UNIVERSITY OF EDUCATION, WINNEBA

DOCTOR-PATIENT COMMUNICATION IN THE CONSULTING ROOM: A STUDY OF TWO UNIVERSITY HEALTH FACILITIES IN GHANA

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JULY, 2015

DECLARATION

STUDENT'S DECLARATION

I, Akosua Asantewaa Anane declare that this thesis, with the exception of quotations and references contained in published works which have all been identified and duly acknowledged, is entirely my own original work, and it has not been submitted in part or whole, for another degree elsewhere.

SIGNATURE : …….

DATE : …….

SUPERVISOR'S DECLARATION

I hereby declare that the preparation and presentation of this work was supervised in accordance with the guidelines for supervision of Dissertation as laid down by the University of Education, Winneba.

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DEDICATION

This work is dedicated to my parents, Dickson Emmanuel Asante and Elizabeth Ama Asante thank you so much for all your support, for being there and showing me love throughout my academic endeavor. God bless you.

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ABSTRACT

This study sought to investigate the experiences of doctors and patients during their encounter in the consulting rooms of the health facilities in the University of Cape Coast and University of Education, Winneba in the Central Region of Ghana. A qualitative study was used to ascertain the actual lived communication experiences of doctors and patients in the consulting rooms. The study was anchored on Goffman's facework and politeness theory. In all, a total of 23 patients and 6 doctors participated in the study. The major findings that emerged from this study revealed differences in the perspectives of doctors and patients on communication in the consulting rooms. Doctor-patient exchanges were characterized diversely as warm, pleasant, caring and welcoming. However, majority of the experiences of patients were also characterized by poor reception, cold attitude among others. Communication between doctors and patients was influenced by patients' attitudes and interest in their health care, disclosure patterns, use of medical jargons, and number of patients. In the views of patients, there were mixed findings; while some were satisfied with their interactions with the doctors in the consulting rooms, others were also dissatisfied. The study concludes that the experiences of doctors and patients in the study were precipitated by different factors including attitudes of patients, workload, day and time, failure of patients to disclose information among others. Also the disposition of doctors, tone of voice, attitude towards them, use of medical terminologies, lack of attention, and failure to explain diagnosis and treatment. While the majority of the patients described their experiences as unsatisfactory the minority on the other hand, disclosed that they were satisfied with their encounter with the doctors in the consulting rooms of the two universities' health facilities.

CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

Doctor-patient communication is an important component of quality health care delivery in every country. It is a significant clinical function in building a satisfying doctor-patient relationship, which is the heart and art of medicine (Fong Ha, 2010). According to Fong Ha, much patient dissatisfaction and many complaints are due to breakdown in the doctor-patient relationship. Literature reveals that the interpersonal aspect of the doctor-patient communication has been recognized as an important aspect within health care, and studies continue to emphasize how a medical experience might be compromised due to miscommunication (Acquah, 2011; Ellis, 2004; Kreps & O'Hair, 1995; Ray, 2005; Roter & Hall, 1992; Thompson, Dorsey, Miller, & Parrot, 2003).

Doctor-patient communication is the foundation on which doctors build relationships with patients and vice-versa (Barret, 2006; Haftel, 2007; Nelson, 2008). In fact, the context, in which doctor-patient communication proceeds, is the means by which doctors get to know the patients and make them feel as humans and not just a medical problem. Recognizing patients' problems, understanding them and their expectations from doctors, shared satisfaction from healthy doctor- patient relationship becomes the desired outcome. Consequently, doctor-patient communication encompasses both the verbal and nonverbal procedures through which doctors obtain and share information with patients. All doctor-patient interactions are influenced by the expectations of both parties because it is always a two-way process. If the doctor has

biased expectations of the patient or if the interaction is affected by partial or unfair judgment, effective communication will never occur. It is therefore imperative that patients at all-time feel that they are accorded respect, and are actively involved in the communication process.

Additionally, patients expect doctors to be competent and able to use all the relevant information and expertise in their best interests. Besides, patients' expectations go beyond clinical competence because they expect doctors to be respectful, polite, sincere, compassionate and interested, behave and dress professionally, and exhibit appropriate manner, avoiding disparaging behavior, with the proper verbal and nonverbal skills and all the attributes that make up a doctor (Roter & Hall, 1992).

Doctors play fundamental role in the provision of quality health care for the citizens of every country. Doctors' role begins from consultation, diagnosis, treatment and surgery to recovery. Throughout this journey, doctors' communication with patients and their families contribute significantly to the recovery of patients. According to Helman (2007) cited by Acquah (2011),

> Doctors and patients even if they come from the same social and cultural background view ill health in very different ways. Their perspectives are based on very different premises, employ a different system of proof, and assess the efficacy of treatment in a different way. Each has its strengths, as well as its weaknesses. The problem is how to ensure some communication between them in the clinical encounter, between doctor and patient (p. 1).

The ultimate objective of any doctor-patient communication is to improve the patient's health and medical care (Duffy, Gordon, Whelan et al., 2004). Basic

communication skills in isolation are insufficient to create and sustain a successful therapeutic doctor-patient relationship, which consists of shared perceptions and feelings regarding the nature of the problem, goals of treatment, and psychosocial support (Arora, 2003; Duffy, Gordon, Whelan et al., 2004; Fong Ha, 2010); interpersonal skills built on basic communication integrate both patient- and doctor-centred approaches (Bredart, Bouleuc & Dolbeault, 2005).

Communication transpires within the context of people, places, situations, and other social and interpersonal conditions. It also involves performing selected tasks and exhibiting behaviours such as establishing shared meaning, offering therapeutic instructions, performing client interviews, eliciting relevant data, explaining procedures, educating clients and families, discussing treatment options, describing adverse effects from medication, and providing crisis intervention (Acquah, 2011).

Essentially, studies on doctor-patient communication have demonstrated patient discontent even when many doctors considered the communication adequate or even excellent (Stewart, 1995). For example, Tongue, Epps and Forese (2005) reported that 75% of the orthopedic surgeons surveyed believed that they communicated satisfactorily with their patients, but only 21% of the patients reported satisfactory communication with their doctors. Patients' survey has consistently shown that they want better communication with their doctors (Duffy, Gordon, Whelan et al., 2004). Furthermore, Tuckett et al., (1985) have argued that doctors rarely ask their patients to volunteer their ideas and inhibit their expression if they do spontaneously bring them up. If discordance between doctors and patients' ideas and beliefs about the illness remains unrecognized, poor understanding, adherence, satisfaction and outcome are

likely to ensue. Effective communication is therefore crucial in building and maintaining good doctor-patient relationships.

Effective communication helps people to understand and learn from each other, develop alternate perspectives, and meet each other's needs. Studies have shown that in many developed countries great emphasis has been placed on doctor-patient communication as an integral part of health care for patients (Aarons, 2005). In Ghana, the Ministry of Health has identified improving the quality of healthcare as one of its five key objectives of health sector reforms. The Ministry envisages that quality of care might be improved through paying more attention to the perspectives of clients, improving the competences and skills of providers and improving working environment by better management, provision of medical equipment and supplies and motivation of staff (MOH, 2002)

It has been suggested that if health programmes are to succeed in resource-poor countries, it is important to get the opinions of the local people in addition to their degree of satisfaction with available services (Newman, Gloyd, Nyangezi, Francison & Muiser, 1998). The patient's perception of quality of care is critical to understanding the relationship between quality of care and utilization of health services and is now considered an outcome of healthcare delivery (Ross, Steward & Sinacore, 1993). The two health facilities of the universities of Cape Coast and Winneba serve a cross-section of people including staff of the universities, their families, students and the general public. The facilities also play complementary roles to the general and private health facilities in the two municipalities.

Factors including doctor-patient ratio, availability of resources, facilities, conditions of services and others which influence medical care and communication, may ultimately affect the quality of health delivery services to the citizenry. However, search in the libraries of the University of Cape Coast and the University of Education, Winneba showed that no substantial study has been done on doctor-patient communication in Ghana in general and in particular at the health facilities of the University of Cape Coast and the University of Education, Winneba.

1.2 Statement of the Problem

As stated in the on-going discussion, among inter-personal relationships in medical facilities, the doctor-patient relation is one of the most complex relationships. It involves interaction between individuals in non-equal positions, it is often non-voluntary, it again concerns issues of vital importance and emotionally laden, and requires close cooperation (Chaitchik et al., 1992, as cited by Ong, De Haes, Hoos & Lammes, 1995). While sophisticated technologies may be used for medical diagnosis and treatment, inter-personal communication is the primary tool by which the physician and the patient exchange information (Street, 1991 as cited by Ong, De Haes, Hoos & Lammes, 1995).

Certain aspects of doctor-patient communication seem to have an influence on patients' behavior and well-being, for example satisfaction with care, adherence to treatment, recall and understanding of medical information, coping with the disease, quality of life, and even the state of health (Ong, De Haes, Hoos & Lammes, 1995). Sometimes, doctors often pursue a doctor-centered closed approach to information gathering, which discourages patients from telling their story or voicing their concerns

(Byrne & Long, 1996). Also, in general, doctors give sparse information to their patients with most wanting their doctors to provide more information than they do (Beisecker, 1990; Pinder, 1990; Waitzkin, 1984). Besides, doctors' use of medical jargons affects effective communication with patients. For instance, Korsch et al. (1968) found that pediatrician's use of technical language such as *oedema* and medical shorthand to write patients' history are barriers to communication in more than half of the 800 visits studied. The report continued that mothers were confused by the terms used by doctors yet they rarely asked for clarification of unfamiliar terms.

Level of communication is placed in the hands of the doctors where they are the communicator and patients are the listeners. Research that has been done in least developed countries has indicated that health counseling and doctor patient communication is consistently weak (Nicholas, Highby & Hatzell 1991) in the efficacy of health care delivery system. Several studies have been done on doctor patient communication across the globe. For example, Černý (2008) asserts that research into the use of medical terminology has received little attention. In a study of some aspects of the use of medical terminology in doctor-patient communication, Černý (2008) found that at the symmetrical level doctors tended to explain the process of examination; they were willing to explain the medical terms used; and patients usually employed medical terminology correctly. However, at the asymmetrical level, doctors initiated the use of medical terms while patients only responded to doctor-initiated questions. According to Černý sometimes doctors use certain terms, which patients may find difficult to understand.

Morasch (2004) believes that cultural and linguistic differences between physicians and patients are among the barriers of effective conversation and clear communication. According to her, medical jargon can contribute to poor communication as well as enhance it, depending on the difficulty of the audience. She thinks that using medical jargons can lead to misinformation and incorrect interpretations that may have adverse effects on a patient's health.

A number of studies have looked at doctor-patient interactions. For example, Swasey (2013) looked at Physician and Patient Communication: A Grounded Theory Analysis of Physician and Patient Web-Log. Acquah (2011) on the other hand, studied Physician-Patient Communication in Ghana: Multilingualism, Interpreters, and Self-Disclosure), while Ofosu-Kwarteng (2012) did a research in healthcare delivery and customer satisfaction in Ghana: A case study of the Koforidua Regional Hospital.

Health communication is yet to advance as an academic field in Ghanaian higher education (De Beer, 2009). Thus, minimal practical research literature exists on specific aspects of physician-patient communication in Ghana. Related studies have narrowly focused on patient compliance with regard to malaria and HIV/AIDS (for example, Adjei et al., 2008; Agyepong et al., 2002). This study which therefore employed phenomenology to interrogate doctor-patient communication in the two health facilities in the universities in Cape Coast and Winneba, was a modest contribution to bridge the lacuna that existed with respect to empirical data on quality services. As stated earlier, the two health facilities serve a cross-section of people including staff of the universities, their families, students and the general public. The facilities play complementary roles to the general and private health

facilities in the two municipalities. Therefore any compromise in the quality of services will have adverse effects on many people within the municipalities and beyond. Thus there was the need for research to investigate doctor-patient communication in the two health facilities.

1.3 Aim

The aim of the study was to understand how doctors communicated with patients in the consulting rooms of the health facilities of the University of Cape Coast and University of Education, Winneba and the level of patients' satisfaction of the services from the two facilities.

1.4 Objectives

The objectives underpinning the study are to:

1. Investigate how doctors communicate with patients in the consulting rooms of University of Cape Coast Hospital and University of Education, Winneba Clinic.
2. Discuss factors which influence the manner in which doctors and patients communicate in the consulting rooms of the two universities' health facilities.
3. Describe patients' views about the manner in which doctors communicate with them in the consulting rooms of the two universities' health facilities.

1.5 Research Questions

The study is guided by the following research questions:

1. How do doctors communicate with patients in the consulting rooms?

2. What factors influence the manner in which doctors communicate with patients in the consulting rooms?
3. What are the perceptions of patients on how doctors communicate with them in the consulting rooms?

1.6 Significance of the Study

As explained earlier, effective doctor-patient communication is a central clinical function, and its subsequent communication is at the core of medicine and a central component in the delivery of health care (Stewart, 1995; Tongue, Epps & Forese, 2005). The study will provide empirical evidence on doctor-patient communication, which will serve as a regulatory standard for the improvement of doctor-patient communication for the authorities of the two universities. The outcomes of the study will be an invaluable source of reference material for management in terms of quality assurance and decisions concerning staff development.

Secondly, the doctors in the two health facilities of the universities will get feedback concerning the manner in which they communicate with patients and the impact of their approach to communication on the quality of health care delivery. This will let them know whether they are achieving the ultimate objective of their profession, which is to provide quality health care to the people.

Also, the outcome of the study when disseminated will provide empirical records for stakeholders including the Ministry of Health about the level of satisfaction the users of the two health facilities with respect to communication with doctors, and ultimately the services rendered by the facilities. This will enable the Ministry adopt measures to

improve doctor-patient communication and ultimately health care delivery to the people not only in the study areas but also in other health facilities across the country.

Besides, improvement in doctor patient communication will ultimately impact positively on quality health care delivery in the two university hospitals for the numerous patients' who patronize the hospitals. This will directly improve health of the workers and students leading to quality teaching and learning as well as increase in productivity.

Since very little empirical data on this issue exists in Ghana, the study will provide empirical data on doctor-patient communication in the Winneba Municipality and Cape Coast Metropolis to fill the vacuum which existed in terms of research. Ultimately, the study will be an invaluable reference material for researchers, who will conduct similar studies in the future.

1.7 Delimitation

This study focused on understanding the interactions that ensue between doctors and patients in the consulting rooms. The study was limited to only doctors and patients in the out-patient department of the health facilities in the University of Cape Coast Hospital and University of Education, Winneba. It is important to state that while the health facility at the University of Cape Coast is of a hospital status, that of the University of Education, Winneba is of a clinic status. Furthermore, while there are other professionals such as nurses, mid-wives, pharmacists, administrators, who offer different services in the two health facilities, this study focused mainly on medical doctors. Besides, the study focused on patients who visited the out-patient department

of the two health facilities during the 2014/2015 academic year, and in particular, patients who were not visiting the health facilities for the first time.

1.8 Organization of the Study

The study is structured into five main chapters that are chapters one to five.

Chapter one sets the preliminary stage for the study. It includes the background of the study, statement of the problem, the aim and objectives of the study as well as the research questions and delimitation, limitations and definition of terms.

Chapter two deals with the review of related literature; some of the key issues discussed were theoretical framework, explanation of the concept of communication, types of communication, doctor-patient encounter, barriers to doctor-patient communication, quality health care delivery in Ghana, and code of ethics.

Chapter three focuses on the methodology, which highlights population, research design, methods of data collection, analysis as well as reliability and validity issues.

Chapter four provides the results and discussions of findings and chapter five offers the summary, conclusions, and recommendations of the study, as well as areas for further research.

CHAPTER TWO

REVIEW OF RELATED LITERATURE

2.1 Introduction

This chapter focuses on the review of literature related literature relevant to the study. The review was guided by conceptual or theoretical framework as well as empirical studies.

2.2 Explaining Communication

Communication is the process of sharing information and it involves many roles, such as seeking social interaction, making requests, sharing ideas and or rejecting an interaction (Owens et al., 2007). It requires sending messages in understandable form (encoding) and receiving and understanding messages (decoding). Keyton (2001) opines that communication always involves a sender and a receiver, but it does not always involve oral language. Thus communication may involve non-verbal cues other than spoken words

In the context of health delivery system, communication can be defined as a transactional process, which is an important part of promoting health (Minardi & Rily, 1997). According to Minardi and Rily (1997) communication is an essential, contributory and a purposeful process. On their part, Northhouse and Northhouse (1998) posit that the communication transaction is one of sharing information using a set of common rules. In health promotion, communication is a planned process (Kiger, 2004). The effectiveness of this planned process comes to fruition when the recipients have achieved, acted on or responded to the message.

2.2.1Types of Communication

The flow of information between the doctor and the patient is a very important aspect in the doctor patient interaction. In the doctor patient encounter, communication can be classified into two, the active or the verbal process and the passive or non- verbal process (Lee, 2002). During the active process, Lee (2002) asserts that the nature of communication flow is controlled. On the other hand, in passive communication, information flow is unconsciously done. These active and passive processes can also be termed as intentional and unintentional communication, but worthy of note is that, what the doctor communicates unintentionally may be perceived by the patient as intentional, or vice-versa.

2.2.2 Active or Verbal Communication

Verbal communication involves the use of words, sentences and phrases during an interaction (Minardi & Rily, 1997). Verbal system affects communication by the production of vocal sounds, which can be organized (as in words) according to definite patterns into utterances or sentences that lead to larger patterns of discourse (Tanner, 1976). The intonation system comprises the covering of the verbal system by different pitches, stresses, and intervals (Bennett, 1976). Subsequently, a rise or fall in the pitch of an utterance may render it a question or a statement.

Researchers have found that patients were less satisfied with the doctor, when the doctor dominated the interview (Hochman, Itzhak, Mankuta, & Vinker, 2008). The use of questions by a doctor is a vital component in interpersonal communication. When a doctor has his or her first interview with a new patient, the doctor's use of

questions can assist in the “free flow of information” from patient to doctor (Osborne & Ulrich, 2008, p. 12).

Fry and Mumford (2011) also point out that, questioning is not just summarizing as a means of showing understanding. The way in which the patient speaks is also very important and a good doctor should be able to interpret the meanings and feelings behind the words. Arnold (2003) describes how the clinical implications of tone, speech rate, pitch, volume, articulation and word choice all convey meaning.

2.2.3 Non-Verbal Communication

Another significant aspect of the doctor-patient interaction is non-verbal communication. As in the words of Fry and Mumford (2011) communication may occur through the paralinguistic system, where although no words are used meaning may still be sent by the use of sounds such as "ums", "ers", stammers, yawns, coughs, belching, and similar sounds, as well as the use of silence during speech. Non-lingual communication, such as body and facial movements that carry clear communicative significance, has been classified under the kinesics system.

Many forms of kinesics occur in culturally standardized forms, for example, the messages sent by particular gestures, postures, or body movements, such as when a doctor sits forward in a chair at the beginning of an interview or leans backward at the end of the interview. Nod or shake of the head may express information regarding the listener's attentiveness or agreement, yet the act of a doctor putting his hand on a female patient’s shoulder may be understood as reassuring in one culture but an

unwanted familiarity in another culture (Bennett, 1976; Bruhn, 1978 cited in Aarons, 2005; Larsen & Smith, 1981).

