

## COMMUNICATION BARRIERS BETWEEN DOCTORS, NURSES AND PATIENTS IN MEDICAL CONSULTATIONS AT HOSPITALS OF LAHORE PAKISTAN

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### ABSTRACT

**Objective:** The objective was to identify the barriers between doctors, nurses and patients that they perceive while communicating with each other in outdoor departments of army and public healthcare hospitals, Lahore, Pakistan.

**Study Design:** Exploratory and descriptive.

**Place and Duration of Study:** The study was conducted in the Combined Military Hospital (CMH) and Jinnah Hospital Lahore, Pakistan, for a period of 3 weeks.

**Material and Methods:** Semi-structured interviews of doctors, patients and nurses (2 each, one male and one female in each category) were conducted and analyzed through Interpretative Phenomenological Analysis (IPA). Snow ball sampling technique was used to recruit the participants from various socio-economic strata, experience and age.

**Results:** The study reveals linguistic, cultural, behavioral and management barriers in doctor nurse patient communication from the perceptions of the participants. In addition to this, lack of training of medical professionals inhibits the interpersonal communication between them and patients.

**Conclusion:** The results suggest that the quality of healthcare can be improved by introducing interventions in doctor nurse patient communication. The hospitals should introduce communication skills training programme in medical practices, with a focus on the linguistic and cultural diversity prevailing in the country and how to improve management skills.

**Keywords:** Communication barriers, IPA, Out-patient departments, Perceptions, Thematic analysis.

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### INTRODUCTION

Communication is an act of transferring information (thoughts, ideas and emotions) such that the sender and the receiver are on the same page for understanding the message. Effective communication is crucial for success especially in the sensitive field of medicine which requires doctors, nurses and patients to collaborate fully and to develop interpersonal relationships. Effective communication provides quality healthcare in terms of better management of patients and helps to organize and control managerial tasks. However, due to the diverse nature of hospital network, language barriers can adversely limit patient provider communication. Communication barriers in medical consultations are hindrances that interlocutors face while under-

standing, receiving or sending the messages which cause communicative and medical errors, resulting in wrong diagnosis of the patients.

Pakistan is a multilingual country with linguistically and culturally diverse regions. Although Urdu and English are the official languages of the country, there are a large number of residents who can neither speak nor comprehend other languages than their own. Due to the lack of resources near to their homes located in remote areas of Pakistan, a large number of patients travel to hospitals located in big cities such as Lahore for their treatment. The medical professionals face a kind of challenge in communication, with linguistically diverse patients that may lead to medical errors<sup>1,2</sup>.

It has been observed that the communication skills of the practitioners suffer in actual clinical contexts<sup>3</sup>. The doctors and nurses in training, tend to substitute verbal communication with

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other means, which leads to the lack of focus on holistic patient care<sup>4</sup>. Alarming, medical negligence has been widely reported on media in Pakistan<sup>5</sup>. However, there are only a few studies conducted on the causes of medical errors in Pakistan<sup>6</sup>, which shows negligence of medical professionals on the important issue. A study conducted in tertiary hospital in Karachi suggested that there are many reasons of medical errors that include communication gap<sup>7</sup>. The current study focuses on the perceptions of doctors, nurses and patients about barriers in communication to achieve a holistic understanding of and to give recommendations on how to improve communication between them in order to avoid preventable communication and medical errors.

## **MATERIAL AND METHODS**

Six participants were recruited to participate in the study using snow ball sampling techniques. The first participant recommended associated colleagues, who had almost an experience of twenty years from CMH (army hospital) and Jinnah hospital Lahore, Pakistan (public hospital) as well as patients. The six participants were three males and three females (from each category i.e. a male doctor and a female doctor, a male nurse and a female nurse and a male patient and a female patient). The doctors and nurses were experienced staff. The female patient was middle aged and illiterate, while the male patient was educated, middle aged and belonged to middle class. The study design was descriptive and exploratory in nature. It was conducted for a period of three weeks in August 2018.

