the Tonga related dialects of the Soli, Lala and Lenje are not spoken as mother tongues. Tonga too which has a close connection with the Soli, Lala and Lenje dialects is nowhere near to Chibemba or Chinyanja. The study has further established that English, Chinyanja and Chibemba are therefore the foundation of cultural communication in Lusaka among doctors and patients.

In terms of lingua franca however, English, Nyanja and Bemba have for a while competed with each other for status. Siachitema (1986: 25) notes that neither language has any close connection with the immediate rural surroundings which is inhabited by groups of people speaking Tonga-related dialects of Soli, Sala and Lenje. The provinces where both Nyanja and Bemba are spoken as mother

tongues are geographically removed from Lusaka, their presence being part of the colonial and political history of the country.

This study has further affirmed that the findings in this study are not related to what Eleftheriadou, (1994) as quoted by Lloyd and Bor (2004:85) who explained that cross-cultural doctor and patient communication poses difficulties when working with patients from dissimilar cultural language groups. In our study, though patients and doctors may have communicated in differing languages, there seemed to be no difficulty noting that they all seemed to be satisfied with communication in the medical encounter.

## **5.2 Recommendations**

This study recommends UTH hospital authorities to endeavour to facilitate patient participation more fully in the medical encounter. Patients may need to be given print materials to read (Frederickson and Bull, 1995; McCann and Weinman, 1996) videotapes or computer programs to view or individual coaching by a patient educator (Socha et al., 1998; Kaplan et al., 1999). These interventions teach patients specific communication skills, such as how to ask questions, disclose information about symptoms and medical concerns, and check understanding of the diagnosis and treatment plan in a language compatible to both the doctor and the patient.

Relying on the mass of good evidence about changing doctors' communicative behaviour, the student believes that language communication skills could be achieved quite easily early in the medical curriculum with proper teaching. For the expatriate doctors, we believe that UTH management could utilise the medical illustration unit in the school of medicine in collaboration with the School of Education at the University of Zambia to teach them the basics of at least two languages. We could benefit from new teaching methods and media that have been developed in the current practice (Levinson and Roter, 1993; Stuart and Lieberman, 1993; Kaplan et al., 1996; Fallow field, 2002; Anthony et al., 2003). If



these recommendations are to work, some of the socio-cultural making it difficult even for indigenous doctors to communicate well in local languages, also need to be addressed. We recommend an in-service training for all serving doctors in this case.

The fact that there were appreciable numbers of doctors and patients' who were not satisfied with the communication the medical encounter, would suggest a need for improvements to be made. These areas are important to explore and incorporate when designing interventions aimed at increasing satisfaction and health service use. If we are to increase use of health services, it is necessary to look outside the narrow contexts of health education and promotion, and the expounding of the benefits of consumer satisfaction. We recommend that the hospital as part of its quality assurance programs, conducts satisfaction studies from time to time which could be used to improve service delivery. It is important to continue to seek and explore the views of patients and doctors and experiences around communication and integrate them into service planning and delivery.

This study also adopts the recommendation by some doctors in the study sample that government should employ official interpreters in hospitals.

### **5.3 Limitations and strengths of the study**

One of the most important issues related to doctor or patient satisfaction with communication has to do with the potential impact of individual service expectations on satisfaction ratings. For patients and doctors to judge whether they are satisfied, they must compare their experiences with their expectations. In this study, we did not include expectations though we relied on experience. However, our findings may not be reliable because many patients had limited experience to assure confidence in their scores. Most patients have little past experience with medical encounters and hospitalization and therefore have no exposure to the medical encounter. Their personal knowledge is based on brief

hospital visits or conclusions drawn from accounts of acquaintances and the media (Locker and Dunt, 1978; Oberst, 1984).

Although we were able to elicit the views of a large number of patients and doctors in this survey, the findings need to be interpreted with caution, and read with an awareness of high levels of dissatisfaction found with the poor service delivery of our health care and large patient loads on the part of doctors. Surveys are not necessarily the best way to elicit opinions on complex issues like quality of care, but in this case the survey included opportunities for brief descriptions of experiences to be incorporated in the responses, and was also set in the context of a multi-method rapid appraisal. However in spite of this limitation, the findings have some validity because they are based on current rather than retrospective capture of views about the quality of services. Hence they do not run the risk of recall bias; on the spot inquiries in eliciting experience are useful because satisfaction immediately after an episode of service utilization tends to reflect the quality of communication between patient and staff (Manthorpe et al., 2007).