According to Cooper (1999) cited by Aarons (2005) doctors show their respect for the patient's private space by knocking on the door or announcing their presence before opening a curtain or by simply greeting the patient before approaching them: "Some conversations with patients…would produce very different results if the distance zones were understood" (p. 116). This was endorsed by Osborne and Ulrich (2008) who stated, "each of us thinks of the space around us as an extension of our bodies. The space serves as a defense between us and other people, and we may grow uncomfortable or resentful when others intrude in it" (p. 116). They also state that, "The size of the personal space varies, but you can often pick out a rough boundary line by noting where the patient has placed his personal belongings" (p. 116).

Cooper (1999) as cited by Aarons (2005) again mentions that, in relieving a patient's anxiety, doctors can sit where the patient can see them. He also suggested that doctors lean forward while the patient is speaking, by so doing, communicating to the patient that what the patient is saying is important. Osborne and Ulrich (2008) assert that non-verbal cues such as body position, facial expression and personal appearance are key components when a doctor is listening to his or her patient. They maintain that facial expressions can reflect how a doctor is interpreting the information they are receiving. Osborne and Ulrich (2008) recommend the use of the "…warm smile," which tells others they feel kindly toward them, and explained the importance of understanding facial cues in addressing the issue of eyes and what role(s) the eyes play in that first doctor-patient interview.

Osborne and Ulrich (2008) add that the eyes, together with the eyebrow, both communicate attitudes such as surprise, compassion, fear, doubt or dislike. They state: "Maintaining friendly eye contact with others often promotes trust. On the other hand, patients may doubt the sincerity or competence of a doctor if they avoid eye contact during conversation" (p. 12). Fry and Mumford (2011) have also addressed the role of eye contact and the use of language, as used by a doctor. They argued that "simply slowing down their speech and maintaining good eye contact significantly improved understanding" (p. 183) and for understanding to occur the skill of listening is necessary for both doctors and patients.

According to Osborne and Ulrich (2008), "effective communication involves more than just mastering speech "it is also linked to a desire and ability to listen" (p. 10). These researchers also recognized that "…the first step in collecting diagnostic information typically begins with listening to our clients concerns" (p. 10). They also indicate that good listening skills are not only vital to receive accurate information, but showing understanding when patients convey an overall interest in the total well-being of the patient.

Osborne and Ulrich (2008) argue that when doctors listen it can be for two primary reasons. First, doctors listen with the intent to render a reply. The second reason, doctors listen in order to provide answers that express the doctor's point of view about their clients' concerns. When doctors are listening to patients, it is vital not to interrupt, unless there is a good reason for the interruption. Osborne and Ulrich (2008) explain that the act of interrupting someone while talking is considered to be a barrier to good communication. They found that doctors interrupted 69 percent of their

patients before they could complete their opening statements and once interrupted, fewer than two percent of patients went on to complete their statements. Effective listening is empathic listening and this goes to show that the doctor is concerned about the patient's total well-being (Osborne & Ulrich, 2008). In addition, non-verbal communication may be influenced by conditions such as the culture, age, gender, and social circumstances surrounding both the sender and receiver of communication, and is not always easy to comprehend or interpret.

2.3 The Doctor-Patient Encounter

Doctors frequently overrate the amount of information they provide to patients, and they also believe that patients are satisfied with the communication they receive during consultation, as it is difficult for patients to convey dissatisfaction in the consultation process (Patridge & Hills, 2000). However, the most common complaints about doctors by patients and the public relate to communication, and mostly that doctors do not listen, will not give information and show a lack of concern or lack of respect for the patient. As a result, Barry et al. (2000) asserted that large numbers of patients leave the consultation without asking questions about things that are troubling them or do not receive what they regard as a satisfactory response.

A recent qualitative study based on 35 patients aged 18 years and over, consulting 20 general practitioners, found that only four of the 35 patients voiced all their concerns during the consultation and their concerns were related to symptoms, requests for diagnoses and prescriptions. The most common unvoiced concerns were worries about possible diagnosis and what the future held, ideas about what are wrong, side-effects and not wanting a prescription.

Additionally, a doctor's willingness to answer all questions without hesitation improves patients' belief in the doctor's abilities. This is typically so with chronic or incurable diseases, which are related with anxiety, stress, and uncertainty for the whole family. A doctor who offers support, compassion, clear and complete explanations at every step can help improve these to a significant extent (Moore et al., 2000). Some patients are sometimes angry by the doctor's refusal to spend quality time with them, give thorough and clear explanations, an uncaring approach to their problems, and a lack of courtesy and care. When all these are followed by a poor treatment outcome, complaints, quarrels, and legal actions are expected. On the other hand, good communication can play a significant part in avoiding complaints and malpractice claims (Levinson et al., 1997).

Doctor-patient communication when done effectively has a positive influence on over-all health outcome of patients. In a study conducted by Roter et al. (1995) which explored the effects of communication skills training on the practice and outcome of care related with patient's emotional distress, improvement in doctors' communication skills was shown to be associated with a reduction in emotional distress in patients.

In a review of 21 randomly selected controlled trials and investigative studies on the effects of doctor-patient communication on patient health outcomes, the quality of communication in both history taking and discussion of the management plan was found to be linked with health outcomes (Stewart, 1995). Effective doctor-patient communication was shown to be associated with better emotional and physical health, higher symptom resolution, and better control of chronic diseases. In a study conducted on 39 randomly selected family doctors and 315 patients, (Stewart, 2001)

again showed that the degree of patient-centred communication was associated with less discomfort, less concern and better mental health in patients.

Additionally, in terms of decrease in application of health services, it was shown that patients who perceived that their visits had been patient centred received fewer diagnostic tests and referrals in the subsequent months. In another study that investigated doctor interaction styles and perceived quality health services by patients, Stewart et al. (1999) looked at 2881 patient visits of 138 family doctors and categorized physicians' interaction styles into four categories: person-focused, bio psychosocial, biomedical, and high doctor control by the use of a primary care instrument. They showed that doctors with a person focused interaction style with patients were associated with the highest reported quality of care by doctors, while doctors with the high control styles were associated with the lowest reported quality of care.

According to Melnikow (1994) low compliance with recommended medical interventions is an important problem in medical practice and it is associated with large medical cost including increased hospital admissions which also creates an ongoing frustration to health care providers. Finding ways to improve compliance is of interest to both health service administrators and doctors. To this end, the doctor patient relationship may have an important role to play. It has been shown that a doctor's attitude towards his patients, his ability to encourage and respect the patients' concerns, the provision of relevant information, and show of empathy and the development of patient trust are the key bases of good compliance with medical treatments in patients (DiMatteo, 1994; Sarfan & Taira, 1998). Furthermore, training

doctors to improve their communication skills could potentially be cost effective as it increases compliance which in turn improves the overall health of patients (Cegala, 2000).

2.4 Barriers to Effective Communication between Doctors and Patients

Traditionally, most doctors have not really given much attention to communicating well. Even today, Bartel et al. (2000) reiterate that only a few of the doctors have come to appreciate the importance of communication skills, and hardly do they make a conscious effort to learn and apply the skills. This is perhaps the only major barrier to good communication. Until they come to value the role of good communication to patient outcomes and patient satisfaction, poor communication is likely to remain the norm in the medical field. Even doctors who appreciate the importance of good communication are not always successful at applying it. Barriers to effective doctor-patient communication include but not limited to: differences in doctor-patient expectations, length of time in communication, use of medical terminologies and patients' disclosure patterns.

2.4.1 Differences in Doctor-Patient Expectations

Communication difficulties between the doctor and the patient may arise due to differences in their assumptive worlds (Fishbein, 1976) as cited in Aarons (2005). Frank (1961) as cited in Aarons (2005) posits that we all make rules about the world in which we live in, and this was vital if we were not to be overcome by the vast number of experiences and impressions which we regularly receive. Our assumptions become each person's assumptive world. Further, in consultations between doctors and patients, doctors may notice difficulties imposed on the patient by a conflict that

exists between his or her assumptive world and that of others (Browne & Freeling, 1976).

Obviously, the closer a doctor is to his or her patients in time and space, in age and nationality, and social class, the more the doctor's assumptive world is likely to be nearer to those of his/her patients. Therefore, separate from the barriers imposed by language, many of the difficulties that doctors have in communicating with patients of different nationalities arise from their mutual ignorance of each other's assumptive worlds (Browne & Freeling, 1976 as cited in Aarons, 2005).

If all assumptions were made at the conscious level, they would be relatively easy to deal with, but many occur at the unconscious level, or if they are conscious then they are reinforced by unconscious needs or repressed experiences (Browne & Freeling, 1976 cited in Aarons, 2005). In order to effect care that would be meaningful to the patient and could ensure his/her cooperation, doctors should be aware of, and seek to know the patient's assumptions and their expectations, as well as being familiar with their own assumptions in communication. Repeated contact between the doctor and patient should educate both persons about the assumptions of the other, and help to reduce the likelihood of any conflict that would impede valuable interaction between them. Moreover, doctors must not be limited by their own expectations in the treatment of their patients.

2.4.2 Length of Time in Communication

Research has suggested that the procedure used in general practice for understanding the patient needed too much time (Ridsdale et al., 1992). However, some authors

propose that a doctor's ability to communicate effectively may be largely due to the time available for the communication, yet the literature on the subject is not very clear, perhaps because communication is defined and measured in many different ways. In their review of the literature, Stewart et al. found two themes: firstly that the communicative style of the doctor (whether positive or negative) was not affected by the length of the interaction; and second that, the length of time available for the consultation affected the nature of the discussion (Stewart et al., 1999)

In regard to communicative style, Stewart et al. (1999) found that some studies indicated that a longer consultation was not required to communicate "well" with patients. In fact, positive consultations (defined as those where both doctors and patients had a positive impression of the consultations) took less time than negative consultations (where both parties had negative impressions). In positive consultations, more time was spent on patients' ideas and concerns. This finding by Stewart et al. was confirmed by other authors, who concluded that it was not the amount of time that was crucial in the doctor patient communication, but rather, the way in which the available time was utilized (Ruusuvuori, 2001). Patient-centered interactions, particularly establishing the patient's main concerns and expectations at the beginning of an interview, would save a great deal of time later and make for a more satisfactory doctor-patient interaction. A patient's perception of a doctor's communication could be affected by the doctor's communicative style, and that patients are more likely to have positive feelings on the matter where the doctor focuses mainly on the patient's concerns.

Other studies (Stewart et al., 1999; Howie et al., 1992; Beisecker & Beisecker, 1990) however, showed that communication which is more detailed required longer consultations. In fact, doctors who saw more than 20 outpatients per day spent much less time giving information and also gave a smaller number of explanations. Subsequently, giving sufficient time to listen and respond to patients' worries and concerns can reduce the number of return visits and hence the total consultation time for an episode of illness.

2.4.3 Doctors' use of Complex Medical Terminologies

Ashkehave and Zethsen (2000) assert that "Medical language is usually regarded as the language used by medical experts when communicating in an expert-to-expert context. It is the language of the 'specialist,' often defined as a special language as opposed to general language used by the general public in everyday situations …" Most if not all doctors use technical language or medical jargons, which is commonly of Latinate origin (Gotti, 2006) which is because Latin was the former Lingua Franca of medicine.

Research (Hadlow & Pitts, 1991; Larsson et al., 1994; Skelton & Hobb, 1999) on the use of medical jargon has revealed that patients often failed to understand the meaning of many common medical terms, particularly medical jargon; while doctors generally over emphasized what their patients have understood. Others are of the view that this is no coincidence, as there was evidence that doctors' use of medical jargon was related to preserving their authority at the expense of the patient's ability to influence the course of a consultation (Salmon & May, 1995). Closed interviewing techniques, limiting information, and focusing attention on physical rather than

emotional concerns were also given as examples of the strategy to preserve the doctor's authority.

Nelson (2008) explains that doctors' use of complex terminology or medical language sometimes lack simple words that patients can easily understand. For example, "excise" which means "to remove by excision" or "resect" might be misunderstood whereas "cutting it out" sounds too painful. Using the verb "removing it" instead is a better way to express the message without worsening the patient's anxiety level.

Furthermore, Morasch (2004) considers the cultural and linguistic differences between doctors and patients also as an obstruction to effective conversation and clear communication. Morasch stresses that; medical jargon contributes to poor communication. She emphasizes that using medical jargons could lead to misinformation and incorrect explanations that may have conflicting effects on a patient's health. Morasch adds that "Avoiding medical jargon is essential to ensuring the concise exchange of information between patients and physicians" (p. 4). Again some health terminologies in English do not have its local equivalent and even if these expressions exist majority of people have no knowledge of them. This ultimately means that doctors and patients would have differing levels of understanding pertaining to those diagnoses. For instance a doctor maybe of the view that he/she has provided a thorough explanation regarding a diagnosis only to realize that, the patient has a different understanding of the diagnosis given or has no clue as to what the doctor is saying.

Tanner (1976) cited in Aarons (2005), explains that many doctors have developed an ability to translate aspects of their explanations into regional dialect terms, but that it may be difficult to avoid this being interpreted as protective and patronizing. He thought that a doctor who deliberately adopted non-medical terms could sound so odd or unexpected to the patient that such communication may have the reverse effect of what was intended. Similarly, other authors (Waitzkin, 1984; Bourhis et al., 1989 cited in Aarons, 2005) held differing views, maintaining that doctors should provide details at the patient's level of understanding.

According to Bartel et al., (2000) some other barriers to good communication are lack of time, arrogance, shyness and language. Bartel et al., assert that most doctors see a large number of patients every working day. This is true of both government and private hospitals. History taking, physical examination, and prescription writing are of course, crucial parts of a clinical encounter. When time is short, it is the communication with patients that is sacrificed (Bartel et al., 2000). Again, (Bartel et al., 2000) point out that arrogance is deeply ingrained in some doctors. They expect their patients to follow commands wholeheartedly yet they do not understand the need for explanations, and often give none. In addition, shyness could also be a barrier to communication where the patients may be very shy and not ask the questions they have on their minds. On the other hand, the doctor may be shy, and either ignore questions, or give minimal and incomplete answers. Shyness on either side stands in the way of suitable information being communicated (Bartel et al., 2000).

Lastly, in any major city, there is likely to be a large population of people from other ethnic and linguistic groups. Communication with them can be a problem, and needs a

special effort. Communication between health care providers and patients is difficult, even when everyone speaks the same language. When patients and health care providers are not able to communicate clearly and effectively with each other, the quality of care suffers (Karliner et al., 2007).

2.4.4 Patients' Self-Disclosure Patterns

The process of sharing personal information with another person can be termed as self-disclosure (Cozby, 1973). Writing down of private information that will be read by another person (i.e., written disclosure) is also considered self-disclosure (Barak & Gluck-Ofri, 2007; Ignatius & Kokkonen, 2007; Joinson, 2001; Joinson, Paine, Buchanan & Reips, 2008). According to Omarzu (2000), during doctor-patient communication, the private information discussed at the history taking stage may concern facts about oneself, personal opinions and attitudes, or information about moods and emotions.

Self-disclosure has also been linked to health benefits, with more disclosure of traumatic experiences improving health outcomes (Pennebaker & Beall, 1986; Pennebaker, Kiecolt-Glaser & Glaser, 1988). The intensions behind a patient's self-disclosure patterns becomes higher when the risks involved are lower and when the patient is confident that the information shared will not be used against them.

The interaction that exists between doctors and patients according to Julliard et al. (2008) is a vital determinant of the success of the doctor-patient consultation. The information communicated by patients to doctors during the consultation process is very crucial to diagnosis and treatment decisions in the doctor-patient encounter (Hall et al 2002). If patients don't feel at ease and encouraged to talk freely they might

never divulge problems that are troubling them, or express their worries and concerns. It is however likely that some patients who feel very embarrassed or worried about a problem will initially present with a condition that does not give rise to these feelings. Whether such patients disclose the real problem that is troubling them, or whether this remains hidden, most often depends on what they identify as the general atmosphere of the consultation and the opportunities available for discussion. The ability of some patients to either share or withhold information during the consulting process could be attributed to the trust the patient might have for the doctor.

Trust is a vital element in the doctor-patient relationship (Mainous et al. 2004; Sheppard et al. 2004). It promotes improved patient quality of life, devotion to treatment plans, satisfaction with health care, greater use of preventive clinical services, and better health outcomes (Hall et al., 2002; O'Malley et al., 2004). Without trust, the doctor-patient relationship may not become firmly established, thus possibly hindering the doctor's ability to help patients.

2.4.5 Doctor- Centred vs. Patient-Centred Communication

The flow of information between a doctor and a patient involves active and passive elements. According to Byrne and Long (1976) cited in Morgan (2003), in doctor-patient communication however, there are two types of communicative behaviors: instrumental (task-focused), and affective (socio-emotional) communication. These two models have also been described as doctor-centered and patient-centered communication.

A doctor-centred consultation is based on the notion that the doctor is the expert and it is only required of the patient to cooperate (Byrne & Long, 1976; as cited by Morgan, 2003). Mostly, doctors who adhere to this approach focus mainly on the physical aspects of the patients' disease and assume a tightly controlled interviewing method to draw the required medical information from the patient. Questions doctors ask are mainly of a 'closed' nature, such as 'how long have you had the pain?' and 'is it sharp or dull?' These questions aim to provide information to enable the doctor to interpret the patient's illness within his or her own medical disease context, while providing little opportunity for patients to express their own beliefs and concerns. In doctor centred consultations the doctor's medical skills and knowledge predominates, and it's reflected in the doctor's behaviours and in giving directions. These serve the doctor's control needs (Mead & Bower, 2000).

2.4.6 Patient-Centred Communication

According to Redman, (2004) Patient-Centred Care is 'treating the patient as a unique individual'. It can also be explained as a normal practice that demonstrates a respect for the patient, as a person (Binnie & Titchen, 1999; Shaller, 2007). Patient-centred care takes into consideration the patient's point of view and circumstances in the decision-making process, and it goes way beyond merely setting goals with the patient (Ponte et al., 2003). Patient-centredness also refers to a style of doctor–patient encounter which is considered as being responsive to patient needs and preferences, using the patient's cognizant wishes to guide activity, interaction and information-giving, and shared decision-making (Rogers et al., 2005). It is a way of viewing health and illness that affects a person's general well-being and an attempt to empower the patient by expanding his or her role in their health

care. Fulford et al., (1996) are of the view that the basic functions of patient-centred care is to make the patient more informed, and providing reassurance, support, comfort, acceptance, legitimacy and confidence.

Patient-centred care according to McCormack & McCane, (2006) delivers care to the patient through a range of activities which includes taking into consideration patient's beliefs and values, engagement, having a sympathetic presence, and providing for physical and emotional needs. Taking into consideration the patient's beliefs and values strengthens one of the important principles of patient-centred care. This is carefully related to shared decision-making and facilitating patient participation through giving information and integrating newly formed perspectives into care activities (Stewart, 2001). Patient-centred care assumes that the patients are qualified to decide their own needs and expectations, and that they are able to make decisions and choices about what they need and want (Lutz and Bowers, 2000). The provision of PCC is to educate patients of appropriate health advice so that they can make informed decisions about their health care (Coulter, 2000).

2.5 Patient Satisfaction

The effectiveness of the doctor-patient encounter is shown to be highly linked with patient satisfaction with health care services. In a study conducted by Jackson (2001) involving 500 patients who were seen by 38 primary care clinicians for physical symptoms, aspects of doctor- patient communication such as "receiving an explanation of the symptom cause, likely duration, and lack of unmet expectations" were found to be the key factors of patient satisfaction . In another review of 17 studies by the Cochran Library that was conducted to study the effects of interventions directed at health care providers to promote patient centred care, training

health care providers in patient focused approaches was shown to influence positively on patient satisfaction with care (Lewin, 2002). Patient satisfaction is a key area that merits attention because dissatisfaction with health care services can result in complaint against doctors by patients, unwanted health care expenses owing to frequent visits, both can be very costly for the health care system.