This study is conducted to supplement the major project, which aims to identify and analyse the communication barriers between doctors, nurses and patients in out-patient departments that lead to the development of an instrument that measures the quality of healthcare services provided to the clients. The data was collected by using semi-structured interviews in the national language, Urdu.

The interviews of doctors, nurses and patients were conducted separately in English.

The semi-structured interview questions were developed after an extensive literature search from 2004-2018. However, they were translated in Urdu for the participants (female patient) who was not proficient in English language. The data was transcribed verbatim by the researchers. The study was conducted in doctors' offices in hospital settings, after getting appointments from them. The participants were informed about the nature of the study and assured of the anonymity of the data collected. They signed the participant information sheet and the consent form that described the ethics and objectives of the research. The thumb print of an illiterate patient (1 female) was obtained after reading her the forms in Urdu. Ethical Review Board of the University of Management and Technology gave permission to conduct this study.

The participants were specifically asked the major question: "What are your experiences of communication with doctors/patients/nurses in health care setups?"

Each interview lasted from 37 minutes to 50 minutes. The participants' voices were recorded, followed by interview transcription and idiographic coding. During the coding of themes, the researchers tried to understand the lived experiences of the participants within their own context and experiences. Notes were taken on the left column of the transcriptions. This led to the linkage and formation of sub-themes and super ordinate-themes by applying IPA principles. In order to remove any confusion and biases, the recordings and transcriptions were not only repetitively heard and read respectively but also the participants were tracked via cell phones for the removal of any confusion in the data collected and to confirm if the researchers had analysed the data in the same sense as was narrated by the participants.

## **RESULTS**

As discussed in the methodology section, the IPA principles led to the formation of given themes: Deterioration of medical professional's communication skills, linguistic barriers, cultural

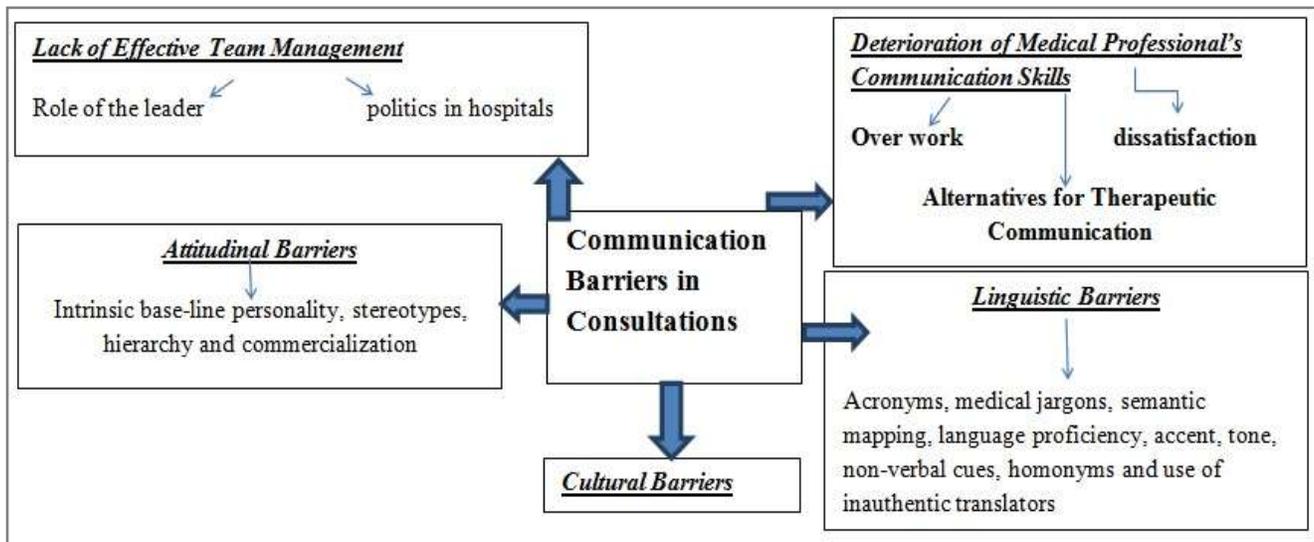
barriers, attitudinal barriers and lack of effective team management. These themes are discussed as follows and are represented in figure 1 below:

**Deterioration of Medical Professional’s Communication Skills**

This theme was divided into three sub-themes: over-work, dissatisfaction and the use of alternatives for therapeutic communication. The participants were of the opinion that a majority of the doctors and nurses lose their focus on holistic patient care because of over-work. A female doctor said:

**Linguistic Barriers**

Linguistic barriers perceived by the participants were: acronyms, medical jargons, semantic mis-mapping, lack of language proficiency, different accents, tone, confusion non-verbal cues, homonyms and inauthentic translators. Communication problems arise in doctor-nurse-patient interaction as most of the patients are illiterate, from lower social class and are not proficient in the varieties used by medical professionals in the hospitals. Patients also believed that due to the linguistic disparity resulting from multilingual and multi-cultural contexts; the wide use of



**Figure: Communication barriers in medical consultations.**

“The doctor nurse patient ratio is unreasonable in hospitals resulting in professionals’ dissatisfaction.”

One of the patients said:

“As medical professionals attend so many patients per day, the monotonous routine makes them physically and emotionally brutal. Instead of being sympathetic and empathetic to the patients, they become robotic in their regular routine check-ups and procedures.”

Instead of providing therapeutic talk to their patients, they employ strategies such as “the use of techniques and skills along with administering a long list of costly tests,” as reported by a female nurse.

medical jargons such as: thallium scan, hypertension, hypoka-laemia etc.; semantic mapping in non-medical contexts such as: Na (for negation), culture, PERRLA (name of a girl), Cap (head cap), stroke, seizures, A.C, etc.; use of acronyms such as: PT, NCP, HRT etc.; Use of nasal and glottal sounds in pronunciation; varying accents and tones, communication gaps existed between them and the medical professionals. The patients lack comprehension because of the inability to express their situations, feelings, complex emotional and physical problems in their little knowledge of the diction. Due to the unintelligibility of vocabulary, some patients use nods or non-verbal communication. The gaps in verbal communication such as substitution of words with non-

verbal expressions lead to reduced production. The doctors sometimes take help from nurses and other healthcare workers to translate or interpret patients. As there is non-availability of trained translators, most of the meaning is either lost or its sense is changed. As a result, the patients do not follow the treatment plan if they could not develop trust in their doctors.

### **Cultural Barriers**

Linguistic and cultural diversity are intrinsically linked with each other. Most of the professionals had difficulty to understand the language and culture of patients specifically from the northern areas of Pakistan. Most of them never bother to understand culture background of patients while giving consultations.

One of the head nurses said that:

“There are patients from rural areas who are brought to the hospital. They refuse our treatment as they prefer to take spiritual treatments such as dum, leaving their matters to Allah. As I am an experienced nurse, I counsel them gradually during their stay at hospital... we tell them to continue their treatment while we provide ours. However, there is a majority of medical professionals who do not know how to deal them.”

### **Attitudinal Barriers**

This theme is further sub-divided into: intrinsic base-line personality, stereotypes, hierarchy and commercialization. This interesting theme emerged when the respondents of the nurse and patient groups brought into focus the hierarchy that expert doctors enjoy. One of the nurses said that:

“There are stereotypes in our society. As soon as children in our families get admission in medical colleges, they are referred as doctors. The junior nurses just cannot dare to speak in front of the doctors. However, the 30 years of experience has taught me how to assert myself.”

The only reason that doctors have power is that they have expert knowledge and without their consent, no medical procedure can take

place. The senior nurse interviewed, a keen educator, said:

“Nurses are now becoming aware of furthering their education. However, I am unsure after gaining education, if they will tolerate doctors’ power over them.”

The patients from lower social status believed that both nurses and doctors “own power.” However, some of the professionals shared their power with patients from upper status due to the commercialization of the medical profession. One of the elderly patients (a retired General) said:

“Yes, medical professionals work in a tensed atmosphere with patients, but they are highly cooperative with me and my family.”