Despite our sampling strategy and particularly for the survey, the 40 and-over age group was under-represented among respondents. Our findings might, therefore, be affected by a potential selection bias since a random based was not used on the existing sampling list. Nevertheless, the study could highlight some interesting features of the patient–doctor relationship in current practice at UTH.

#### **5.4 The meaning of the study**

We do not doubt that any clinician or patient will be surprised by the accounts given, but the case study methods achieve authenticity in the sense that they are fair (all views are included) and catalytic (the findings lead to actual or potential stimulation of action according to Jackson et al., (2001). Although this small-scale local survey may seem to lack the robustness of larger studies,

these findings may be applied in medical settings in some towns along the line of rail (from Livingstone to Chililabombwe) where we might find similar conditions to those obtaining at the UTH. While this suggests that this case study has value as an evaluation of service performance, the trustworthiness of the data and our analysis of it depend on (i) its credibility to others with experience of the topic, (ii) transferability to other settings especially to those on the line of rail, (iii) dependability (depth of description of methods, peer analysis of data, third-party evaluation of data gathering) and confirmability (iv) by independent review of the raw data (Guba and Lincoln, 1981). In our view the dependability of this case study and particularly the qualitative accounts rests on the methods used and described here and confirmation through UTH's review and utilization of the findings. The credibility, and transferability or generalisability to health settings on the line of rail are left for the reader to judge.

## **5.5 Conclusion**

The evaluation of service delivery and patients' reception of them in the form of satisfaction can be formative (guiding change) or summative (judging performance). My interpretation of this case study is that it could only be formative. Small-scale satisfaction surveys do not measure the desired satisfaction in any scientific sense, and cannot be used as robust and reliable measurement for service evaluation. But when used as formative case studies they can identify problems in service provision that may require remedial action. Clinicians and managers should avoid interpreting these findings as 'league table' results but instead use them to demonstrate that they are working collaboratively to respond to patients' communication concerns and doctors' communication concerns too.

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## **APPENDICES**

## **Appendix I Permission to Conduct Research**

The Director

UTH

Dear Sir/Madam,

### **RE: PERMISSION TO CONDUCT RESEARCH**

I am a Zambian and a postgraduate master's programme in Communication for Development in the School of Humanities and Social Sciences, Department of Mass Communication.

I am writing to you seeking permission to conduct my research as part of my requirement for the masters' degree. My research is centred on communication between doctors and patients and I shall very much appreciate if I was to do this study there. Below are some details about the study.

**SUBJECT:** Doctor Patient Relationship

**TOPIC:** Language discordance and satisfaction between doctors and patients in a medical encounter.

**SAMPLES:** Doctors and patients

**DATA COLLECTING TOOLS:** Questionnaires

**SAMPLING METHODS:** Probability Sampling and purposeful sampling

**STUDY DURATION:** Two months.

Should there be a need for me to do other things, in case this request found merit and favour, I shall be most grateful to oblige.

Thanking you in advance for your cooperation.

Yours sincerely

Kenneth Chanda



## **Appendix II — Doctor's Introductory Letter**

Dear Sir/ Madam,

My name is Kenneth Chanda I am a student at UNZA doing my masters degree. May I ask for your help concerning the study I am doing for my masters' degree dissertation? I am finding out a few important facts about the communication between you and your patients. I shall explain the project to you in detail should this information contained in this letter is insufficient.

I have sent this letter to you and a few other doctors. To make sure that I hear all your points of view, I am eager to get a reply from you. I do hope that you will agree to assist me in this study and spare some time later at your convenience for a discussion concerning my study prior to the interview. The aims of my study are:

1. To present a detailed lived account of hospital experiences by observing and listening to doctors and patients who have reproductive health problems and other social actors found in the medical setting about their lived experiences.
2. To generate a theory relevant to lived experiences.

I will not interfere in the clinical examination at all. What you will share with me will be highly appreciated. I present here a copy of the consent form for you to sign should you be willing to help me in this study. I should be most grateful for your help. I am optimistic that you will be of great help to this cause.