Though much importance has been put on the significance of effective communication and good doctor-patient communication in affecting patient health outcomes and satisfaction, doctor's satisfaction with their professional life can also be a vital factor in a good doctor-patient communication. Grembowski et al., (2004) asserts that doctor's satisfaction with their professional life was linked with greater patient trust and confidence in their primary care outcomes. Hall & Dronan, (1990) posits that doctors who are themselves more fulfilled may be better able to address patient's concern. Doctors who are themselves fulfilled with their professional life may have more positive effect, which may subsequently affect their communication with patients which then affect patient satisfaction.

The particular mechanism for how doctor satisfaction is related to patient satisfaction is not known, even though scholars have suggested that both could be affected by a third factor such as one's personality an attribute that relates to both empathic and communication skills await further research (Roter et al., 1997). All these studies emphasised the significance of communication and the role of a good doctor patient relationship in cushioning against patients' dissatisfaction with health services.

2.6 Code of Ethics Ghana Health Service

The Ghana Health Service is guided by a code of conduct that helps shape the medical practitioners who are found in that organization. The Code of Ethics for the Ghana Health Service (GHS) defines the general, moral principles and rules of behavior for all service personnel in the Ghana Health Service. The following are the code of ethics guiding the medical profession among others. These include and not limited to the following: that all Service personnel shall be competent, dedicated, honest, client-focused and operate within the law of the land. Service personnel shall respect the Rights of patients/clients, colleagues and other persons and shall safeguard patients'/client' confidence. All Service personnel shall work together as a team to best serve patients'/clients' interest, recognizing and respecting the contributions of others within the team. Again all Service personnel shall co-operate with the patients/clients and their families at all times. No service personnel shall discriminate against patients/clients on the grounds of the nature of illness, political affiliation, occupation, disability, culture, ethnicity, language, race, age, gender religion, etc. in the course of performing their duties. Also all Service personnel shall respect confidential information obtained in the course of their duties. They shall not disclose such information without the consent of the patient/client, or person(s) entitled to act on their behalf except where the disclosure of information is required by law or is necessary in the public interest. In addition, all Service personnel shall provide information regarding patient's condition and management to patients or their accredited representatives humanely and in the manner they can understand.

2.6.1 The Patient's Rights

The Ghana Health Service is for all people living in Ghana irrespective of age, sex, ethnic background and religion. The service requires collaboration between health workers, patients/clients and the society. Hence health facilities must therefore provide for and respect the rights and responsibilities of patients/clients, families, health workers and other health care providers. They must be sensitive to patient's socio-cultural and religious backgrounds, age, gender and other differences as well as the needs of patients with disabilities. This is made to protect the Rights of the patient in the Ghana Health Service therefore it addresses: the patient has the right to quality basic health care irrespective of his/her geographical location. Entitled to full information on his/her condition and management and the possible risks involved except in emergency situations when the patient is unable to make a decision and the need for treatment is urgent. Further, it is the right of the patient to know of alternative treatment(s) and other health care providers within the Service if these may contribute to improved outcomes. Again, the patient has the right to privacy during consultation, examination and treatment. Additionally the patient is entitled to confidentiality of information obtained about him or her and such information shall not be disclosed to a third party without his/her consent.

2.7 Theoretical Framework

Generally, principles from different theories can be used to explain the findings from a phenomenological study into doctor-patient communication in consulting rooms at the Cape Coast University Hospital and the University of Education, Winneba Clinic in the Central Region of Ghana. However, the researcher found the following two

theories, Facework and Politeness Theories, as more relevant to the study. The following sections provide discussion of the two theories.

2.7.1 Facework Theory

As part of the process of socialization humans learn to interpret utterances using knowledge of the social rules which govern interaction, shared background information with the speaker, our general powers of rationality and inference, and the principles of cooperation (Malmkjær, 1991; Spiers, 1998). Knowing how and when to modify one's language is an important aspect of language proficiency.

Face is a social phenomenon; it comes into being when one person comes into the presence of another. As first proposed by Goffman, the notion of face represents the social identities people claim for themselves or attribute to others (Thomas, 1995). As Goffman explained, face is "the positive social value a person effectively claims for himself by the role others assume he has taken during a particular contact" (Brown & Levinson 1987 cited in: Holtgraves 1992: 141). Ting-Toomey (2001) on the other hand describes face as ''a claimed sense of desire for social self-worth or self-image in a relational situation'' (p. 19). Generally, face indicates our self-image with regard to the public. Face is not our actual image but what others see when we interact with them. It is the self-image that ''we wish to project concerning our social position, social status, and credibility and what we perceive to be the way others see us as a result'' (Ginkel, 2004, p. 476). Face is an important part of social interaction in everyday life, as we want to uphold, maintain, or save our face in almost every type of social interaction.

Our face is damaged when we are teased or criticized, while our face is enhanced when we are complimented. Many social scientists have recognized that this inborn desire to maintain a positive self-image significantly influences people's emotions and decisions when they face disputes for example, negotiation and conflict management (Spiers, 1998; White, Tynan, Galinsky, & Thompson, 2004) and that much of what happens in daily communication for example, politeness, complimenting, apologies can be considered ''facework'' designed to maintain face for self and others (Bond, 1991; Garcia, 1996).

Another school of thought perceives Facework in two forms: face support and face attack. Face support or face giving is ''the facework which actively promotes the given face want of the other'' (Lim, 1994, p. 213). Face support is usually carried out through compliments or expressions of admiration for the other's achievement or abilities and is generally aimed to provoke favorable emotion from the hearer. By contrast, facework can also be employed to attack face. Tracy (1990) defined facework as the ''communicative strategies that are the enactment, support, or challenge of those situated identities'' (p. 210). Face-challenging tactics are commonly observed in the context of dispute or negotiation. One may challenge the others' face through showing disrespect to the other party to hold them in low status, esteem, and standing (Lim, 1994). Through this tactical move, one may expect to gain a more preferable position or enhanced power in conflicts.

Also Thomas (1995) posits that facework is a routine part of a social matrix in which behavior is a response to internalized norm, one has the opportunity to construct different faces for different audiences. Subsequently, faces can be damaged in various

ways. For that reason, face maintenance is an important aspect of social interaction. Actions that catch people out of face have impact not only for the actor but also for the interaction and the social structure.

According to Goffman (1959) cited in Spiers (1998) facework can be classified into two groups as avoidance processes and corrective processes; "Avoidance process" stands for efforts to avoid negative impressions and prevent threats to self's or others face. People engaging in avoidance processes often avoid situations that could be embarrassing or humiliating and thus forgo certain opportunities to convey favorable impressions. Avoidance-based maneuvers according to Goffman are diverse. Avoidance processes can be considered a rather passive form of attempts to create a desirable impression. In contrast to avoidance process", the corrective process involves individuals' attempts to correct undesired identities or to minimize the damage after an attack or threat to one's face.

2.7.2 Facework in Doctor-Patient Interaction

Facework is the actions a doctor and patient take to either maintain face or save a threatened face. Goffman (1959) grouped facework into the avoidance process, where persons avoid contexts where face threat has occurred and individuals attempt to restore face. These ideas of face can be applied when looking broadly at doctor-patient communication in consulting rooms. The patient enters the interaction with a face, which has developed through previous interactions with their doctors as well as from the patients' view about their own health, their abilities to understand the information discussed with the doctor and subsequent ability to communicate concerns and questions effectively. The doctor however also enters the interaction

with a face, defined as how he/she sees him/herself as a doctor in relation to all patients, as well as to a specific patient. As agents in a social interaction, both parties are likely to show concern for the others face.

According to Spiers (1998) positive face is enhanced by giving and receiving affection, solidarity, positive evaluations, and appreciation of individual qualities by showing understanding. This aspect of face is threatened by things such as violent and negative emotions, disapproval, criticism, taboo subjects and non-cooperation, which in turn threaten the individual's self-esteem, belonging and competence. Negative face is threatened by imposing on the individual's desire for autonomy, territoriality and independence in thought and action (Spiers, 1998); for example, by putting the hearer in a position whereby cooperating causes inconvenience, but where failure to do so would offend. Negative face is enhanced by respecting the individual's need for privacy and independence, giving the option of not getting involved, respecting hierarchical differences and being polite.

Within an interpersonal interaction, such as health care interaction, both a doctor and a patient are concerned with, and even attached to their face. Goffman stated the information given during an interaction that establishes a better face than one has assumed for him or herself will lead to positive feelings, while information consistent with one's face will probably go unnoticed (Lim,1994). Discomforting information transmitted during an interaction may damage one's face, resulting in sadness or hurt feelings

In therapeutic encounters, where doctors and patients discuss the severity of patients' illnesses, as well as lifestyle changes, there are frequent opportunities for patients to interpret what their doctors say as face threatening. On the other hand, doctors threaten patient 'face' when conveying bad news. Furthermore, when doctors prescribe treatment programs, they may limit patients' lifestyle choices and so, violate face.

2.8 Politeness Theory

Understanding and describing the idea of linguistic politeness can be quite challenging. The confusion can be identified in the linguistic and lay usages of the term, and also those writing about linguistic politeness have a tendency not to specify what they mean by the term (Eelen, 2001; Fraser, 1990; Sifianou, 1992; Watts, 2003). Politeness occupies two different fields within linguistics. The first area is concerned with the conventional, lay understanding of politeness. In this context "politeness" refers to the everyday concept of politeness i.e. good manners, or one's ability to be considerate or courteous (Fraser, 1990), the opposite of being rude. This view of politeness has been referred to as first order politeness (Watts, 1992) or the social-norm view (Fraser, 1990).

Interest has emerged in a different aspect of politeness known as second order or linguistic politeness, in recent times (Watts, 1992) which is aimed at explaining the structure and indirectness of verbal communication (Spiers, 1998). From this standpoint, politeness is commonly viewed as a concept referring to the strategic management of conflict-avoidance, one which involves social indexing (Eelen, 2001:29) and functions as a means of managing social relations.

2.8.1 Grice's View on Politeness Theory

The field of linguistic politeness appears to have developed largely as a response to Grice's theory (Fraser 1990) that the prevailing principle in conversation was the "Cooperative Principle" (Grice 1975 cited in: Wardhaugh, 2006: 287). The success of conversations depends, in part, upon cooperation, to a mutual commitment to making the interaction work. Grice (1989) identified four principles (known as Grice's Maxims) which influence the way in which people speak and its subsequent interpretation. These are quantity, quality, relation and manner.

According to Grice (1989) quantity should be as informative as possible, that is too much information should not be provided. Again quality should be true, meaning one should not say things believed to be false or for which there is insufficient evidence. Also, relation should be relevant and lastly, manner should be clear - one should not use obscure expressions or be ambiguous, one should be brief and orderly. Grice's maxims were based on the belief that, generally speaking, speakers' primary concern was efficiency. Fraser (1990) points out that, Grice's logical maxims failed to explain why in reality these rules were often flouted in ways that were actually considered to be socially acceptable.

2.8.2 Robin T. Lakoff's View on Politeness

Lakoff, (1979) defines politeness as "a system of interpersonal relations designed to facilitate interaction by minimizing possible conflict and confrontation inherent in all human exchange" (Eelen, 2001:2). (Lakoff, 1979 cited in Fraser, 1990) identified different types of politeness: Formal/Impersonal Politeness, Informal Politeness and Intimate Politeness.

Lakoff again emphasized the significance of context and the possibility of utterances being interpreted in more than one way (Lakoff, 1972 cited in Spiers, 2000). Her criteria demonstrate that if, for example, the main goal of an utterance is the message, then the emphasis of the speech act will be on clarity; whereas politeness will become the emphasis if the status of the participants and/or the situation is the speaker's main concern (Spiers, 2000). One of the limitations identified in relation to Lakoff's theory is that she is said to use terms such as formality and aloofness to mean politeness without defining them, when in actual fact such behaviours are not always intended to convey politeness (Spiers, 2000).

2.8.3 Geoffrey Leech's View on Politeness

Leech (1983) cited in Watts (2003) deals with politeness as part of interpersonal rhetoric. Building upon Grice, he claims that politeness is necessary to ensure that communication will be successful. It involves a violation of Grice's conversational maxims of achieving maximally efficient communication, and sees it not only as strategic conflict avoidance but also as the establishment and maintenance of friendliness. Sifianou (1992) cited in Watts (2003) points out that meeting the needs of others, for example, by attending to face, not only acts as a model for others to follow, but also instills in individuals a sense of satisfaction. Common to many of the differing views pertaining to politeness theory is the idea that politeness is a strategic means of conflict management involving social indexing (Eelen, 2001). Leech's (1983) cited in Fraser (1990) contribution to this view of politeness was to provide explanations for the factors which guide and constrain conversations by elaborating on Grice's. His work, along with that of Lakoff (1972; 1973; 1979) and Brown and Levinson (1987) have been described as forming part of the "core" of politeness

research (Eelen, 2001: 23). His principles focus on the importance of minimizing expressions that might be unfavourable to the hearer and maximising those that are more favourable, classifying utterances as either polite or impolite (Fraser, 1990; Watts, 1992).

2.8.4 Brown and Levinson's Politeness Theory

Brown and Levinson (1987) dominate the field of politeness research. As well as being a central piece of politeness research (Eelen, 2001: 23). They view politeness as a complex system for face threatening acts (Sifianou, 1992 cited in: Watts, 2003). Brown and Levinson's (1987) theory of politeness builds on Goffman's (1967) observation that when people interact they constantly worry about maintaining a face (Pinker, 2007). Brown and Levinson (1987: 61) explain face as: "the public self-image that every member wants to claim."

Spiers (1998) points out that, it is important to understand that although face can be compared with the concept of "self," the comparison is of limited use since face does not refer to something that resides within the individual, but rather it is manifested through interactions with others, although as Brown and Levinson (1987: 85) explain, face needs and the performance of facework are not something that one is necessarily conscious of. Spiers (1998) explain that one's sense of self can be enhanced through self-gratification, whereas face-needs can only be satisfied by others. Because of this reliance on others for the satisfaction of face-needs, known as *mutual vulnerability* (Brown & Levinson, 1987: 61), it is in everyone's interest to attend to each other's face-needs. To this end, supporting others' face also goes to attend to one's own face-needs

According to Brown and Levinson (1987) two main strategies for performing speech acts are distinguished: positive politeness and negative politeness. Positive politeness aims at supporting or enhancing the addressee's positive face, whereas negative politeness aims at softening the intrusion on the addressee's freedom of action.

Politeness strategies provide individuals with a range of mechanisms for obtaining cooperation. For example, those of higher status might use positive politeness strategies, such as developing rapport as an indirect means of expressing power (Spencer-Oatey, 2000 cited in Holmes & Stubbe, 2003), a feature that Holmes and Stubbe (2003) refer to as collaborative power.

2.9 Summary

Literature has highlighted strides that have been accomplished in the study of doctor-patient communication in the consulting rooms. In relation to such studies theories such as facework and politeness have been discussed. Within the context of conceptual framework, explanation of communication, types of communication, doctor-patient encounter, effective communication between doctor-patient, barriers to effective communication between doctors and patients, which interrogated the use of medical jargons, length of time, patient disclosure patterns, patient satisfaction, the Ghana Health Service Code of Ethics as well as Patients' rights have been reviewed. However, none of the studies reviewed focused on Health facilities of universities in Ghana; this current study focused on doctor-patient communication in consulting rooms of health facilities at the University of Cape Coast and University of Education, Winneba both in the Central Region of Ghana.

CHAPTER THREE

METHODOLOGY

3.1 Introduction

This section highlights the procedures that were adopted to conduct the study on doctor-patient communication in the consulting room. It includes the research approach, research design, population, sample and sampling technique, data collection, analysis of data as well as the discussion of validity and reliability of the study.

3.2 Research Approach

The study adopted the qualitative approach. In explaining qualitative study, Denzin and Lincoln (1994) state that qualitative implies an emphasis on processes and meanings that are not rigorously examined, measured in terms of quantity, amount, intensity or frequency. For their part, Gay, Mills and Airasian (2009) emphasise that a qualitative study is involved with the collection, analysis and interpretation of comprehensive narrative and visual; that is, non-numerical data to gain insights into a particular phenomenon of interest.

Besides, Lindloff and Taylor (2002) argue that in qualitative approach researchers seek to preserve and analyse the situated form, content and experience of the social action rather than subject it to mathematical or other formal transformations. Qualitative research aims at explaining emerging social phenomena. That is to say, it aims to help us to understand the world in which we live and why things are the way they are (ibid, 2002). According to De Vos et al. (2002), the qualitative research model refers to research that stimulates participant's meaning, experience or

perceptions. Qualitative researchers do not accept the view of a stable, coherent, uniform world. They argue that all meaning is situated in a particular perspective, and because different people or groups often have different perspectives and contexts, the world has many different meanings, none of which is necessarily more valid or true than another (Gay, Mills & Airasian, 2009; cited in Hayford, 2013).

These views have been endorsed by Domegan and Fleming (2007) who explain that qualitative research aims to explore and to discover issues about a problem on hand, because very little is known about the problem. There is usually uncertainty about the degree and characteristics of the problem; the approach uses 'soft' data and gets 'rich' data' (p. 24). Furthermore, Myers (2009) points out that qualitative research is designed to help researchers understand people, and the social and cultural contexts within which they live.

The researcher adopted the qualitative approach because she was interested in understanding how doctors in the hospitals of the universities of Cape Coast and Winneba communicate with patients in their consulting rooms, the reasons informing the manner the doctors communicate with their patients and the experiences of patients, most of whom are staff and students, during consultation with doctors in consulting rooms. The interviews conducted in this study, were recorded and transcribed using a tape recorder. Some open-ended questions were posed which required in-depth responses from interviewees. In these processes useful information that was closely linked to their experiences emerged. The individual responses were analysed, compared and categorised with the results of transcription of the interview, and subsequently interpreted to draw conclusions.

3.3 Research Design

Research design according to Carriger (2000) can be explained as an approach, a plan, and or a way of conducting a research project. The selection of a research design is also based on the nature of the research problem, the experiences of the researcher, and also the audiences that are involved in the study (Creswell, 2007). As a qualitative study, the design adopted by the researcher to explore doctor-patient communication in the consulting rooms at the University of Cape Coast and Winneba hospitals was the phenomenological design. The following sub-section discusses phenomenology.

3.3.1 Phenomenology

Phenomenology has been defined by Langdridge (2007) as a discipline that focuses on people's perceptions of the world in which they live in and what it means to them or people's lived experience" (p.4). Phenomenology is a way to investigate subjective phenomena, and it is based on the belief that essential truths about reality are grounded in everyday experience (van Manen, 1990). According to Littlejohn and Foss (2008) theories under this concept usually assume that people actively interpret their experience and come to understand the world by their personal experience of it. Phenomenologists describe the central principles to this approach as: to determine what an experience means for the persons who have had the experience and are able to provide a comprehensive description of it. From the individual descriptions, general or universal meanings are derived, in other words, the essences of structures of the experience (Moustakas, 1994, p.13)

As Lester (1999) pointed out, the purpose of the phenomenological research is to identify phenomena through how they are perceived by the actors in a situation. This involves gathering ‘deep’ information and perceptions through qualitative methods

such as interviews, discussions and participant observation, and representing the information from the perspective of the research participants. According to Lester (1999) phenomenology is concerned with the study of experience from the perspective of the individual. Phenomenological studies are powerful for understanding subjective experience, gaining insights into people's motivations and actions, and cutting through the chaos of taken-for-granted assumptions and conservative wisdom. Phenomenological methods are particularly effective at bringing to the fore the experiences and perceptions of individuals from their own perspectives, and therefore at challenging structural or normative assumptions (Lester, 1999).