Yours sincerely

Kenneth Chanda

## **Appendix III — Doctor's Consent Form**

### **The request:**

I have been asked by Kenneth Chanda to take part in the project. He will explain to me in detail about the project. I should feel free to ask him questions pertaining to the project. If I have additional questions later, Kenneth Chanda, the person who is responsible for the project, will come here to discuss them with me.

### **Description of the project:**

I have been asked to take part in the project that is dealing with how patients and I talk about their health problems. The aim of the project is to enable Kenneth Chanda to learn about how the patient and I communicate.

### **What will be done?**

If I decide to take part in the project, I will be involved in a series of interviews.

My part in the project will involve allowing Kenneth Chanda the person who is responsible for the project to listen to the talk that I have with the patient or if not having a series of interviews with me as time may permit. The interview will last between twenty to thirty minutes and the interview may be recorded if I am willing. My name will not be on the tape. If I agree to have the interview recorded, the tape will be destroyed soon after it has been transcribed.

### **Risks:**

The possible risks in the project are not there at all. I may however feel some discomfort with some questions, which is usual, in case I am anxious. If that will be the case, and if I feel to stop the interview, I shall do so voluntarily because the decision to be part of the study is entirely up to me and I may terminate the interview any time. Whatever I decide, it will not be held against me. I understand that Kenneth Chanda, the person who is responsible for the project, is not a member of any health management or regulatory board and that my participation will not have an impact on my job or on any other matter.

### **Benefits:**

There are no guaranteed direct benefits to me immediately on account of this research. My taking part will help improve the doctor and patient relationship in future. It will also provide Kenneth Chanda an opportunity for him to obtain a masters degree.

**Confidentiality:**

My participation in the project is confidential to the extent permitted by law. None of the information will identify me by name once in the thesis. Kenneth Chanda will use pseudonyms instead of real names in his study. All information provided by me will be confidential. This guarantees me that no any other person will have information related to me.

**Decision to quit:**

The decision whether to take part or not is up to me. I do not have to be in the study. If I decide to take part in the study, I can quit any time. Whatever I decide is Okay for me. I shall tell Kenneth Chanda the person who is responsible for the project that I am quitting or I cannot go further in the interview.

**Rights and complaints:**

If I have concerns about the project; I may contact Kenneth Chanda or the University of Zambia Biomedical Research ethics committee. I have read the consent form and understood what is stated. All questions I have about the research have been answered. By signing the form, I am indicating my willingness to participate in this good cause. The consent form will be kept in the locker in safety and will not be attached to any transcript or other materials.

**Researcher's signature****Participant's signature**

## **Appendix IV — Patient's Introductory Letter**

Dear Madam,

My name is Kenneth Chanda. I am a student at UNZA doing my masters degree. May I ask for your help concerning the study I am doing for my masters' degree dissertation? I am finding out a few important facts about the communication between you and your doctor. I shall explain the project to you in detail should the information in this letter insufficient.

I have sent this letter to you and a few other patients. To make sure that I hear all your points of view, I am eager to get a reply from you. I do hope that you will agree to assist me in this study and spare some time later at your convenience for a discussion concerning my study prior to the interview. The aims of my study are:

1. To present a detailed lived account of hospital experiences by observing and listening to doctors and patients who have reproductive health problems and other social actors found in the medical setting about their lived experiences.
2. To generate a theory relevant to lived experiences.

I will not interfere in the clinical examination at all. What you will share with me will be highly appreciated. I present here a copy of the consent form for you to sign should you be willing to help me in this study. I should be most grateful for your help.

Yours sincerely

Kenneth Chanda

**The request:**

I have been asked by Kenneth Chanda to take part in the project. He will explain to me in detail about the project. I should feel free to ask him questions pertaining to the project. If I have additional questions later, Kenneth Chanda, the person who is responsible for the project, will come here to discuss them with me.

**Description of the project:**

I have been asked to take part in the project that is dealing with how doctors and I talk about my health problems. The aim of the project is to enable Kenneth Chanda to learn about how the doctor and I communicate.

**What will be done?**

If I decide to take part in the project, I will be involved in a series of interviews.