As discussed earlier in the section on research approach, the researcher focused on understanding the experiences of doctors and patients of the two university hospitals during consultations at the consulting rooms. The study would highlight how doctors communicate with their patients, why they communicate in the manner they do, and how the patients feel during the communication with their doctors in the consulting rooms.

3.4 Scope of the Study

The study was organized in two (2) public universities in Ghana; the University of Education, Winneba Clinic (UEW) and the University of Cape Coast (UCC), Hospital. The choice of universities was based on reasons of proximity and the researcher's familiarity with some staff of the two universities, which allowed for easy and quick access to information, and the fact that these two universities are among the popular universities in Ghana.

3.5 Population

Brynard and Hanekom (2005) explain that in research methodology, 'population' refers to the objects, subjects, phenomena, cases, events or activities specified for the purpose of sampling. A population is the total group of subjects that meet a designated set of criteria. Polit and Hungler (2004) distinguish between the target population and the accessible population. The target population includes all the cases about which the researcher would like to make generalisations. The accessible population, on the other hand, comprises all the cases that conform to the chosen standards and are available to the researcher as a pool of subjects for a study. In this study the target population included all doctors of the University of Education Clinic, Winneba and Cape Coast University Hospital as well as patients who attended the hospitals' outpatient department during the period of the study.

3.6 Sample and Sampling Technique

Since the study adopted the qualitative approach and phenomenological design the researcher used a non-probability sampling technique to select participants for the study. Qualitative sampling involves the selection of participants for a study in a manner that the individuals chosen would be key informants or respondents who would contribute to the researcher's understanding of a given phenomenon (Gay, Mills & Airasian 2009; cited in Hayford 2013). According to Hayford, the characteristics of key informants include the ability to be reflective and thoughtful, to communicate orally and/or in writing effectively and comfortably with the researcher at the research site. In line with this, the purposive sampling technique, which according to Wimmer and Dominick (2006) include specific types of people who can provide the desired information and also possess specific characteristics was adopted.

The researcher purposively selected six medical doctors who were willing to participate in the study and 23 patients at the Winneba University Clinic and Cape Coast University Hospital. Individuals who were willing to participate in the study, and were able to provide specific information regarding the research questions were included (Creswell, 2007; Lindlof & Taylor, 2011; Patton, 1999). The researcher also included both male and female respondents in the sample in order to capture the views of both sexes.

3.7 Methods for Data Collection

The researcher adopted semi structured interview as the main tool for data collection. The choice of semi-structured rather than structured interview was because it offered sufficient flexibility to approach different respondents differently while still covering the same areas of data collection. Thomas, Walker and Webb (1998) suggest that semi-structured interviews when employed enable respondents to shift the agenda and contribute their own line of thought as they wish to do so. The aim was to obtain accurate uninhibited accounts from informants that were based on their knowledge and experience. Furthermore, as Fetterman (1998) suggests, the use of semi-structured interviews also enables the researcher to explore further interesting dimensions that are not anticipated prior to the interviews. This view is endorsed by Kitchin (2000) who states that interviews allow respondents to 'express and contextualize their true feelings rather than having them pigeon-holed into boxes with little or no opportunity for contextual explanations' (p. 43).

Additionally, Wragg (2002) notes that this instrument allows the interviewer to ask initial questions, followed by probes meant to seek clarification of issues raised. It has

features of both structured and unstructured interviews and therefore use both closed and open questions. As a result, it has the advantage of both methods of interview. In order to be consistent with all participants, the researcher had a set of pre-planned core questions for guidance such that the same areas were covered with each interviewee. For example, the researcher focused on issues such as rapport, language, time, patient's view and feeling about doctor's communication with them. However, as the interview progressed, the interviewee was given opportunity to elaborate or provide more relevant information as they opted to do so.

The interviews with the doctors and patients lasted between 25 to 40 minutes. All interviews were conducted with the aid of an interview guide. (See Appendix A). Again the interviews were recorded with the recording application on the researcher's mobile phone. The recorded interviews were played back over and over again before eventually transcribing them. After transcribing was done, the researcher did a close reading of the text paying particular attention to issues that centred on the research questions and objectives. Emerging themes were then generated from the issues.

The researcher again created rapport with the respondents in order to put the respondents in a relaxed mood for the interview. An informal approach was adopted by the researcher, which according to Lindlof and Taylor (2002), sets the tone that relaxes individuals, making it more comfortable for them to share their intimate thoughts. Some techniques which the researcher adopted to create rapport among respondents include an introduction of the researcher of herself to the respondents, researcher's clarity of purpose for the research, and encouraging the respondents to bring up issues that could be relevant to the research topic.

3.8 Data Analysis and Procedure

Bogdan and Biklen (2003) define qualitative data analysis as working with the data, organising, breaking them into handy units, coding, synthesizing, and searching for patterns. The primary objective of analysis of qualitative data is to discover patterns, concepts, themes and meanings. Yin (2003) discusses the need for searching the data for patterns which may explain or identify links in the data base. In the process, the researcher concentrates on the whole data first, and then attempts to take it apart and re-construct it more meaningfully. Categorisation helps the researcher to make comparisons and contrasts between patterns, to reveal certain patterns and complexities of the data and make sense of them.

In order that the researcher's identity comes to the fore to avoid doubts and suspicions, an introductory letter was acquired from the researcher's department; Communication and Media Studies, UEW, Winneba. The introductory letter was used to gain access to the field where the data was collected. The researcher scheduled interview dates and times with interviewees, depending on the convenience of the latter. The traditional face-to-face interview as indicated by Giorgi (2009) was used for the study. The researcher also used probes to get the respondents to further clarify some statements made in their responses. Field notes were also taken to supplement the interviews conducted.

Data analyses done were aimed at preserving the distinctiveness of individual interviewee's lived experiences while allowing an understanding of the phenomenon under study. The first interview conducted began the process of data analyses. A vital consideration in this study was to clarify biases about the phenomenon under study.

This is in tandem with Tesch (1992) who explains it as "bracketing" which signifies, suspending the researcher's meaning and understanding of a phenomenon and entering into the world of the interviewee. The recorded interviews were played and transcribed. The transcripts were thoroughly read through while the researcher underlined and noted all vital issues relevant to the research questions.

The relevant issues were categorized according to their similarities, and then developed into themes for the discussion. The themes that emerged include**;** the nature of doctor-patient communication in consulting rooms, language usage and posture of doctors and Doctor's communication skills among others.

In interpreting the data, the researcher identified emerging issues as they were narrated by respondents, how the issues relate to each other, also meanings were drawn and discussed. The researcher again identified important accounts, which she used to substantiate her claims in the analysis and discussions of the issues.

3.9 Ethical Issues

The researcher identified some issues that came up for consideration relating to confidentiality and anonymity. That is even though the consent of respondents were sought for their participation in the interviews, some patients and a doctor refused to be recorded during the interview but preferred notes taking. According to the doctor, he didn't want his voice in any recording since he didn't want any surprises in the future. However respondents were assured of their privacy, anonymity and confidentiality, since some of the responses were considered personal and confidential. For example, individual respondents were neither named nor were their

responses credited to their institutions; rather all responses were linked to codes, to ensure that respondents' privacies were protected.

3.10 Validity and Reliability

Commenting on issues relating to validity and reliability, Brannen (2005), Spencer, Lewis and Dillon (2003) cited by Hayford (2013) argue that universal agreement seems to have been reached that quality concepts developed for quantitative research such as generalizability, validity, reliability and replicability should not be applied to qualitative research. Rather, drawing upon Lincoln and Guba (2000), broadly equivalent concepts can be found and apply to qualitative research. For example, credibility, trustworthiness - internal validity; fittingness- external validity and auditability - reliability. For their part, Cohen and Crabtree (2006) state that validity might be addressed through honesty, depth, richness and scope of the data achieved, the participants approached, the extent of triangulation and the disinterestedness or objectivity of the researcher. In line with these suggestions, in the current study the researcher gave back copies of typed transcripts of doctors to verify whether or not their views were captured as they were expressed. Also, the researcher checked the tapes with her supervisor and other course mates to ensure that the content were the same as what had been used in the presentation of results. Finally, records on dates for the interviews have been documented for audit and verification.

Again this study provided a detailed account of field experiences through Rich, thick description. Thick description according to Holloway (1997) refers to the in-depth interpretation of field experiences; in other words, paying attention to contextual details when observing and interpreting social meanings in qualitative research. A

thorough account of field experiences had been included in relevant sections of the study. Thus, the researcher did a vivid description of the actual lived experiences of doctor-patient communication in the consulting rooms of the two universities.

3.11 Summary

Chapter four introduces the methods used to gather data for the study. The reasons for the choice of research design and approach are explained. The various steps outlined include the research design, sampling technique, methods for data collection, data analysis and procedure, ethical issues and validity.

CHAPTER FOUR

FINDINGS AND DISCUSSIONS

4.1 Introduction

This chapter presents the analysis of data and discussion of findings with respect to a phenomenological study on doctor-patient communication at two health facilities namely, University of Cape Coast Hospital and the University of Education, Winneba Clinic. As a phenomenological study, the researcher used semi structured interviews to address the following three research questions:

1. How do doctors communicate with patients in the consulting rooms?
2. What factors influence the manner in which doctors communicate with patients in the consulting rooms?
3. What are the perceptions of patients on how doctors communicate with them in the consulting rooms?

The subsequent section provides the demographic data of the participants in the study. For the purpose of ensuring participants' anonymity the researcher used pseudonyms for all the participants; however, the statements were verbatim quotes from the participants (doctors and patients).

4.2 Demographic Data of Participants

As stated in Chapter three a sample of 29 comprising six doctors and 23 patients from the two health facilities, University of Cape Coast Hospital and University of Education, Winneba Clinic was used for the study. Four doctors and 14 patients were interviewed at University of Cape Coast Hospital, while two doctors and nine patients were interviewed at the University of Education Winneba, Clinic. The disparities in

the number of participants from Cape Coast and Winneba as explained in Chapter Three were due to the differences in the status of the medical facilities in the two universities. While University of Cape Coast has a hospital with a total of 19 medical doctors, the University of Education, Winneba has a clinic with only two medical doctors one of whom is on post retirement contract. Table 4.1 highlights the details of the background of the medical doctors who participated in the study.

Table 1: Medical Doctors and Areas of Specialization

Facility	**Number of Doctors**		**Area of Specialization**
	M	**F**	
UCC Hospital	2	2	General Medicine
UEW Clinic	1	1	General Medicine & Critical Care Specialist

Table 4.1 shows that six medical doctors participated in the study. Four of the doctors, comprising two males and two females were interviewed at the University of Cape Coast Hospital and two doctors, who were a female and a male, were interviewed at the University of Education, Winneba Clinic. Besides, while all the four medical doctors from the University of Cape Coast Hospital were General Practitioners, the Clinic of the University of Education, Winneba had a general practitioner and a Critical Care Specialist. The results show that one of the six medical doctors was a specialist.

With respect to working experience or practice, the six medical doctors had worked from 2 to 32 years. Table 4.2 highlights the details of the working experiences of the medical doctors.

Table 2: Working Experience of Medical Doctors

Doctor	Medical Facility	No. of years in Practice
Dr. Roy	UCC	30
Dr. Doh	UCC	15
Dr. Odo	UCC	4
Dr. Atta	UCC	2
Dr. Han	UEW	32
Dr. Fue	UEW	14

As shown in the table (4.2) four of the six doctors who were interviewed had practiced for 14 to 32 years and were therefore experienced or senior medical doctors; while two of them were young doctors, who had few years of working experience ranging from 2 to 4 years. The most experienced medical doctor, who had 32 years of working experience, works at the University of Education, Winneba Clinic. Also, the two less experienced or young medical doctors were both at the University of Cape Coast Hospital, where they had experienced medical doctors to mentor them. Table 4.3 highlights detailed background information on the patients who were interviewed.

Table 3: Distribution of Patient-Interviewees

Location	No. of Patient Interviewees		Total
	F	M	
UCC	6	8	14
UEW	5	4	9
Total	**11**	**12**	**23**

From Table 4.3 above, 14 patients were interviewed at the University of Cape Coast Hospital while nine patients were interviewed at the University of Education, Winneba Clinic. Among the interviewees, 11 were females and 12 were males. The next table (4.5) provides information on the age ranges of the patients who participated in the interviews.

Table 4: Age Distribution of Patients

Age	No. of Patients
18 - 23 years	13
24 – 29 years	8
30 – 35 years	1
36 – 41 years	1
Total	**23**

Table 4.6 reveals that majority of the patient (13) interviewees were within the age range of 18 – 23 years; eight patients were within the age range of 24 – 29 years, a patient each was in the age ranges of 30 – 35 years and 36 – 41 years. Thus, the patient-interviewees were mostly young adults with only two of them being in the middle age range (30 – 41 years). Young adults in this context refer to individuals

who were above 20 years of age but below 30 years at the time the study was conducted. The next table highlights the types of ailment that the patient-interviewees reported.

Table 5: Types of Ailments Reported

Type of ailment	**No. of Patients**		**Total**
	F	**M**	
Malaria	6	2	8
Menstrual Disorders	3	0	3
Skin Rashes	0	2	2
Stomach Discomfort	0	2	2
Candidiasis	1	0	1
Eye Problem	0	1	1
Pain in the breast	1	0	1
Painful urination	0	1	1
Prostate enlargement	0	1	1
Surgery Complication	0	1	1
Non-Disclosure	0	2	2
Total	**11**	**12**	**23**

Malaria appeared as the most predominant ailment that the patient-interviewees reported to the two health facilities. Of the 23 patient-interviewees over a third, that is, seven of them, comprising six females and one male reported of malaria. This was not strange because malaria is endemic in the entire country, including Cape Coast

and Winneba; malaria is a major cause of death in pregnant women and children under five years of age (Ghana DHS, 2008). Malaria is by far the leading cause of diseases and death in all age groups in the country (GHS, 2007).

According to Ghana DHS, nationally, there are more than three million suspected cases of malaria, which account for 30-40% of outpatient treatment. The second predominant ailment was menstrual disorders, which was reported by three patients. Besides, two patients reported of skin rashes and stomach discomfort respectively; while a patient each reported of candidiasis, eye problem, pain in the breast, prostate enlargement, painful urination, and surgery complication respectively. However, two male patients declined to disclose their ailment. The focus on the nature of ailment reported by patients was to ascertain whether the nature of ailment also influenced the manner patients communicated with doctors in the consulting rooms.

The subsequent sections highlight issues that have been extracted from the data to address the three research questions which were formulated to guide the study.

4.3 The Nature of Doctor-Patient Communication in Consulting Rooms

The broad themes, which were extracted from data in respect of the three research questions, were: reception and rapport, language and posture, and level of satisfaction; that is, the prologue, dialogue and post dialogue. These themes were the refinement of views of respondents through examination and re-examination of the data from the transcriptions of the doctors and patients who participated in the phenomenological study. The sections provide a holistic picture of communication between doctors and patients from reception to treatment. Also, as explained in Chapter Two, Facework

and Politeness theories were found apt in providing insights into doctor-patient communication in the consulting rooms.

RQ1: How do doctors communicate with patients in the consulting rooms?

By way of addressing this research question, the focus was on the prologue and data from doctors' reception and establishment of rapport with the patients were used.

4.3.1 Doctors' Reception and Rapport with Patients

From the literature, Malmkjær (1991) and Spiers (1998) have explained that inherent in the process of socialization is humans' ability to interpret utterances using knowledge which govern interactions, shared background information, general power of rationality and inferences as well as the principle of cooperation. Also, a key component of language proficiency is the knowledge of how and when to modify one's language. These aspects are the tenets of Facework and Politeness theories. The term 'face' is a social construct or phenomenon which comes to the fore when people engage one another (Thomas, 1995). It is the self-image that humans project to the public, and it can be positive or negative (Van Ginkel, 2004). In terms of politeness, it is where the individual exhibits behaviour that is consistently considerate, courteous and good manners (Fraser, 1990; Watts, 1992).

During the phase characterized as reception and rapport, prior to examination and diagnosis, both doctors and patients assume a 'face', which has been developed through previous interactions. While patient's face is indicative of their view about their own health, their ability to understand the information discussed with the doctor

and subsequent ability to communicate concerns and question effectively; the doctor, on the other hand, enters the interactions with a face, defined as how they see themselves in relation to all patients as well as a specific patient. Thus as agents in a social interaction, both doctors and patients are conscious of each other's face (Goffman, 1959).

For instance in the current study, the doctors stated that they were receptive to patients who visited their consulting rooms for treatment. They welcomed patients with compliments and offered them seat before interrogating the patients concerning their illness. This is a demonstration of positive face (Spiers, 1998) and politeness, that is, being considerate or courteous (Fraser, 1990; Watts, 1992, 2003). Positive face and politeness reverberated in the transcriptions of all the doctors as captured in some of the statements below:

> Hello, you welcome, good morning sit down; and some of them (referring to patients) will greet me in Fante … I respond and then I ask what brings you here. However, when they enter and I find that the patient is stressed as a result of waiting for long what I do is that because I'm not too familiar with the Fante language … I say a word in Fante to make the patient feel at ease to talk to me. Or sometimes with the kids I make them watch cartoons so that they relax. I always bring my laptop to the consulting room (Dr. Roy).

> First of all, they knock and I ask them to enter they greet and I respond then I give them a seat then the entire chain starts (Dr. Atta).

> I greet them first good morning, good afternoon depending on the time of day. Then I check on the folder before me to make sure the name is the right person sitting in front of me then I ask them what brought them here (Dr. Odo).

> I welcome them and ask them to sit down and I ask them of their complaint (Dr. Fue).

The analyses revealed similarities in the reception accorded patients by the medical doctors from the two universities' health facilities.

4.3.2 Patients' Experiences of Doctors' Reception

For the part of the patient-interviewees the experiences were mixed. While some of the patients corroborated the views from the doctors, others expressed hostile experiences during their encounter with doctors in the consulting rooms. These disparities in patients' encounter with doctors in the consulting to a large extent influence their level of satisfaction derived from the services received from the health facilities (Acquah, 2011; Arora, 2003; Duffy, Gordon, Whelan & et al., 2004; Fong Ha, 2010;). The analysis revealed that out of the twenty-three patients interviewed, eleven of them were accorded warm reception from the doctors they consulted, which confirmed the positive face and politeness that emanated from the doctors. In this context, the positive face was not projected by the doctors but rather ascribed to the doctors by the patients. For example:

> The doctor asked me how I am faring, what brings me to the hospital … he is very welcoming… (P16 UEWC)

> The doctor was friendly and nice; he made me feel relax and I was able to open up (P7 UCCH).

> When I got into the consulting room the doctor was very receptive. He acted as a father trying to chat me up. I liked the way I was received (P13 UCCH).

> When I entered the consulting room the doctor spoke in a very relaxed manner. He treated me well; I liked it. (P5 UCCH)

> When I entered it was in the morning. She was smiling and kind she asked me what was wrong with me. (P19 UEWC)

The patients were accorded warm reception. Warm reception in this context refers to a doctor making a patient feel she/he is welcomed, a doctor smiling while exchanging greeting with patient, expressing friendship, being nice and speaking calmly to patients. Furthermore, as reported by P13UCCH … *he acted like a father trying to chat me up*…. was a demonstration of affection, solidarity and understanding (Spiers, 1998), which was designed to make the patient feel comfortable. Research shows that initially inquiring into non-medical areas of the patient's life makes patients feel that they also have a right to be at the doctor's office to seek for help and be helped. This act creates a common ground where both the patient and the doctor feel comfortable (Nelson, 2008).

Contrary to positive face and politeness, the majority of the patients in the study (thirteen of them), on the other hand, reportedly experienced cold reception when they encountered doctors in the consulting rooms. The experiences of these patients can be interpreted in another school of thought on facework theory as face attack. In this circumstance, the doctors' cold reception, which was characterized by failure to respond to patient's greeting, stern voice, limited communication and time spent with

patients, were indicative of face attack. This is a communicative strategy designed to challenge (Tracy, 1990) the patients. Literature shows that face-challenging tactics are commonly observed in the context of dispute or negotiation of which doctor-patient encounter falls under. Through that tactics the doctors anticipated to gain a more preferable position or enhanced power in their encounter with the patients (Lim, 1994). For instance in the current study some of the patients stated:

> The doctor asked in Akan, "ɛdeɛn na ɛyɛ wo?" (what is wrong with you?) But I told him I don't understand Akan so he asked in English what was wrong with me. In fact, when I entered the consulting room, I greeted the doctor but he did not respond, he only asked in a stern voice what was wrong. Then went on to scribble something in my folder and asked me to go to the dispensary for my prescription (P15UEWC).

> When I entered the doctor was not friendly at all he did not look up to see who had entered it was only after I sat down before he raised his head. He asked straight forward questions and did not for once look at my face. All he did was to write on a piece of paper and afterwards he asked me to take it to the pharmacy (P3UCCH).

The patients ascribed negative face of the doctors, who did not demonstrate politeness, caused damage to their face (Thomas, 1995) or self-image as well as being rude (Watts, 2003). Other patients complained that:

> When I entered the consulting room the doctor was on the phone, so I waited for some time before he was done. After that he asked how he can help me. To me that was not the best he is there to serve me and not make calls whiles I was seated in front of him. He had no idea what was wrong with me at the time. (P12UCCH)

In this instance the doctor was aloof (Lakoff, 1972 cited in Spiers, 2000). It was not polite for the doctor to be on the phone while the patient sat waiting for attention. The Code of Ethics for the Ghana Health Service (GHS) is silent on the use of phones in the consulting rooms. In reality, health personnel particularly doctors may respond to phones calls in their consulting rooms as such calls may be official and/or emergency. It is equally possible that phone calls during doctor-patient consultation may be social and private. However, whether official or private, the fact that the doctor did not use any non-verbal expression or gesture to acknowledge the presence of the patient to assure her that he would attend her to as soon as possible projected a damaged face (Ting-Toomey, 2001; Van Ginkel, 2004).

In the words of the respondent (P12 UCCH), because the doctor did not make any gesture to acknowledge her presence or say any word thereafter 'made her to feel bad'. She felt the doctor did not care, and simply ignored her presence in the consulting room by continuing to chat on the phone. Mindful that facework is the actions a doctor and patient take to either maintain face or save a threatened face, a nod from the doctor to acknowledge the presence of the patient or even an eye contact or gesture would have communicated 'warmth' to her. As explained by Sifianou (1992) cited in Watts (2003) meeting the needs of others for example by attending to face not only acts as a model for others to follow but also instills in individuals a sense of satisfaction.

As explained in Grice's theory on linguistic politeness in the literature review, the success of conversations depends in part, upon cooperation to mutual commitment to making interaction work. As Grice (1989) emphasized quantity should be informative.

Perhaps, the doctor was irritated because the patient asked too many irrelevant questions. Since the interview was held in the afternoon just after the patient had seen the doctor, it could also be speculated that the doctor became irritated out of exhaustion. Nonetheless, as explained below, the code of ethics obligates the doctor to allow the patient to ask for information about their illness. In this case, the doctor's conduct became a source of frustration to the patient as encapsulated in the statement below:

> I didn't like the way I was received by the doctor; he became irritated during the course of the consultation because I was asking him too many questions (P23UEWC).

This conduct was contrary to the Code of Ethics of the Ghana Health Services, which state inter alia that, the patient is entitled to full information on his/her condition and management and the possible risks involved except in emergency situations (GHS, 2007). According to the Ghana Health Service, the patient is entitled to know of alternative treatment(s) and other health care providers within the Service if these may contribute to improved outcomes. Arguably, patients can access such vital information by asking questions.

Another patient in the study stated:

> I had a very bitter experience with the doctor, he asked me to go home and come the next day because he said I am not serious. The reason was that I stayed home for three days before reporting my sickness at the hospital (P5UCCH).

The turning away of the patient because she reported her ailment three days later again could be described as unprofessional and risky. While it is advisable for patients

to seek medical attention as soon as possible for obvious reasons, based on the adverts on radio and television which normally say, 'when symptoms persist for more than three days consult a doctor, one can assume that it is acceptable for a patient to do a self-observation of his/her condition over that period of time before seeking medical attention provided the condition is not life-threatening. Indeed, many people administer first aid for a day or two before they seek medical attention if their conditions do not improve. Also, factors such as conditions in our health facilities, the nature of services from personnel, attitudes of personnel and the length of time spent at hospitals and clinics in the country make attendance to hospital and clinics a last resort.

In the case of patient P2CCH as encapsulated in the comment below, the unpleasant experience was precipitated by the rude conduct of the patient. The failure to greet on entering the consulting room also connotes disrespect for the doctor in the Ghanaian cultural context. The patient recounted:

> When I entered the room the way he behaved was not good at all. That is because when you enter, he just expects you to greet him before you bring out what the problem is. When you don't greet him, he will tell you to go out (P2CCH).

Politeness is necessary to ensure successful communication (Sifianou, 1992 cited in Watts, 2003). The patient's conduct made it impossible for any effective communication to ensue; however, in order to avoid further damage to the face (White, Tynan, Galinsky & Thompson, 2004), the doctor tactically ordered the patient out of the consulting room. Politeness strategies not only provide doctors with a range of mechanisms for obtaining cooperation but in developing rapport the politeness

strategies are used as indirect means of expressing power (Spencer-Oatey, 2000 cited in Holmes & Stubbe, 2003), which portray collaborative power (Holmes & Stubbe, 2003).

Literature on doctor-patient communication acknowledges the relevance of rapport in doctor-patient consultations. According to Nelson (2008) the ability of the doctor to communicate successfully largely depends not only on the doctors' clinical knowledge and technical skills, but also the nature of the rapport that is established between the doctor and the patient. Rapport building is characterized by a warm greeting, eye contact, a brief non-medical interaction, or checking on an important life event of the patient in less than a minute. All these will go a long way to put the patient in a better and relaxing mood to open up to the doctor in the consultation process.

Essentially, the ongoing discourse has revealed the intricacies of doctor-patient communication in the consulting rooms. The perspectives of both doctors and patients in the study about the initial exchanges between doctors and patients in the consulting room were varied. To some of the doctors and patients the initial exchanges were warm and pleasant, caring, welcoming, showing of interest and patronizing; for other patients the experiences were unpleasant and characterized by poor reception, harsh voice, aloofness, and denial of attention.

The experiences captured under the first major theme, reception and rapport with patients, are intrinsically connected to the second research question which sought to examine factors that influenced the manner in which doctors and patients communicated in the consulting rooms. Logically, exchange of compliments, conduct

of doctors and patients, as well as mood to a large extent influence the manner of communication that may ensue.

Discussions of other factors that influence the doctor-patient communication sought to answer the second research question, which is, the factors that influence the manner in which doctors and patients communicated in the consulting rooms.

4.4 Doctor-Patient Dialogue

The second major theme that was revealed from the interviews with patients and doctors could be considered as the main dialogue, which focused on language use and posture of doctors. The sub-themes include: verbal and non-verbal communication, explanation of patient's condition, duration of time with patients and patients' disclosure. Data from the transcriptions of both doctors and patients were again used to address the second research question which read:

RQ2: What factors influence the manner in which doctors communicate with patients in the consulting rooms?

4.4.1 Verbal Communication

As stated in the methodology chapter (3), the patients who attend the health facilities of the two universities are staff and their families as well as students and the general public. While majority of members of staff and students may naturally communicate in English during consultations with doctors, some members of staff, particularly the junior staff, some families of staff and some members from the public may not be very literate and will speak the local language during consultation. Thus, in terms of

verbal communication, the focus was on the use of either English or a native language such as Akan or Ewe. Data from the transcripts revealed instances where some of the doctors had to switch code to facilitate understanding. For example, they changed from English to a local language while communicating with patients as highlighted in the comment below:

> Language barrier is my biggest challenge working in this hospital you see I am an Egyptian and I don't know the local language so sometimes it is very difficult giving information and obtaining one from my patients. Most often I rely on my nurse to explain to my patients' information I want from them. I sometimes also ask for help from my fellow colleagues (Dr. Roy).

Dr. Roy sometimes encountered difficulty in communicating with his patients because he was a foreigner. This was understandable, communication requires sending messages in understandable form (encoding) and receiving and understanding messages (decoding) (Owen et al., 2007). In the context of health delivery system, communication is a transactional process, which is key in promoting health (Minardi & Rily, 1997). It is a planned process, the effectiveness of which comes when the recipient achieves and acts on as well as responds to the message (Kiger, 2004). From the patient, it was deduced that code switching occurred in both facilities. For while the doctor's comment came from the University of Cape Coast Hospital, a patient from University of Education, Winneba Clinic also stated:

> We use code mixing- that is, Fante and English; … yes, when I can't say what is wrong with me in English very well, then I switch code and say it in Fante to describe it to him how I'm feeling (P20 UEWC).

Indeed, the doctors in the two health facilities of universities at Cape Coast and Winneba were mindful of the need for effective communication; they therefore did not allow language to become a barrier to quality health care delivery for the patients:

> Language is not really a problem for me because if my patient does not speak English, we find an alternative for him or her when necessary. If she speaks my language Ewe, the better but if not I ask for assistance (Dr. Fue).

This finding is vital because studies have shown that language plays a pivotal role in doctor-patient communication (Eckler, Worsowicz & Downey, 2009; Jacobs et al., 2006; Karliner et al, 2007), nonetheless differences exist in languages used by doctors compared to that of patients (Herget & Alegre, 2009; Whaley, 2000). Besides, while language did not pose as barrier in the case of establishing rapport, the situation was however different when it came to explanation of patients' illness as shown in a subsequent section. The next issue is on non-verbal communication.

4.4.2 Non-Verbal Communication

In terms of non-verbal communication, the issue that emerged from the transcripts of some of the patients was doctors' failure to maintain eye-contact with patients during consultation. Some of the patients described their experiences as follows:

> The doctor did not look at me in the face during the brief encounter in the consulting room. Indeed, there was no eye contact with the doctor. The doctor's disposition at that time was not very welcoming. He did not smile or appear cheerful in any way. The doctor needs to go through proper training in communication skills (P17UEWC).

> He asked straight forward questions and did not for once look at my face. All he did was right on a piece of paper and afterwards he asked me to take it to the pharmacy (P10UCCH).

Doctors' failure to maintain eye-contact had negative impact on the patients' level of satisfaction. Besides, lack of eye-contact may connote reasons such as being uncaring, disinterested, or less concerned about the plight of others. Maintaining friendly eye contact with patients promotes trust. In fact, literature has established the importance of eye-contact in doctor-patient communication in the consulting room; on the other hand, patients may doubt the sincerity or competence of a doctor who avoid eye contact during conversation (Osborne & Ulrich, 2008). This is endorsed by Fry and Mumford (2011), who argued that maintaining good eye contact significantly improve understanding. By maintaining eye contact, looking attentive, nodding encouragingly and using other gestures, the doctor can provide positive feedback to the patient and facilitate his or her participation (Silverman et al., 1998).

Additionally, nonverbal cues expressed by the doctor may be interpreted differently by the patient and vice-versa. In support of this, Non-verbal cues such as body position, facial expression and personal appearance are key components when a doctor is listening to his or her patient (Osborne & Ulrich, 2008). Osborne and Ulrich maintained that facial expressions can reflect how a doctor is interpreting the information they are receiving. According to Osborne and Ulrich (2008), warm smile tells others you feel kindly toward them.

By contrast, where a doctor continues to flick through notes, fidgets with a pen or fails to look directly at the patient, as described by patient P10UCCH, they convey the message of disinterest which results in patients failing to describe their problems or to seek information and explanation (Lloyd & Bor, 1996). Essentially, the expectations of every patient go beyond clinical skill because patients expect the doctor to be respectful, polite, sincere, and compassionate and interested in him or her as a person, behave and dress like a professional, with the appropriate demeanor, avoiding judgmental behavior, with the proper verbal and nonverbal skills (Nataša & Bakic, 2008). The Ghana Health Service (2007) reiterates that client satisfaction with the quality of health care is based on many considerations including promptness of attention, good staff attitude, respect for patients and their rights, and provision of adequate information.

4.4.3 Medical Jargons

A major issue that emerged from the transcriptions of patients with respect to the explanation of their illness by the doctors was the use of medical jargons. The patients complained that medical jargons were incomprehensible and unhelpful. However, the doctors reportedly endeavored to avoid the use of medical jargons in the dialogue with patients. For instance:

> No, I don't use medical jargons; I try to explain in the lay man's language for them to understand. I always draw a pattern you know to explain patients' conditions to them when necessary. What you see you remember what you don't see definitely you can't remember. That is what I do but I don't know about the others. It's just individual differences (Dr. Doh).

> They will not understand so I don't use it. Medical terms we use it with our colleagues who understand … Maybe you will have to take a medicine morning and evening so I will write it BD but if I tell you BD you won't know what BD is (Dr. Fue).

On the contrary, the patients contended that some doctors used medical jargons while explaining their illness in the consulting rooms:

> … He will let me go and lie down and then just ask me and pressing my body, waist and asking me, 'do you feel pain here'? I say yes and here I say yes. Where he doesn't touch, I tell him I also feel pain there. When we go and sit down he will say you are suffering from dysmenorrhea. Then I'll ask him what is that and he will say it comes with age as you are growing it comes with it so you have to give birth and things will become normal (P20 UEWC).

> … the doctor told me I had cataract and it is at its early stage I shouldn't worry and that he will give me a drug for that. What he meant by a cataract I don't know and I didn't want to ask since I don't want to make the doctor angry so I left like that (P8 UCCH).

The discrepancies in the views of the patients and the doctors were understandable. Logically, it is not possible for doctors to know the indigenous terms for all medical conditions even if this was the case, given that there are many dialects and languages in the country. Elsewhere in Angola, Matheson (2009) found that several people in Angola are not fluent in Portuguese which is the official language, and in health care settings, medical words do not have translations in ethnic Angolan dialect. In that circumstance, Matheson explained that even with skilled translators, language barriers persist.

Understandably, it is a common practice among doctors to use medical jargons, which is of Latin origin (Gotti, 2006) because Latin was the former Lingua Franca of medicine (Zethsen & Ashkehave, 2006). However, Zethsen and Ashkehave (2006) have argued that medical language should be regarded as the language used by medical experts when communicating in an expert-to-expert context. It is the language of the specialist, often defined as a special language as opposed to general language used by the general public in everyday situation.

Studies show that patients often fail to understand the meaning of many common medical terms, particularly medical jargons; while doctors generally overestimated what their patients have understood (Skelton and Hobb, 1999). Others have claimed that it is not a sheer coincidence; rather, doctors' use of medical terminologies is closely related to preservation of their authority at the expense of the patients' ability to influence the course of consultation (Salmon & May, 1995).

For her part, Morasch (2004) has explained that linguistic differences between doctors and patients are obstruction to effective conversation and clear communication. She stressed that medical jargon contributes to poor communication and that the use of medical jargons could lead to misinformation and incorrect explanations that could have conflicting effects on a patient's health.

4.4.4 Doctors' Reactions to Patients' Questions

According to literature, doctors' willingness to answer all questions without hesitation improves patients' belief in the doctors' abilities (Moore et al., 2000). Besides, history taking, physical examination, and prescription writing are of course, crucial

parts of a clinical encounter; however, when time is short, it is the communication with patients that is sacrificed (Bartel et al., 2000). The features mentioned above emerged in the current study as shown in the statements below:

> The doctor asked me what was wrong with me, and I explained then he asked me to go and lie down for him to examine me. After that we came and sat down at his table and he wrote a drug for me (P18 UEWC).

> Actually he did the talking; he asked me in a calm voice what was wrong with me and I described how I was feeling (P9 UCCH).

Another patient manifested the avoidance process, which is characterized by efforts to avoid negative impressions and prevent threat to self or other's face (Goffman, 1959, cited by Spiers, 1998). Besides, other issues relating to doctor-patient communication, which adversely affect communication, are lack of time, arrogance, shyness and language (Bartel et al., 2000). The consequences are that large number of patients leave the consultation without asking questions about things that are troubling them or do not receive what they regard as a satisfactory response (Barry, et al., 2000). For instance some of the patients said:

> Because I always come with malaria so l don't see the need to ask questions (P13 UCCH).

> I was not able to ask the doctor what was wrong with me and he didn't offer to tell me either… it just didn't occur to me to ask the doctor what was wrong with me (P11 UEWC).

Another female patient was scared to ask the doctor any question while another patient did not want to provoke the doctor:

> I was not able to ask the doctor questions about my candidiasis because hmmmm I was scared (P9 UCCH).

> Because I don't want to provoke them I just let it go. I see it as someone doing his job so if you probe too much you might not know his reaction (P7 of UCCH).

From the comments above the patients exhibited positive politeness, which aimed at supporting or enhancing the doctor's positive face (Brown & Levinson, 1987), by avoiding asking the doctor questions. This conduct is however not helpful in quality health care delivery as explained in the ongoing discourse.

Some of the doctors were not happy with patients' unwillingness to ask questions about their illness. It was however, not clear whether that was due to shyness or ignorance, because this was not disclosed during the interviews. The doctors said:

> Patients do not ask me questions relating to their illness. They do not ask questions about the drugs you prescribe for them, its possible side effect etc. As educated as they are it seems they are in a hurry to get out of the consulting room that is a major factor influencing communication here (Dr. Roy).

> I think with time patients will begin to show more concern about their medical care. We are not there yet but will get there. It is quite interesting when you find a patient who engages you in an active conversation regarding treatment plans but some patients leave that sole responsibility to the doctor (Dr. Odo).

Some patients felt they lacked the capacity to engage in any dialogue with the doctor:

> I have patients who tell me you know best and what you suggest will be the best for them. I guess all their concern is to get better and they leave the process to getting there in our hands (Dr. Fue).

From the current study, the patients' inability to communicate effectively with doctors during consultations was due to reasons such as perceived awareness of illness, forgetfulness, fear, and the desire not to provoke the doctor. In spite of these explanations, patients need to understand that failure to ask for information about their diagnosis not only adversely affect their treatment but patients' failure to ask questions is detrimental and can cause frustrations among doctors. As explained by Corbett (2012) if a patient does not speak up, the doctor will make assumptions based on their own experiences and perceptions of what the patient's needs really are, and this approach may not be the best for the patient. Patient's inquiry is very vital in the doctor-patient communication process. In fact, patients have the responsibility to ask for more information about their health (GHS, 2007).

Studies suggest that patients' lack of interest about their diagnosis can foster silence (Charmaz, 2006). According to Charmaz this can be due to the fact that some patients tend to see doctors as experts and trust their judgments. Hence they do not make any attempt to engage doctors in any healthy discussions regarding their health care options. However, the idea of partnership and shared decision-making in doctor-patient communication is highly encouraged in medical consultation (Gray & Spatz, 2009; Müller-Engelmann, Keller, Donner-Banzhoff, & Krones, 2011; Ray, 2005; Wennberg, 2010).