My part in the project will involve allowing Kenneth Chanda, the person who is responsible for the project, to listen to the talk that I have with the doctors or if not having a series of interviews with me as time may permit. The interview will last between twenty to thirty minutes and the interview may be recorded if I am willing. My name will not be on the tape. If I agree to have the interview recorded, the tape will be destroyed soon after it has been transcribed.

**Risks:**

The possible risks in the project are not there at all. I may however feel some discomfort with some questions, which is usual, in case I am anxious. If that will be the case, and if I feel to stop the interview, I shall do so voluntarily because the decision to be part of the study is entirely up to me and I may terminate the interview any time. Whatever I decide, it will not be held against me. I understand that Kenneth Chanda, the person who is responsible for the project, is not a member of any health management or regulatory board and that my participation will not have an impact on my job or on any other matter.

**Benefits:**

There are no guaranteed direct benefits to me immediately on account of this research. My taking part will provide Kenneth Chanda an opportunity for him to obtain a masters degree.

**Confidentiality:**

My participation in the project is confidential to the extent permitted by law. None of the information will identify me by name once in the thesis. Kenneth Chanda will use pseudonyms instead of real names in his study. All information provided by me will be confidential. This guarantees me that no any other person will have information related to me.

**Decision to quit:**

The decision whether to take part or not is up to me. I do not have to be in the study. If I decide to take part in the study, I can quit any time. Whatever I decide is Okay for me. I shall tell Kenneth Chanda, the person who is responsible for the project, that I am quitting or I cannot go further in the interview.

**Rights and complaints:**

If I have concerns about the project; I may contact Kenneth Chanda or the University of Zambia Biomedical Research ethics committee.

I have read the consent form and understood what is stated. All questions I have about the research have been answered. By signing the form, I am indicating my willingness to participate in this good cause. The consent form will be kept in the locker in safety and will not be attached to any transcript or other materials.



**Researcher's signature**



**Participant' signature**

**UNIVERSITY OF ZAMBIA**  
**SCHOOL OF HUMANITIES AND SOCIAL SCIENCES**  
**DEPARTMENT OF MASS COMMUNICATION**  
**APPENDIX VI PATIENT'S QUESTIONNAIRE**

**SECTION A PATIENT'S BIODATA**

**Unit or firm seeing the patient**

1. What is your age?

2. What is your sex?

3. Which one is your highest educational attainment?

1. I have never been to school

2. Primary level education

3. Junior secondary level

4. Senior secondary

5. College

6. University

4. What is your marital status?

1. Single

2. Separated

3. Divorced

4. Widowed

5. Married

## SECTION B

6. Please indicate how well you understand all of the following languages

	Very well	Well	Just a bit	Not well	Not at all
1. Chinyanja					
2. Chibemba					
3. Chiluvale					
4. Chilunda					
5. Chilozi					
6. Chitonga					
7. English					
8. Other					

7. Did you speak Chinyanja with your doctor today? Yes----- No -----
8. Did the doctor you met in the consultation room or ward use Chinyanja today? Yes----- No -----
9. Did the doctor you met in the consultation room or ward use Chibemba today? Yes----- No -----
10. Did the doctor you met in the consultation room or ward use Chiluvale today? Yes----- No -----
11. Did the patient you met in the consultation room or ward use Chilunda today? Yes----- No -----
12. Did the doctor you met in the consultation room or ward use Chlozi today? Yes----- No -----
13. Did the doctor you met in the consultation room or ward use Chitonga today? Yes----- No -----
14. Did the doctor you met in the consultation room or ward use English today? Yes----- No -----
15. Did the doctor you met in the consultation room or ward use any other language toay? Yes----- No -----



16. Which of the following languages did your doctor use when you met in the ward or consulting room to day?

- |                                 |                          |
|---------------------------------|--------------------------|
| 1. Chinyanja                    | <input type="checkbox"/> |
| 2. Chibemba                     | <input type="checkbox"/> |
| 3. Chiluvale                    | <input type="checkbox"/> |
| 4. Chilunda                     | <input type="checkbox"/> |
| 5. Chilozi                      | <input type="checkbox"/> |
| 6. Chitonga                     | <input type="checkbox"/> |
| 7. English                      | <input type="checkbox"/> |
| 8. Other (Please specify) _____ |                          |

17. How much did your doctor use the medical language when communicating to you in the ward or consulting room today?

Very Much	Much	Average	Little	Very little
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Please consider each statement carefully. Patients have different positions about the statements below. After each statement, please put a cross on the answer box below your ne choice that reflects your position.**