In order to address this setback in quality health delivery as a result of poor doctor-patient communication, Corbett (2012) offered some tips that would assist patients when interacting with their doctors. For example, patients should tell the doctor what they want and not assume that the doctor knows what they want; patients should take the initiative by educating themselves first about treatment options available to them before they go to see their doctor. Where unsure the patient can jot down questions before they go for treatment. Corbett added that patients could prepare questions in writing, which would go a long way in preventing forgetfulness. Also, patients should be bold and confident in expressing their lack of understanding in what a doctor says if the need arises.

4.4.5 Patients' Disclosure

In addition to patients' unwillingness to ask questions, another factor that influenced doctor-patient communication in the consulting rooms was lack of disclosure. Self-disclosure was a problem encountered by some of the doctors in the study. Self-disclosure in this context refers to the process of sharing information with the doctor (Barak & Gluck-Ofri, 2007; Cozby, 1973 Ignatius & Kokkonen, 2007). According to the doctors, some patients did not find it necessary to disclose vital information about their illness. One of the doctors stated:

> … some with direct questioning but with others you will have to probe and keep doing so until they tell the truth. They hide information. That is why I earlier said that with some you will have to probe further for all the options available to get to the root of the matter (Dr. Fue).

This revelation is an important factor in doctor-patient interaction in the consulting rooms; self-disclosure is a vital factor in the success or other wise of a treatment

procedure and a lack thereof on the patient's part may prevent the doctor from forming a precise representation of which symptoms are experienced, the patient's complaints and medical history. On the other hand, a patient that feels free to disclose more information in general, and more personal information in particular, enables a doctor to make a more accurate diagnosis and prescribe a better patient treatment (Cegala, 2000). Self-disclosure has been linked to health benefits (Pennebaker & Beall, 1986).

As explained in the literature review, in therapeutic encounters where doctors and patients discuss the severity of patients' illnesses and lifestyle changes, patients frequently interpret what their doctors say as face threatening. Indeed, any prescription of treatment programme which limits patients' lifestyle choices violates face (Lim, 1994). In order to limit violation of patients' face and promote respect, the doctors guarantee their patients privacy. One of the doctors remarked:

> It depends on the symptoms they present. Some may not be a direct questioning but somehow you will get the real information by the time you start from the back but if you start from the front they will not give you the information you want. For some instances, I excuse my nurses so that I can communicate well with them. So I ask them what is it that is bothering you but they are a little hesitant to come out with what is actually bothering them (Dr. Odo).

The Ghana Health Service Code of Ethics (2007) provides for the right of the patient to privacy during consultation, examination and treatment, which was complied by the doctors.

Alternatively, patients could be asked to write down private information for the doctor to read as in written disclosure, which is also considered self-disclosure (Barak & Gluck-Ofri, 2007; Ignatius & Kokkonen, 2007; Joinson, 2001; Joinson, Paine, Buchanan & Reips, 2008). During doctor-patient communication, the private information discussed at the history taking stage may concern facts about oneself, personal opinions and attitudes, or information about moods and emotions (Omarzu, 2000). Self-disclosure has also been linked to health benefits, with more disclosure of traumatic experiences improving health outcomes (Pennebaker & Beall, 1986; Pennebaker, Kiecolt-Glaser & Glaser, 1988). The intension behind a patient's self-disclosure patterns becomes higher when the risks involved are lower and when the discloser is confident that the information shared will not be used against them.

4.4.6 Patterns of Patients' Disclosure

In terms of patients' disclosure, two models that have been described in literature are doctor-centred and patient centred communication (Morgan, 2003). The doctor-centred communication occurs where the doctor is portrayed as the expert, who requires the patient to cooperate. Doctors who adopt this communication model focus mainly on physical aspects of the patient's disease and assume a tightly controlled interviewing method to draw the required medical information from patients. In the current study, the patients stated:

> …actually he did the talking and I was just sitting there answering the questions. He just directed me to go for an injection that's all (P4 UCCH).

> He is not caring it is his task he is just doing his job and does not care about who comes in (P1 UCCH).

> No laboratory examination, no scanning, or X-ray done on me to know the real cause of the problem. I just told you my problem and you then prescribe a drug for me without telling me due to this and that is why you are experiencing this problem (P15 UEWC).

Other patients described doctors who displayed patient-centred communication. Patient-centred communication is characterized by treating the patient as a unique individual (Redman, 2004). Doctors who adopt this approach demonstrate respect for patients (Binnie & Titchen, 1999; Shaller, 2007), take into consideration the patients' point of view and circumstances in the decision-making process and go beyond merely setting goals with patients (Ponte et al., 2003). In fact, some of the doctors in the study exhibited this approach as encapsulated in statements below:

> … he went the extra mile to know what was wrong with me by the tests he took others won't. He has this kind of friendliness he tries to get to know what is personally wrong with you by asking series of questions (P10 of UCCH).

> She is friendly the last time I was here I saw a female doctor who spent a lot of time with me and asked a lot of questions (P19 of UEWC).

The doctors assigned different reasons for the approaches they adopted in their practice, particularly during consultation with patients. One of the doctors said:

> ...my name is very important to me hence I take my job very seriously I don't want patients who come in to see me to carry the wrong impression about me. I have done thirty years of practice and I know what is best for my patients (Dr. Roy).

While another doctor stressed:

> There should be a mutual understanding between the doctor and patient when communicating. The doctor must not think she/he knows everything and the patient doesn't know anything. The doctor should ask of the opinion of the patient as well (Dr. Odo).

Care-related treatment also known as patient-centred is the ability of health care providers to take into account the patient's need for information and for shared decision making (Stewart, 2001). This type of care involves an in-depth explanation of disease to patients, their feelings, beliefs and expectations (Bauman, Fardy & Harris, 2003). However, Shalowitz and Wolf (2004) cautioned that even though it is best to promote and practice shared decision-making, the possible barriers which exist should not be ignored. According to Shalowitz and Wolf during interactions doctors should aim at understanding the patient's desires, and the level at which they want to be involved in the decision-making process.

4.4.7 Length of Time in Communication

Factors such as patients' willingness to ask questions and engage doctors in discussion about their ailments, doctors' readiness to engage in health conversation and respond to patients' queries, the number of clients waiting for doctors' attention, and the time of the day may to a large extent influence the length of time doctors spend with patients during consultations in the consulting rooms.

In this study, comments from some patients recorded in previous subsections connote that some doctors spend less time with patients. For example, some of the patients (P15 UEWC and P3UCH) stated that their doctors hurriedly sent them away from the consulting rooms to the pharmacy with prescriptions. Comments like, "*then went on*

to scribble something in my folder and asked me to go to the dispensary for my prescription…" and "all he did was to write on a piece of paper and afterwards asked me to take it to the pharmacy…" succinctly described their experiences. However, it is critical to consider the context of the doctors' conduct. That is, the time of the day, the number of patients waiting for their turn, previous knowledge of the patient and the case history. Some authorities have explained that it is not the amount of time that is crucial in doctor-patient communication, but rather, the way in which the available time is utilized (Ruusuvuori, 2001; Stewart et al., 1999). Studies further show that doctors who see more than 20 outpatients per day spend much less time giving information and also smaller number of explanations.

The data show that for some patients even though the doctors offered them time to ask questions and discuss their treatment, they still were not satisfied with the services from the doctors. In fact, a patient (P20 UEWC) expressed dissatisfaction about the treatment from the doctor. She lamented:

> Yes he has time for me …, just that they are not able to give me services that I want that's all I have come with my problem, you see I am sick that problem needs to be solved I have been there several times complaining of the same illness. It means I want that problem to be solved. But each time I go, you keep on giving me the same drugs which is not solving the very problem I have been coming there and when I tell you what is wrong with me, you will not listen but you will do what you know (P20 UEWC).

The ability of some patients to either share or withhold information during the consulting process could be attributed to the trust the patient might have for the doctor. Trust is a vital element in the patient-doctor relationship (Hall, et al 2002;

Mainous et al. 2004; Sheppard et al. 2004). It promotes improved patient quality of life, devotion to treatment plans, satisfaction with health care, greater use of preventive clinical services, and better health outcomes (Hall et al., 2002; O'Malley et al., 2004). Without trust, the doctor-patient relationship may not become firmly established, thus possibly hindering the doctor's ability to help patients.

Although, doctors' ability to communicate effectively can be attributed to a function of time available for the communication, other skills, such as assisting patients to contribute and clarifying the nature of patients' medical problem, are employed more frequently only by those doctors who already emphasised these aspects of communication (Howie et al., 1992).

For example, sometimes, the length of time doctors spent with patients was influenced by the mood of the doctor:

> …it is stressful sometimes I am very tired like today I have not eaten since morning but I have seen close to forty patients. I am feeling very dizzy and if a patient comes and complains that I have been sitting outside for a very long time definitely I will not be amused. But as much as possible we try not to allow that to interfere with our consultation but as human as we are it sometimes happen (Dr. Odo).

> I try as much as possible not to allow my mood to interfere with my work but on some occasions as a result of the load and stress I sometimes take it out on some of the patients especially the stubborn ones (Dr. Han).

As revealed above, doctors' mood is influenced by factors such as exhaustion and stress, which were characteristics of some days of the week:

> Mondays are very busy days for me, also on Tuesdays when the fishermen don't go for fishing so they all pile their problems and come and dump them on me. And in the afternoons you know how it is but we try and manage our way around it. It hasn't been easy though (Dr. Roy).

Some of the patients in the study were aware of doctors' stressful days and time and therefore avoided attending the hospital or clinic on those days of the week and time:

> Some are welcoming but often times some of them are in a rush like in the afternoon they just wish they are done and gone (P1 UCCH).

> I usually will want to go to the hospital in the mornings very early like today. Those times you get the best of the doctor but in the afternoons they become tired and easily become irritated (P9 UCCH).

These strategies are not effective because humans have no control over their health, and it is not always possible to predict when an individual will become ill and has to see the doctor. One of the doctors proposed an ideal duration for doctor- patient consultation in the consulting room:

> …ideally each doctor is expected to spend at least about forty-five minutes with a patient at a time depending on the medical problem they present with or even more. But looking at the fact that the time and the number of patients they must attend to within a day, they usually spend less time with their patients. So I usually do the quick question-answer conversation (Dr. Han UCCH).

As explained by the doctor, many factors influence the duration of doctor-patient consultation. Studies have shown that more detailed communication requires longer

consultations and doctors who see more than 20 patients a day are more likely to spend less time during consultation than those who see less (Stewart et al., 1999).

In the current study, the manner in which doctors communicated with patients in the consulting rooms, according to the ongoing discourse, was influenced by many factors including patients' attitudes, and interest in their own health, use of medical jargons, patients' disclosure patterns, mood of doctors, number of patients and the day of the week.

The next sub-section addresses the third research question:

4.5 Views of Patients about Communication with Doctors

The underlying concept of phenomenology as practiced by scholars like Ponty and Husserl in their studies, and also elaborated by Littlejohn and Foss (2009), which is the perceptions people have about a phenomenon depend on their personal experiences of it, guided the third research question. The purpose of the phenomenological research is to identify phenomena through how they are perceived by the actors (participants) in a situation (Lester, 1999). Phenomenology is concerned with the study of experience from the perspective of the individual (Chapter Three). In pursuance of this overall goal, patients were also asked to express their perceptions about the manner in which doctors communicated with them in the consulting rooms. Two relevant themes relating to patients' perceptions about doctor-patient communication: doctors' communication skills and patient satisfaction are discussed in an attempt to address the Research Question Three:

RQ 3: What are the perceptions of patients on how doctors communicate with them in the consulting rooms?

4.5.1 Doctor's Communication Skills

A sub-theme which emerged from the data was the views of patients about doctors' communication skills, which was linked to patients' satisfaction. Literature suggests that while it is difficult for patients to convey dissatisfaction in the consulting process (Patridge et al., 2000), the most common complaint about doctors by patients and the general public relates to communication (Barry et al., 2000). In the current study, some of the complaints from patients were related to the use of medical jargons and communication skills. As discussed earlier, for the part of the use of medical jargons, a patient complained:

> Some use medical jargons that we don't understand others also don't understand our local language well enough to better communicate with their patients (P1 UCCH).

Other patients felt the doctors needed refresher course in communication skills:

> …they should go back to school and learn more about communication skills (P18 UEWC).

> …they should work on how they communicate not only the doctors but some of the nurses too. They have to train medical doctors to interact well with patients. They should exercise patience when they want to talk to any patient because it is because of us that they are here. Their job is to take time to interact with the sick patients (P7 UCCH).

> They have to train medical doctors to interact with patients. They should exercise patience when they want to talk to any patient because it is because of us they are here (P3 UCCH).

> I think some of their services need to be upgraded especially in terms of their relations with patients (P14 UEWC).

> They should welcome all patients. At times even your tone will relieve him/her from their pain so it is better they welcome all their patients than to be rude (P5 UCCH).

Perhaps, the deficiencies in the doctors' communication could be attributed to their training since four of the six doctors had their training 14 to 32 years ago. As suggested by Wilkins (2012) many doctors, until recently, were never taught how to become good patient or person-centered communicators. However, Grembowski (2004) asserts that doctor's satisfaction with their professional life was linked with greater patient trust and confidence in their primary care outcomes. Also, Hall (1990) have suggested that doctors who are themselves more fulfilled may be better able to address patient's concern. Thus, doctors who are themselves fulfilled with their professional life may have more positive effect, which may subsequently affect their communication with patients which then affect patient satisfaction.

The importance derived from the introduction of communication skills training contributes to cost and resource and effective health care given the potential for more accurate diagnosis and better compliance with treatment plans. Such improvements could help prevent unnecessary prescriptions for medication that are either wrongly prescribed or not properly used by patients (Kaplan et al., 1989; Sandler, 1980). Poor communication leads to accidents and subsequent litigation (Vincent, 1992).

4.6 Patient Satisfaction

Effective doctor-patient communication is a vital component of quality health care delivery system in every country. It is an essential clinical function in building a satisfying doctor-patient relationship, which is the heart and art of medicine (Fong Ha, 2010). Jackson (2001) found that aspects of doctor-patient communication such as, receiving explanations, duration and lack of unmet expectations, were found as key factors of patient satisfaction. In the current study, out of the twenty-three respondents interviewed, fourteen were dissatisfied with the way the doctor communicated with them in the consulting room. According to the respondents:

> …as I am talking, he cuts me short then he says madam I know all that you are talking about then I will also say no I feel pain in my right leg whenever I have my menses as a result I am not able to walk then he will say for that, he hasn't heard some before. It's just a normal menstrual pain women go through. Meanwhile I see my own not to be normal that is the problem I have with him. And when I complain that in fact I am suffering, give me proper drugs, he will say 'oooo' we don't have any different drug. The drug he has been giving me every day so I've stopped going there because I can't continue to waste my money (P20 UEWC).

> I didn't feel well I even thought that going to the pharmacy would have been better (P6 UCCH).

Doctors' communication and interpersonal skills encompass the ability to gather information in order to facilitate accurate diagnosis, counsel appropriately, give therapeutic instructions, and establish caring relationships with patients (Bredart, Bouleuc, & Dolbeault, 2005; Duffy, Gordon, Whelan et al., 2004). Studies have shown that much patient dissatisfaction and many complaints are due to breakdown in

the doctor-patient relationship. However, many doctors tend to overestimate their ability in communication (Fong Ha, 2010). For example, some of the respondents stated:

> Some are good, when you go to them they take their time and give you the necessary attention, some will not also give you the chance to even talk… They are there because of their patients so if the people come they are supposed to take their time and do a thorough investigation before they conclude on the type of drug they give out to their patients and the necessary advice but some doctors in Ghana generally do not do that (P14 UEWH).

It was not surprising that a degree of dissatisfaction emerged during the interactions between doctors and patients in the study. It has been well documented that poor communication on the part of the doctor is a major factor leading to patients' and relatives' dissatisfaction with care. Patients were found to be less satisfied when doctors dominated the interview by talking more or when the emotional tone was characterized by physician dominance (Jackson, 2001)). This may well be related to the changes in the patient's expectations of the doctors' role as people see themselves as more active participants in their own health care. This level of dissatisfaction was reflected in the following comment from respondents:

> It is fine, good just that he would not allow me to really tell him what is actually wrong with me. The moment I say I'm having menstrual pain he will conclude and write a drug. Every time I go there I spend about 150 -200 Ghana cedis each time and it's the same kind of drugs he gives to me (P7 UCCH).

> The doctor did not look at me in the face during the brief encounter in the consulting room. Indeed, there was no eye contact with the doctor. The doctor's disposition at that time was not very

> welcoming. He did not smile or appear cheerful in any way. The doctor needs to go through proper training in communication skills (P14 UEWC).

In order to provide quality health care delivery the patients suggested among others that:

> …what I would want them to do is that we all get out of our houses to hospitals to get cure for our sickness so if we come to them they should have time and listen to us the patient. Secondly I would prefer thorough examination into what the patient reports to them before they prescribe the drug or advice. They shouldn't just jump to conclusion that it is a common thing people have been reporting to the hospital, for all you know it might be that or not. (P20 UEWC)

On the other hand, five of the ten patients who felt satisfied with their encounter with the doctors in the consultation rooms made the following remarks:

> I was satisfied with the consultation (P17 UEWC).

> Yes I was very satisfied I think they are okay (P11 UCCH).

> I think they should keep doing the good work (P8 UCCH).

> Well, I liked some of the doctors. They treated me well when I went to visit them (P21 UEWC).

> Compared to other hospitals in this place the patients are treated well and so they come here more than those other places. I like them (P6 UCCH).

Patients' views as expressed above are crucially important as argued in the introductory chapter; in fact, if health programmes in a resource-poor country like Ghana are to succeed, it is vitally crucial to collect and examine the opinions of the local people with respect to their degree of satisfaction with available services (Newman, Gloyd, Nyangezi, Machabo & Muiser, 1998). In fact, patients' perceptions of quality of care are vital to understanding the relationship between quality of care and utilization of health services, and are now considered outcomes of healthcare delivery (Ross, Steward & Sinacore, 1993).

4.7 Summary

This chapter presented the findings of the interviews conducted with doctors and patients on the topic doctor-patient communication in consulting rooms. The analyses have revealed that the actual lived experiences of doctor-patient communication in the consulting rooms of two universities' health facilities. For example, the reception and establishment of rapport, language and posture; factors such as language barrier, unwillingness to ask questions, lack of disclosure, use of medical jargon, attitudes and workload influenced how doctors communicated with their patients in consulting rooms of the universities' health facilities.

In terms of patients' views, the findings were mixed; while some patients were satisfied with their interactions with doctors in the consulting rooms others were dissatisfied and suggested the need for the inclusion of communication skills in the programmes for medical doctors.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This chapter captures the summary and the conclusion based on the findings of the study as well as recommendations to improve doctor-patient communication in the consulting room. It also outlines suggestions for further research.

5.2 Summary of the Major Findings

The study was a phenomenological study which set out to describe the experiences of doctors and patients during their encounter in consulting rooms of the health facilities at the University of Cape Coast and the University of Education, Winneba. In terms of reception and rapport, the findings revealed some disparities in experiences of both doctors and patients in their encounter at the consulting rooms of the two health facilities.

5.2.1 Experiences during Reception and Rapport

From the findings, while none of the doctors complained about any unpleasant experience during reception and establishing rapport with patients in the consulting rooms, there were disparities in the experiences of patients who participated in the study. The majority said they had some unpleasant experiences such as receiving little attention from the doctor, lack of recognition or respect and care from the doctor, cold reception, being prevented from seeking explanation about illness or diagnosis, and not getting sufficient explanation.

For patients who experienced pleasant reception, on the other hand, their experiences were characterized by being welcomed with smiling face, warmth, interest and care. In fact, some of the patients described the doctors' conduct as 'fatherly'. Other patients disclosed that the doctors tried to 'chat them up' in order to make them relax. These initial experiences were important because patients' general impression about the quality of health care delivery not only from the doctors but also from the medical facility as a whole could be influenced to a large extent by the impression about how they were handled by the doctor. It is commonly said first impression is always critical.

5.2.2 Factors that Influence Doctors' and Patients' Experiences

Factors which influenced doctors' and patients' experiences included language use and posture. All the doctors but one and patients in the study did not experience barriers in communication during reception and establishing of rapport. The only doctor who encountered some difficulties a doctor at the University of Cape Coast Hospital. The doctor sometimes encountered difficulties providing information to patients or obtaining information from them. However that was not a major problem because the doctor usually solicited help from his colleagues.

Furthermore, the findings revealed that some patients were uncomfortable with the use of medical terms or jargons by doctors in the study. Some of the patients described how they were baffled by medical terms such as *dysmenorrhea* and *cataract* during diagnosis. However, the doctors on their part indicated that they were cautious and tried to avoid the use of medical jargons since they knew these jargons were

incomprehensible to patients and would not facilitate understanding among the patients.

Additionally, there were indicators of experience of exhaustion and frustration among the doctors and patients as a result of the number of patients to attend and long waiting time. In the study it was noted that Mondays were particularly busy days for the doctors. This was understandable, since cases which happen during the weekend are usually referred to Mondays and even patients whose conditions are not critical may choose to report to the doctor on Monday. Logically, whenever the number of patients is large or high doctors would be stressed and their disposition would be affected. On the other hand, large number of patients would lead to long waiting time, which would also translate into frustrations among the patients. As discussed in the literature the doctor-patient ratio in Ghana is high and sometimes patients had to wait long hours before receiving attention from doctors, who had also become stressed and exhausted from attending to too many patients.

A concern raised by the doctors was some patients' attitudes towards their own health status, some patients delayed reporting to the hospital for attention, others exhibited lack of interest in their own health condition, refused to give adequate information (lack of disclosure), while a few asked too many questions. The issue of lack of disclosure is critical because if a patient does not speak up, doctors will make assumptions based on their own experiences and perceptions of what the patient's needs really are, and this approach may not be the best for the patient (Corbett, 2012). It is also possible that some patients decline to provide information due to the sensitive nature of their illness; for instance if the issue is related to sexual habits. It

becomes imperative for doctors to use their professional expertise and assumptions for the diagnosis and treatment. It is important to state that in the course of the interviews two patients declined to disclose their illness to the researcher, which was treated as normal in research.

5.2.3 Level of Satisfaction

The study revealed that in terms of patient satisfaction, majority of the participants, almost half of the respondents expressed an overall dissatisfaction with how the doctors communicated with them in the consulting rooms. It was not surprising though given the fact that some of the patients complained about unpleasant encounters with doctors in the consulting rooms in the two health facilities. Some of the patients in the study described the doctors as not caring, not smiling, talking in stern voice, no eye contact, offering straight responses, spending little time, not explaining diagnosis and treatment, and not allowing patients to ask questions. However, some of the patients also indicated that they were satisfied with the way the doctor communicated with them.

5.3 Conclusion

From the findings the following conclusions were drawn: firstly, the findings revealed that doctors in the study did not have any unpleasant experiences with patients in the consulting rooms; however, there were disparities in the experiences of the patients in the study. The majority had unpleasant experiences but many others had pleasant experiences with the doctors in the consulting rooms.

Secondly, the experiences of doctors and patients in the study were precipitated by different factors. For the doctors, their experiences were influenced by attitudes of patients, workload, day and time, failure of patients to disclose information, report to hospital on time among others. For the patients on the other hand, their experiences were influenced by doctors' disposition, tone of voice, attitude towards them, use of medical terms and jargons, lack of attention, and failure to explain diagnosis and treatment.

From the ongoing reasons, while the majority of the patients described their experiences as unsatisfactory the minority on the other hand, disclosed that they were satisfied with their encounter with doctors in the consulting rooms of the two universities' health facilities.

5.4 Recommendations

From the findings the following recommendations have been proposed for consideration: the authorities of the two universities should recruit more doctors to improve doctor-patient ratio so that doctors would not become unduly stretched, but attend to patients on time, spend more time with patients and work in a more relaxed manner.

As suggested by the patients, the Human Resource Departments of universities should provide in-service training or workshop for the doctors in customer care with emphasis on communication.

Again, patients should be sensitized to cooperate with doctors by providing relevant information to facilitate diagnosis and treatment, as well as ask their doctors for further explanation about prognosis.

5.5 Limitations

The aim of the study was to explore the doctor-patient communication in the consulting rooms of the Cape Coast University Hospital and University of Education, Winneba Clinic. Locating patients who were willing to participate in the study was a major challenge since majority of the patients were in a hurry to see the doctor or desiring to exit the health facilities after consultation and treatment. This affected the number of patients who agreed to participate; this notwithstanding the few patients who participated provided requisite information aptly described their experiences with doctors in the two health facilities.

Secondly, getting doctors to interview also posed a major challenge since their work load did not afford them time to spare for interviews outside their practice. However, the researcher must add that the very few doctors that availed themselves to be interviewed provided very useful insight into their experiences with respect to communicating with patients in their consulting rooms.

Another challenge was some patients and a doctor refused to be recorded hence the researcher was restricted to only the notes which were taken during the interviews. Notes taking during interviews cannot be as comprehensive as recorded interviews.

Finally, as a phenomenological study, the researcher could not involve large number of participants to get representative views of doctors and patients from the two facilities. These difficulties notwithstanding, the procedures adopted during the interviews ensured that the findings were credible and trustworthy.

5.6 Future Research

From the study, it will be necessary to conduct a study on patients' self-disclosure and quality health care delivery in Ghana. This will give an insight into the reasons why patients decide not to self-disclose very personal information to the doctor and how it affects quality healthcare delivery. Secondly, a further study should be conducted on patients' knowledge of their responsibilities and roles in quality health care delivery. This will empower patients to contribute effectively towards their own health needs when they go to see the doctor. For instance the results of my study revealed that a lot of patients didn't ask questions when they went to see the doctor and also didn't feel the need to seek further explanations even when they didn't understand the information regarding their treatment plans and outcome.

REFERENCES

Aarons, D. E. (2005). Ethics, Medicine and Society: imperatives for the Future. *West lndian Medical Journal*, 48(4), 179-182.

Acquah, S. (2011). The relational and communication dynamics between Ghanaian physicians and illiterate patients. Unpublished manuscript.

Adjei, G. O., Darkwah, A. K., Goka, B. Q., Bart-Plange, C., Alifrangis, M. L., Kurtzhals, J. A., & Rodrigues, O. P. (2008). Parents' perceptions, attitudes and acceptability of treatment of childhood malaria with artemisinin combination therapies in Ghana. *Ghana Medical Journal*, 42, 99-106.

Arnold, R. M., (2003). Do we really care about doctor-patient communication or is it just talk? *Journal of Palliative Medicine,* 6(2), 189-192.

Agyepong, I. A., Ansah, E., Gyapong, M., Adjei, S., Barnish, G., & Evans, D. (2002). Strategies to improve adherence to recommended chloroquine treatment regimens: A quasi- experiment in the context of integrated primary health care delivery in Ghana. *Social Science & Medicine*, 55, 2215-2226

Arora, N. K. (2003). Interacting with cancer patients: the significance of physicians' communication behavior. *Social Science Medicine*, 57(5), 791-806.

Ashkehave, I., & Zethsen, K. K. (2000). Medical texts made simple: Dream of reality? *Hermes-Journal of Linguistics,* 25, 63-74.

Barak, A., & Gluck-Ofri, O. (2007). Degree and reciprocity of self-disclosure in online forums. *Cyber Psychology & Behavior* 10, 407-417.

Barret, S. (2006). Doctor- patient communication. Retrieved from http://www.quackwatch.org

Barry, C. A., Bradley, C. & Britten, N. (2000). Patients' unvoiced agendas in general practice consultations: qualitative study. *British Medical Journal,* 320, 1245-50

Bartel, D. A., Engler A. J., Natale J. E., Misra, V., Lewin A. B. & Joseph J. G., (2000). Working with families of suddenly and critically ill children. *Arch Ped. Adolescent Med*, 154, 1127-1133.

Bauman, A., Farrdy, J. & Harris, P. (2003). Getting it right: why bother with patient centred care? MJA, 179, 253-256.

Beisecker, A. E., & Beisecker, T. D., (1990). "Patient Information-Seeking Behaviors When Communicating with Doctors." *Medical Care.* 28 (1), 19-28.

Bennett, A. E., (1976). *Communication between Doctor and Patients.* London: Oxford Alberta Press.

Binnie, A. & Titchen, A. (1999). Freedom to practice: the development of patient-centred nursing. Butterworth Heinemann, London

Bogdan, R. C. & Biklen, S. K. (2003). *Qualitative Research for Education: An Introduction to Theories and Methods* (4th ed.). New York: Pearson Education Group.

Bond, W., (1991). Detection methods and strategies for improving medication compliance. *American Society of Hospital Pharmacists*. 48, 1978-1987

Bourhis, R. Y., Roth, S., & MacQueen, G. (1989). Communication in the hospital setting: A survey of medical and everyday language use amongst patients, nurses and doctors. *Social Science & Medicine*, 28, 339-346.

Brannen, J. (2005). "Mixed Methods research: A discussion paper", ESRC National Centre for Research Methods. NORM Methods Review papers, Retrieved fom http:/www.bournemouth.ac.uk/cap/documents/MethodsReviewPaperNCRM-005.pdf.

Bredart, A., Bouleuc, C. & Dolbeault, S. (2005). Doctor-patient communication and satisfaction with care in oncology. *Current Opinion in Oncology,* 17(4), 351-354

Brown, P. & Levinson, S. (1987). *Politeness: some universals in language usage.* Cambridge: Cambridge University Press.

Browne, K. & Freeling, P. (1976). *The Doctor-Patient relationship.* (2nd ed.). London: Churchill Livingston.

Bruhn, J. G. (1978). *The doctor's touch: tactile communication in the doctor-patient* CA: Sage.

Brynard, P. A. & Hanekom, S. X. (2005). *Introduction to research in Public Administration and related academic disciplines*. Pretoria South Africa.

Byrne, P. S. & Long, B. E. L. (1976). *Doctors talking to patients. London*: HMSO.

Carriger, M. S. (2000). Research design. Retrieved from http://dogbert.mse.cs.cmu.edu/Mse2001/Studio/resdes.pdf

Cegala, D. J. (2000). The effects of patient communication skills training on compliance. *Archives of Family Medicine*, 9, 57-64.

Černý, M. (2008). Some Observations on the Use of Medical Terminology in Doctor-Patient Communication, *SKASE Journal of Translation and Interpretation*. 3: 39-53. Retrieved from http://www.skase.sk/Volumes/JTI03/pdf_doc/4.pdf

Chaitchik, S., Kreitler, S. Shaked, I. & Schwartz, R. (1992). Doctor-patient communication in a cancer ward. *Journal of Cancer Education*; 7(1), 41-54.

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. Thousand Oaks, CA: Sage Publications.

Cohen, D. & Crabtree, B. (2006). Qualitative research guidelines project. Retrieved from http://www. Quatres.org/HomeTria-3692.html.

Cooper, L. A. (1999). "Patient-Centred Communication, Ratings of Care, and Concordance of Patient and Physician Race." *Annals of Internal Medicine.* 2; 139(11): 907-15

Corbett, H. (2012). Your doctor may be keeping secrets. Prevention. Retrieved from http://www.prevention.com/health/healthy-living/doctors-arent-always-honest-patient-study

Coulter, A., (2000). After Bristol: putting patients at the centre. Qual Saf Health Care, 15, 1-7.

Cozby, P. C. (1973). "Self-Disclosure: A Literature Review," *Psychological Bulletin,* 79, 73-91. Diagnostician, compassionate doctor and manager. DVM News Magazine. doi:10.1016/j.pec.2010.04.025.

Creswell, J. W. (2007). *Qualitative inquiry and research design: Choosing among five approaches* (2nd ed.). Thousand Oaks, CA: Sage.

De Beer, A. S. (2009). Communication as an academic field: Africa. *The international encyclopedia of communication*. Retrieved from http://www.communicationencyclopedia.com/subscriber/uid=1163/tocnode?query=health+communication+in+africa&widen=1&result_number=1&from=search&fuzzy=0&type=std&id=g9781405131995_chunk_g97814051319958_ss58-1&slop=1

Denzin, N. K, & Lincoln, Y. S. (1994). *Handbook of Qualitative Research*. Thousand Oaks, California: Sage Publications Inc.

DeVos, A. S., Strydom, H., Fouche, C. B. & Delport, C. S. L. (2002). *Research at grass roots: For social sciences and human service professions* (2nd ed.). Pretoria: Van Schaik Publishers.

DiMatteo, M. R. (1994). Enhancing patients' adherence to medical recommendation. *JAMA*, 271, 79-83.

Domegan, C. & Flemming, D. (2007). *Marketing Research in I reland, Theory & Practice*. Third Edition, Gill and MacMillan.

Duffy, F. D., Gordon, G. H., Cole-Kelly, K., Frankel, R., Buffone, N. (2004). Participants in the America Academy on Physician and Patients' conference on Education and Evaluation of competence in communication and Interpersonal Skills. *Academy of Medicine,* 79; 495-507

Eckler, P., Worsowicz, G. M., & Downey, K. (2009). Improving physician-patient communication. In J. C. Parker, & E. Thorson (Eds.), *Health communication in the new media landscape* (pp. 283-302). New York: Springer.

Eelen, G. (2001). *A critique of politeness theories.* Manchester and Northam Clienton: St Jerome Publishing.

Ellis, M. R. (2004). Patients' views about discussing spiritual issues with primary care physicians. *South Medical Journal*, 97 (12), 1158-64

Fetterman, D. M. (1998). "Ethnography". In L. Bickman and D. J. Rog (Eds.), Handbook of Applied Social Research Methods. London: Sage Publications Inc.

Fishbein, M. (1976). "Persuasive communication: A social-psychological perspective on factors influencing communication effectiveness," p. 99-127. In A. E Bennet (e.d). *Communication between Doctors and Patients.* Nuffield Provincial Hospitals Trust, London: Oxford University Press.

Fong Ha, J. (2010). Doctor-Patient Communication: A Review. *Ochsner Journal*. 10 (1), 38-43.

Frank, J. D. (1961). *Persuasion and Healing*. Baltimore: Johns Hopkins Press

Fraser, B. (1990). An approach to discourse markers. *Journal of Pragmatics* 14: 383-395.

Fry, M. & Mumford, R. (2011). An innovative approach to helping international medical graduates to improve their communication and consultation skills: whose role is it? *Teaching Exchange.*

Fulford, K. W. M., Ersser, S. & Hope, T. (1996). *Essential practice in Patient-centred care*. Blackwell Science Ltd, UK.

Garcia, J. A. (1996). "Patient Preference for Physician Characteristics in University-Based Care Clinics." *Ethnic Disparities*; 13(2): 259-67.

Gay, L. R., Mills, G. E. & Airasian, P. (2006). *Educational Research: Competencies for Analysis and Application* (8th ed.). Upper Saddle River, NJ: Merrill.

Gay, L. R., Mills, G. E. & Airasian, P. (2009). *Educational Research: Competencies for Analysis and Application* (9th Edition) Upper Saddle River NJ: Merrill/Pearson Education, Inc.

Ghana Health Service (2008). The Health Sector in Ghana: Facts and Figures 2008. 1-41, Ghana Ministry of Health. Retrieved from http://www.moh-ghana.org/

Ghana Health Service. (2007). Patient Charter. Retrieved from http://www.ghanahealthservice.org/aboutus.php?inf=Patients%20Charter

Giorgi, A. (2009). *The descriptive phenomenological method in psychology*: *A modified Husserlian approach.* Pittsburgh, PA: Duquesne University Press.

Glesne, C. (1999). *Becoming qualitative researchers: An Introduction* (2nd ed.). Don Mills, Ontario, Canada: Longman.

Goffman, E. (1959). *The presentation of self in everyday life*. Garden City, NY: Doubleday Anchor Books.

Goffman, E. (1967). *Interactional ritual: essays on face-to-face behavior*. New York: Garden City.

Gotti, M. (2006). *Advances in Medical Discourse Analysis-Oral and Written Contexts*. Bern: Peter Lang.

Gray, C. F., & Spatz, M. A. (2009). Access to information: Informing and empowering diverse populations. In S. B. Frampton, & P. Charmel (Eds.), *Putting patients first: Best practices in patient-centered care* (2nd ed., pp. 27-49). San Francisco, CA: Jossey-Bass

Grembowski, D., Paschane, D., Diehr, P., Katon, W., Martin, D. & Patrick, D. (2004). Managed care, physician job satisfaction, and the quality of primary care. *Journal of Gen. Intern Med*; 20: 271-277.

Grice, H. P. (1975). "Logic and conversation". In P. Cole and J. L. Morgan (eds.) *Syntax and semantics, Vol. 3: Speech acts.* New York: Academic Press.

Grice, H. P., (1989). *Studies in the Way of Words*. Harvard: Harvard University Press.

Hadlow, J. and Pitts, M. (1991). The understanding of common health terms by doctors, nurses and patients. *Social Science and Medicine,* 32(2), 193-7.

Haftel, L. (2007). Patient-Doctor Communication: The Fundamental Skill of Medical Practice. Medical School University of Michigan; 1-6

Hall, J. A., & Dronan, M. C., (1990). "Patient socio demographic characteristics as predictors of satisfaction with medical care: a meta-analysis. *Social Science Med*, 30, 811-8.

Hall, J. A., Roter, D. L. & Katz, N. R., (2002). Meta-analysis of correlates of provider behavior in medical encounters. *Medical Care*; 26: 657-75.

Hayford, S. K. (2013). *Special Educational Need and Quality Education for All*. Winneba: Department of Special Education Books

Helman, C. G. (2007). *Improving communication in medical visits*. Westport, CT: Auburn House.

Herget, K., & Alegre, T. (2009). Translation of medical terms. *Translation Journal,* Retrieved from http://accurapid.com/journal/49medical1.html

Hochman, O., Itzhak, B., Mankuta, D., & Vinker, S. (2008). The relation between good communication skills on the part of the physician and patient satisfaction in a military setting. *Military Medicine.* 173, 9: 878.

Holloway, L. (1997). *Basic concepts for qualitative research*. Oxford: Blackwell Science.

Holmes, J. & Stubbe, M. (2003). *Power and Politeness in the Workplace: A Sociolinguistic Analysis of Talk at Work*. Edinburg: Pearson Education Limited.

Holtgraves, T. M. (1992). The linguistic realization of face management: Implication for language production and compensation, person perception, and cross-cultural communication. *Social Psychology Quarterly.* 55, 141-159.

Howie, J., Hopton, L., Heaney, D., & Porter, A. (1992). Attitudes to medical care, organization of work and stress among general practitioners. *British Journal of General Practice,* 42, 181-185.

Ignatius, E. & Kokkonen, M. (2007). Factors contributing to verbal self-disclosure. *Nordic Psychology,* 59, 362-391.

Jackson, J. L., Chamberline, J., & Kroenke, K. (2001). Predicators of patient satisfaction. *Social Science & Medicine,* 52, 609-620. doi: 10.1016/S0277-9536(00)00164-7.