18. In terms of greeting you in a language you understand, what would you say about the doctor greeting you?

1. Very satisfied	2. Satisfied	3. Not sure	4. unsatisfied	5. Totally un Satisfied
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

19. What can you say about your satisfaction level from the doctor's effort in exploring your problem?

1. Very satisfied	2. Satisfied	3. Not sure	4. unsatisfied	5. Totally un Satisfied
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

20. In terms of you exploring your when you were with your doctor what can you say about your level of satisfaction?

1. Very satisfied	2. Satisfied	3. Not sure	4. unsatisfied	5. Totally un Satisfied

21. In terms of the doctor considering or making decisions about investigations to be done and results of investigations done, what would you say about your level of satisfaction?

1. Very satisfied	2. Satisfied	3. Not sure	4. unsatisfied	5. Totally un Satisfied

22. In terms of you considering or making decisions about the preferred or affordable investigations to be done, what would you say about your level of satisfaction?

1. Very satisfied	2. Satisfied	3. Not sure	4. unsatisfied	5. Totally un Satisfied

23. In terms of you considering making decisions about the preferred or affordable treatment to be provided, what would you say about your level of satisfaction?

1. Very satisfied	2. Satisfied	3. Not sure	4. unsatisfied	5. Totally un Satisfied

24. In terms of the doctor checking your own understanding of issues surrounding the illness and treatment that have been discussed, what would you say about your level of satisfaction?

1. Very satisfied	2. Satisfied	3. Not sure	4. unsatisfied	5. Totally un Satisfied

25. In terms of the doctor checking your own understanding of issues surrounding the illness and treatment that have been discussed what would you say about your level of satisfaction?

1. Very satisfied	2. Satisfied	3. Not sure	4. unsatisfied	5. Totally un Satisfied

Below are some strategies that could be used to overcome the language communication barrier between doctors and patients. Please consider each statement carefully. Patients have different positions about the statements below. Below each statement, please put a cross in the answer box that has been provided to reflect your position as you see or have experienced things. Would you say: you agree completely or agree or somewhat agree, disagree, or completely disagree?

26. Patients should be provided with print materials to read on selected topics

1. Strongly agree	2. Agree	3. Somewhat agree	4. Disagree	5. Strongly Disagree

27. Patients should be provided with videotapes to view as a way of getting educated on some topics.

1. Strongly agree	2. Agree	3. Somewhat agree	4. Disagree	5. Strongly Disagree

28. Patients should be provided with group educational programs to teach patients specific communication skills, such as how to ask questions, disclose information about symptoms and medical concerns, and check understanding of the diagnosis and treatment plan.

1. Strongly agree	2. Agree	3. Somewhat agree	4. Disagree	5. Strongly Disagree

29. Teaching communication skills should be included at all levels of medical education and programmes of continuing medical education.

1. Strongly agree	2. Agree	3. Somewhat agree	4. Disagree	5. Strongly Disagree

30. Teaching communication skills should be a mandatory element of the medical school curriculum and programmes of continuing medical education.

1. Strongly agree	2. Agree	3. Somewhat agree	4. Disagree	5. Strongly Disagree

**Thank you very much for participating in this study.**

**APPENDIX VII**  
**SECTION A DOCTOR'S BIODATA**

1. Unit or firm\_\_\_\_\_

2. What is your age?

3. What is your sex?


4. Professional level\_\_\_\_\_

**SECTION B**

5. Please indicate how well you understand all of the following languages

	Very well	Well	Just a bit	Not well	Not at all
Chinyanja					
Chibemba					
Chiluvale					
Chilunda					
Chilozi					
Chitonga					
English					
Other					

6. Did you speak Chinyanja with your patient today? Yes----- No -----

7. Did the patient you met in the consultation room or ward use Chinyanja today?  
Yes----- No -----

8. Did the patient you met in the consultation room or ward use Chibemba today?  
Yes----- No -----

9. Did the patient you met in the consultation room or ward use Chiluvale today?  
Yes----- No -----

10. Did the patient you met in the consultation room or ward use Chilunda today?  
Yes----- No -----

11. Did the patient you met in the consultation room or ward use Chlozi today? Yes-  
----- No -----

12. Did the patient you met in the consultation room or ward use Chitonga today?  
Yes----- No -----

13. Did the patient you met in the consultation room or ward use English today?  
Yes—— No ——
14. Did the patient you met in the consultation room or ward use any other language today? Yes—— No ——
15. How much did your doctor use the medical language when communicating to you in the ward or consulting room today?

Very much	Much	Somewhat ok	little	Not at all

**Please consider each statement carefully. Doctors have different positions about the statements below. After each statement, please put a cross on the answer box below your ne choice that reflects your position.**

16. How satisfied were you with the language the doctor used during physical examination?

Very satisfied	Satisfied	Not sure	unsatisfied	Totally un Satisfied

17. How satisfied were you with the language you used when explaining the investigations that needed to be carried out on the patient?

Very satisfied	Satisfied	Not sure	unsatisfied	Totally un Satisfied

18. How satisfied were you with the language you used when explaining the results of the investigations carried out on the patient?


19. How satisfied were you with the language you used when explaining the diagnosis to the patient?

Very satisfied	Satisfied	Not sure	Unsatisfied	Totally un Satisfied

20. How satisfied were you with the language the patient used when explaining the treatment for your patient's problem?

Very satisfied	Satisfied	Not sure	unsatisfied	Totally un Satisfied

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21. How satisfied were you with the language you used when checking the patient understanding of issues surrounding the illness and treatment?

Very satisfied	Satisfied	Not sure	Unsatisfied	Totally un Satisfied

Below are some strategies that could be used to overcome the language communication barrier between doctors and patients. Please consider each statement carefully. Doctors have different positions about the statements below. Below each statement, please put a cross in the answer box that has been provided to reflect your position as you see or have experienced things. Would you say: you agree completely or agree or somewhat agree, disagree, or completely disagree?

22. Patients should be provided with print materials to read on selected topics.

Strongly agree	Agree	Somewhat agree	Disagree	Strongly Disagree

23. Patients should be provided with video tapes as a way of getting educated on some topics

Strongly agree	Agree	Somewhat agree	Disagree	Strongly Disagree

24. Patients should be provided with group educational programs to teach patients specific communication skills, such as how to ask questions, disclose information about symptoms and medical concerns, and check understanding of the diagnosis and treatment plan.

Strongly agree	Agree	Somewhat agree	Disagree	Strongly Disagree

25. Teaching communication skills should be included at all levels of medical education and programmes of continuing medical education.

Strongly agree	Agree	Somewhat agree	Disagree	Strongly Disagree

26. Teaching communication skills should be a mandatory element of the medical school curriculum and programmes of continuing medical education.

Strongly agree	Agree	Somewhat agree	Disagree	Strongly Disagree

**Thank you very much for participating in this study.**

## **Appendix VIII— Introductory Letter to Participant**

Dear Sir/ Madam,

### **Why have we visited you?**

You/your/clinic / has been visited because:

You have this experience, your opinions may be important to this study.

### **Who am I?**

My name is Kenneth Lengwe Chanda I am a Postgraduate student at the University of Zambia working on Language discordance and satisfaction between doctors and patients in a medical encounter.

I am giving this letter to you and a few other people who have been selected because of your special nature as I have indicated in the reason for visiting you. To make sure that I hear all your points of view or questions, I am eager to get a response from you. You will find a copy of the consent form explaining the details of this study. You may sign it as acknowledgement for you to participate in the study. This is enclosed here in and if you could be kind to read it. I am optimistic that you will be of great help to this cause and spare some time later at your convenience to spend some time with for a discussion concerning my study.

I will not interfere in how you go about your life or routine of work, not even your treatment. What you will share with me will be highly appreciated. If after receiving this letter, you have any questions about this study, or would like additional information to assist you in reaching a decision about participation, please feel free to contact me on phone (0955455518) or e mail klchanda@yahoo.com

I would like to assure you that this study has been reviewed and received ethics clearance through the Office of Biomedical Research Ethics Committee of School of Medicine. However, the final decision about participation is yours. Should you have comments or concerns resulting from your participation in this study, please contact.....in the Biomedical Research Ethics Committee at .....

Thank you in advance for your interest in this project.

Yours sincerely,

Kenneth Lengwe Chanda