Jacobs, E., Chen, A., Karliner, S., Agger-Gupta, N., & Mutha, S. (2006). The need for more research on language barriers in health care: A proposed research agenda. *The Milbank Quarterly, 84*, 111-133.

Joinson, A. N. (2001). Self-disclosure in computer-mediated communication: the role of self-awareness and visual anonymity. *European Journal of Social Psychology,* 31, 177-192.

Joinson, A. N., Paine, C. B., Buchanan, T., & Reips, U. D. (2008). Measuring self-disclosure on line: Blurring and non-response to sensitive items in Web-based surveys. Computers in Human Behavior. *Journal of Palliative Medicine*, 6 (2), 189-192.

Julliard, K., Vivar, J., Delgado, C., Cruz, E., Kabak, J., & Heidi, S. (2008). What Latina patients don't tell their doctors: A qualitative study. Annals of Family Medicine, 6, 543-549. doi:10.1370/afm.912

Kaplan, S. H., Greenfield, S. & Ware, J. E. (1989). Assessing the effects of physician-patient interactions on the outcomes of chronic disease. *Medical Care*. 27; 110-127.

Karliner, L. S., Jacobs, E. A., Chen, A. H., & Mutha, S. (2007) "Do Professional Interp reters Improve Clinical Care for Patients with Limited English Proficiency? A Systematic Review of the Literature." *Health Services Research*, vol. 42, no. 2, pp. 727–754

Keyton, J. (2001). *Communication and Organization Culture: A key to understanding work experience*. Thousand Oaks, CA: Sage

Kiger, P. (2004). The art of the apology. *Workforce Management* 83 (10), 57-62.

Kitchin, R. (2000). The researched opinions on research: disabled people and disability research. *Disability and Society*, 15 (1), 25-46.

Korsch, B. M., Gozzi, E. K. & Francis, V. (1968). Gaps in doctor-patient communication: Doctor-patient interaction and patient satisfaction. *Pediatrics.* 42; 855-871.

Kreps, G. L., & O'Hair, D. (Eds). (1995). *Communication and health outcomes.* Cresskill, NJ: Hampton Press.

Lakoff, R. (1972). "Language in context." *Language*. 48 (4): 907-927.

Lakoff, R. (1973). The logic of politeness: Or minding your P's and Q's. *Papers from the 9th Regional Meeting of the Chicago Linguistic Society,* (pp.292-305). Retrieved from http://www.pittsburgpamedicalmalpracticeattorney.com

Lakoff, R. (1979). "Stylistic strategies within grammar of style." In Language sex and gender. Orasanu, Jea (ed.) *The annals of the New York academy of Sciences*; 53-80.

Langdridge, D. (2007). *Phenomenological psychology: Theory, research and methods*. London: Pearson.

Larsen, K. M., & Smith, C. K. (1981). Assessment of non- verbal communication in the patient-physician interview. *Journal of Family Practice*, 12, 48-492

Larsson, U. S., Johanson, M., & Svardsudd, K. (1994). Sensitive patient-doctor communications relating to the breast and prostate. *Journal of Cancer Education,* 9, 19-25.

Lee, T. H. (2002). A broader conception of medical errors. *New England Journal of Medicine,* 347, 1965-1967

Leech, G. (1983). *Principles of pragmatics*. *London: Longman.*

Lester, H., Tait, L., England, E. (2006). 'Patient involvement in primary care mental health: a focus group study.' *British Journal of General Practice*, 56 (527), 415-22.

Lester, S. (1999). *An introduction to phenomenological research*. Taunton UK: Stan Lester Developments. Retrieved from www.sld.demon.co.uk/resmrthy.pdf

Levinson, W, Roter, D. L., Mullooly, J. P., Dull, V. T., & Frankel, R. M. (1997). Physician patient communication. The relationship with malpractice claims among primary care physicians and surgeons. *JAMA*; 277: 553-559.

Lewin, S. (2002). Interventions for providers to promote a patient-centred approach to clinical consultations. The Cochrane Library. doi: 10.1111/j.1525.2004.30268.x

Lim, T. S. (1994). Facework: Solidarity, approbation, and tact. *Human Communication Research,* 17, 415-450.

Lincoln, Y. S., & Guba, E., G. (2000). Paradigmatic controversies, contradictions and emerging confluences. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of Qualitative Research* (2nd ed.). (pp.163-188). Thousand Oaks, CA: Sage Publications, Inc.

Lindlof, T. & Taylor, B. (2002). *Qualitative Communication Research Methods*. Thousand Oaks, CA: Sage Publications.

Lindlof, T. & Taylor, B. (2011). *Qualitative Communication Research Methods*. (3rd ed.). Thousand Oaks, CA: Sage Publications.

Littlejohn, S. & Foss, K. (2009). *Encyclopedia of communication theory*. Thousand Oaks, CA: Sage Publications.

Littlejohn, S. W. & Foss, K. A. (2008). *Theories of human communication*. (9th ed.). Belmont, CA: Thompson Wadsworth.

Lloyd, M. & Bor, R. (1996). *Communication skills for medicine*. Churchill Livingstone, London.

Lutz, B. J. & Bowers, B. J. (2000). Patient-centered care: understanding its interpretation and implementation in health care. *Nursing Practice* 14(2): 165-82

Mainous, III A. G., Kern, D., Hainer, B., Kneuper-Hall, R., Stephens, J. & Geesey, M. E. (2004). The relationship between continuity of care and trust with stage of cancer at diagnosis. *Family Medicine*, 36; 1: 35-39.

Malmkjaer, K. (1991). *The linguistics encyclopedia*. London and New York: Routledge.

Matheson, D. (2009). A right to health: Medicine as Western cultural imperialism? *Disability and Rehabilitation*. 31; 1191-1204

McCormack, B. & McCane, T. V. (2006). Development of a framework for person centred nursing. *JADV Nurse*. 56(5), 472-9

Mead, N. & Bowe, P. (2000). "Patient-centredness: a conceptual framework and review of the empirical literature." *Social Science & Medicine;* 51 (7); 1087-1110

Melnikow, J. (1994). Patient compliance and medical research: issues in methodology. *Journal of General Internal Medicine*. 9; 96-105.

Minardi, H. A. & Riley, M. J. (1997). *Communication in health care: A skill based approach*. Butterworth-Heinemann, Boston.

Ministry of Health (2002). Annual Report, Accra Ghana.

Moore, P. J., Adler, N. E. & Robertson, P. A. (2000). Medical malpractice: the effect of doctor patient relations on medical patient perceptions and malpractice intentions. *West J Med*; 173: 244-250.

Morasch, L. J. (2004). Medical Jargon & Clear Communication, *Molina Healthcare and California Academy of Family Physicians*: 1-16. Retrieved from www.familydocs.org/assets/Multicultural Health/MedicalJargon.pdf

Morgan, M. (2003). The doctor-patient relationship. *Sociology as applied to medicine*, 17; 49-65. doi: 10.1177/1049732307301498

Moustakas, C. (1994). *Phenomenological research methods*. Thousand Oaks, CA: Sage

Müller-Engelmann, M., Keller, H., Donner-Banzhoff, N., & Krones, T. (2011). Shared decision making in medicine: The influence of situational treatment factors. *Patient Education & Counseling, 82*, 240-246. doi:10.1016/j.pec.2010.04.028

Myers, M. D. (2009). *'Qualitative Research in Business & Management'*. Sage, London.

Natasa, M. B. & Bakic, N. M. (2008). Successful doctor-patient communication and rapport building as the key skills of medical practice. *Medicine and Biology,* 15: 74-79.

Nelson, R. (2008). Improving communication skills enhances efficiency and patient-clinician relationship, *Arch Intern Med*, 168(13), 586-598.

(Newman, R. D., Gloyd, S., Nyangezi, J. M., Francison, M., & Muiser, J. (1998). Satisfaction with outpatient health care services in Manica Province, Mozambique. *Health Policy and Planning*, 13(2), 174-180

Nicholas, D. D., Heiby, J. R., & Hatzell, T. A. (1991). The quality assurance project: Introducing quality improvements to primary health care in lesser developed countries. *Journal of Family Practice*, 3, 65-147

Northouse, L. L. & Northouse, P. G. (1998). *Health Communication: Strategies of Health Professionals*. London: Pearson Education.

Ofosu-Kwarteng, J. (2012). Healthcare Delivery and Customer Satisfaction in Ghana. A Case Study of the Koforidua Regional Hospital. Unpublished Manuscript.

O'Malley, A. S., Beaton, E., Yabroff, K. F., Abramson, R. & Mandelblatt J. (2004). Patient and provider barriers to colorectal cancer screening in the primary care safety net. *Preventive Medicine;* 39, 56-63.

Ong, L. M., De Haes, J. Hoos, A. M. & Lammes, E. B. (1995). Doctor-patient communication: a review of the literature. *Soc. Sci. Med*. Apr; 40(7): 903-18.

Ormarzu, J. A. (2000). Disclosure decision model: Determining how and when individuals will self-disclose. *Personality and Social Psychology Review*, 4, 174-185.

Osborne, C. A., & Ulrich, L. K. (2008). Lessons on listening: Lessons on listening: Techniques to improve your skill as diagnostician, compassionate doctor and manager. *DVM News magazine*.

Owens, R. E., Metz, D. E. & Haas, A. (2007). *Introduction to communication disorders: A lifespan perspective*. Boston : Allyn & Bacon Oxford University Press.

Partridge, M. R., & Hill, S. R., (2000). Enhancing care for people with asthma: the role of communication, education, training and self-management. *Journal Family Practice,* 16, 333-348.

Patton, M. Q. (1999). Enhancing the quality and credibility of qualitative analysis. *Health Services Research.* 34 (5) Part II. 1189-1208

Pennebaker, J. W. & Beall, S. K. (1986). Confronting a traumatic event. Toward an understanding of inhibition and disease. *Journal of Abnormal Psychology*, 95, 274-281.

Pennebaker, J. W., Kiecolt-Glaser, J. K. & Glaser, R. (1988). Disclosure of traumas and immune function. Health implications for psychotherapy. *Journal of Consulting and Clinical Psychology,* 56, 239-245.

Pinder, R. (1990). *The Management of Chronic Illness: Patient and Doctor Perspectives on Parkinson's Disease*. Basingstoke: Macmillans

Pinker, S. (2007). "The evolutionary social psychology of off-record indirect speech acts". *Intercultural Pragmatics*. 14 (4): 437-462.

Polit, D. & Hungler, B. (2004). *"Nursing Research, Principles and Methods"*. Philadelphia, Lippincourt.

Ponte, P. R., Conlin, G. & Conway, J. B. (2003). Making patient-centered care come alive: achieving full integration of the patient's perspective. *Journal of Nurse Adm.* 33(2), 82-90

Ray, E. B. (Ed.). (2005). *Health communication in practice: A case study approach*. Mahwah, NJ: Erlbaum.

Redman, R. W. (2004). Patient-centered care: an unattainable ideal? *Nurse Practice* 18(1): 11-14

Ridhdale, L., Morgan, M., & Morris, R. (1992). Doctors' interviewing technique and its response to different booking time. *Family Practice,* 9, 57-60

Rogers, A., Kennedy, A., Nelson, E. & Robinson, A. (2005). Uncovering the limits of patient enteredness: implementing a self-management trail for chronic illness. *Qual Health Research*; 125(2), 224-39.

Ross, C. K., Steward, C. A. & Sinacore, J. M. (1993). The importance of patient preferences in the measurement of health care satisfaction. *Medical care*; 31: 1138-1149.

Roter, D. L., & Hall, J. A. (1992). *Doctors talking to patients-patients talking to doctors: Improving communication in medical visits*. Westport, CT: Auburn House.

Roter, D. L., Putname, S. M., Lipkin, M., Stiles, M. J. & Inui, T.S. (1997) Communication patterns of primary care physicians. *JAMA;* 277: 350-6.

Roter, D., L. Hall, J. & Kern, D. (1995). Improving physicians' interviewing skills and reducing patients' emotional distress: a randomized trial. *Arch Intern Med*; 155: 1877-84

Ruusuvuori, J. (2001). Looking means listening: coordinating displays of engagement in doctor patient interaction. *Social Science and Medicine;* 52, 1093-1108.

Safianou, M. (1992). *Politeness Phenomena in England and Greece. A Cross-Cultural Perspective*. Oxford, Clarendon Press.

Salmon, P. & May, C. (1995). Patients' influence on doctors' behaviour: A case study of patient strategies in somatization. *International Journal of Psychiatry in Medicine,* 25, 319-329.

Sandler, G. (1980). The importance of the history in the medical clinic and the cost of unnecessary tests. *American Heart Journal*; 100; 928-931.

Sarfan, D. & Taira, D. (1998). "Linking primary care performance to outcomes of care". *Journal of Family Practice*; 47: 213-220

Shaller, D. (2007). Patient-centered care: what does it take? Picker Institute, Oxford and the Commonwealth Fund. Retrieved from http://tinyurl.com/shaller

Shalowitz, D. I., & Wolf, M. S. (2004). Shared decision-making and the lower literate patient. *Journal of Law, Medicine & Ethics, 32*, 759-764. doi:10.1111/j.1748-720X.2004.tb01981.x

Shepperd, V. B., Zambrana, R. E. & O'Malley, A. S. (2004). Providing health care to low income women: A matter of trust. *Family Practice*, 21, 484-491.

Silverman, J., Kurtz, S. & Draper, J. (1998). *Skills for communicating with patients*. Oxford: Radcliffe Medical Press.

Skelton J. R., Hobbs, F. D. (1999). Concordance: use of language-based research in *Soc. Sci. Med.*, 28(4), 339-46.

Spencer, L., Ritchie, J., Lewis, J. & Dillion, L. (2003). *Qualitative Evaluation: a Framework for Assessing Research Evidence.* London: Cabinet Office.

Spencer-Oatey, H. (2000). Culturally speaking: managing rapport through talk across cultures. London: Continuum International Publishing Group.

Spiers, J. A. (1998). *The use of Face Work and Politeness Theory.* Qualitative *Health Research. Sage Publication, Inc*. Sage pub.

Stewart, M .A. (1995). Effective physician-patient communication and health outcomes: a review. *CMAJ*, 152, 1423–33.

Stewart, M. (2001). Towards a global definition of patient-centred care. *British Medical Journal,* 322(7284), 444-5

Stewart, M., Belle Brown, J., Boon, H. (1999). Evidence on patient-doctor communication. *Cancer Prev. Control*, 3, 25-30.

Street, R. L. (1991). Information-giving in medical consultations: the influence of patients' communicative styles and personal characteristics. Soc. Sci. Med., 32, 541

Swasey, M. L. (2013). Physician and Patient Communication: A Grounded Theory Analysis of Physician and Patient web-logs. Unpublished manuscript.

Tanner, B.A. (1976). Language and Communication in General Practice. Problems in communication. *Prim Care,* 3(3), 25-47

Tesch, R. (1992). *Qualitative research. Analysis, types and software tools*. London: Falmer Press.

Thomas, G., Walker, D. & Webb, J. (1998). *The Making of the Inclusive School*. London: Taylor and Francis Group.

Thomas, J. (1995). *Meaning in interaction: An introduction to pragmatics.* London and New York: London.

Thompson, T. L., Dorsey, A. M., Miller, K. I., & Parrot, R. (Eds.). (2003). *Handbook of health communication*. Mahwah, NJ: Erlbaum.

Ting-Toomey, S. (2001). *Managing intercultural conflict effectively*. Thousand Oaks, CA: Sage.

Tongue, J. R., Epps, H. R., & Forese, L. L., (2005). Communication Skills for Patient-Centred Care. *The Journal of Bone & Joint Surgery,* 8, 476-486

Tracy, K. (1990). The many faces of facework. In H. Giles & P. Robinson (Eds), *Handbook of language and social psychology* (pp. 209-223). London: Wiley.

Tuckett, D., Boulton, M. & Olson, C. (1985). Anew approach to the measurement of patients Understanding of what they are told in medical consultations. *Journal of Health and social Behaviour, 26, 27-38*

Van Ginkel, J. R. (2004). *Multiple imputation of item scores in test and questionnaire data, and influence on results of classical test theory and Mokken scale analysis. 69th Annual meeting of the Psychometric Society, California*

van Manen M. (1990). *Researching Lived Experience: Human Science for an Action Sensitive Pedagogy*. New York: Sunny Press.

Vincent, C. A. (1992). Medical Accidents in Mann, R. Ed Audit and Accountability, London. *Royal Society of Medicine*, 2, 19-87.

Waitzkin, H. (1984). Doctor-Patient Communication: Clinical Implications of Social Scientific Research. *JAMA*, 2, 2441-6.

Wardhaugh, M. A. (2006). Existential phenomenology. In H. L. Dreyfus, & Wrathall, M. A. (Eds.), A companion to phenomenology and existentialism (pp. 229–239). Oxford: Blackwell Publishing Ltd.

Watts, R. J. (1992). *Politeness in Language: studies in its History, Theory and Practice*. Berlin/New York: Mouton de Gruyter.

Watts, R. J. (2003). *Politeness*. Cambridge: Cambridge University Press.

Wennberg, J. E. (2010). *Tracking medicine: A researcher's quest to understand health care*. Oxford University Press.

Whaley, B. B. (Ed). (2000). *Explaining illness: Theory, research and strategies*. Mahwah, NJ Erlbaum Associates, Inc.

White, J. B., Tynan, R., Galinsky, A. D. & Thompson, L. (2004). Face threat sensitivity in negotiation: Roadblock to agreement and joint gain. *Organizational Behavior and Human Decision Process, 94, 102-124*

Wilkins, S. (2012). More money, more time: Will that improve physician-patient communications? [Web log comment]. Retrieved from

http://www.cfah.org/blog/2012/more-money-more-time-will-that-improve-phsyican-patient-communication

Wimmer, R. & Dominick, J. (2006). *Mass Media Research* (8th ed.). Belmont CA: Thomson Wadsworth.

Wragg, T. (2002). Interviewing. In M. Coleman & A. R. J. Briggs (Eds.). Research methods in educational leadership and management (pp.143-158). London: Paul Chapman Publishing.

Yin, R. K. (2003). *Case study research: Design and methods* (3rd ed.). Thousand Oaks, CA: Sage.

Zethsen, K. K. & Askehave, I. (2006). Medical Communication: Professional-Lay, in K. Brown (Ed.), *Encyclopedia of Language and Linguistics*. Oxford: Elsevier: 644-648.

APPENDIX A

INTERVIEW GUIDE- DOCTORS AND PATIENTS

DOCTOR-PATIENT COMMUNICATION IN THE CONSULTING ROOMS: A STUDY OF TWO UNIVERSITY HEALTH FACILITIES IN GHANA

1. How do doctors communicate with their patients in the consulting room in this hospital?
2. How do doctors explain to patients about their conditions in this hospital?
3. How would you describe the attitude of doctors towards their patients in this hospital?
4. How did the doctor explain your condition to you when you went to see him?
5. What time of day was it when you went to see the doctor?
6. Can you describe the mood of the doctor when you saw him?
7. What are the factors that affect your interaction with the doctor in the consulting room?
8. When you met the doctor, were you able to talk feely with him/her?
9. Does the doctor allow you to express yourself freely in the consulting room?
10. Were you allowed to ask questions relating to your ailment?
11. How long did you spend with the doctor?
12. Were you satisfied with your visit to the doctor?
13. What is your general impression of how doctors communicate with their patients in this hospital?
14. What changes if any would you like to see in the attitudes of doctors towards patients in this hospital?

15. What do you think could be done to improve doctors' communication with patients in this hospital?
16. Any final comment?