### **Lack of Effective Team Management**

This theme is further divided into: role of leader as a communicator and politics in hospitals. A senior nurse was satisfied with her previous job in PIC, because medical professionals worked and communicated as a team for the common benefit of the patients. She was paid better in the new job but wanted to go back due to politicizing of the medical profession. She said that:

“Times have changed.... There is variety of people in a hospital. The leader’s strategies to unite everyone on the same platform will reduce barriers in doctor-nurse-patient communication but right now, it is lacking in most of the hospitals.”

All the participants opined that the lack of an effective team leader is an important factor that causes communication barriers.

## **DISCUSSION**

The findings of this research are consistent with Gadit and Mugfort<sup>9</sup> who stated that there are many factors responsible for medical errors that include lack of: Accountability, career structure, rule implementation and government surveillance. However, our study indicates the existence of many other factors too, most important of which are communication barriers. Weller *et al*<sup>3</sup> deduced that an ideal healthcare system can be

built through operational team work that involves active communication between all interlocutors<sup>10</sup>. Likewise, Daniel *et al* concluded that teamwork has a direct influence on patient safety and health outcomes due to the complex nature of specialized healthcare<sup>11</sup>. The responsibilities of doctors, nurses and patients are mutually interdependent<sup>12</sup>. The hierarchical nature of Medicine sometimes makes it impossible to establish and run teams effectively. The doctors hold power over the mutual interdependence of other medical professionals and patients due to their knowledge and skills to cure the patients<sup>13</sup>. In that regard, a doctor's interpersonal communication skills help gather information from the patient and give instructions to the staff in order to facilitate accurate diagnosis, counselling of patients and allied healthcare workers<sup>14</sup>. More importantly, the medical professionals must take responsibility of their diction, volume and sound quality, to communicate clearly with their patients. The importance of teamwork and effective communication has not been translated into practice especially in Pakistan, where cultural norms of communication may mitigate against teamwork<sup>17</sup>. Consistent with Murata *et al*<sup>13</sup>, the participants of this study perceived that positive communication between doctors, nurses and patients in hospitals helps reduce hierarchy of one group over another. One of the doctors said "we have to come down to their level" to satisfy the patients. Use of therapeutic communication results in better outcomes and satisfaction of all interlocutors<sup>15</sup>.

The demanding nature of healthcare and huge workload on professionals results in their dissatisfaction<sup>16</sup>. For the sustenance of a the rapeutic doctor-nurse-patient relationship, it is important to have shared perceptions and feelings about the treatment of the problem. Similar to Fischer *et al*, our study shows that information exchange<sup>12</sup> and looped communication are currently the dominant models used in hospitals due to its commercialization, that involves consumers in decision making process

and uses patient centred approaches in communication<sup>18</sup>.

Most of the medical professionals ignore the cultural norms of patients during the medical interview and treatment<sup>7</sup>. This cultural insensitivity leads to non-adherence of the treatment plan, as perceived by the patients. For example, most of the patients are modest and their religious rituals intervene in the treatment plan, which must be negotiated. Cultural competency and effective communication are interdependent<sup>19</sup>. A simple command by doctor, such as "put it down" can be laden with ambiguity<sup>20</sup>. Our mental maps of word associations help us determine the meaning of words and phrases<sup>21</sup>. Not knowing the pragmatics of a language use can lead to utter mis-understandings and dissatisfaction. This involves the correct norms of using both verbal and non-verbal communication i.e., when to speak what, use of gestures, eye contact, touch, getup and facial expressions<sup>22</sup>. Our perceptions are based on our education, family backgrounds, social capital, our professions, our lived experiences and our knowledge of the world<sup>23</sup>. We think and understand according to the frame of reference that our experiences have shaped in a particular context and being a part of a particular culture<sup>23</sup>. The doctors develop a culture which is different as well as similar to some extent to the culture of the nurses, as they work in the same institutions. This culture influences their interaction as well as interpersonal relationship with the patients<sup>24</sup>. The results of this study shall inform and benefit the medical curricula as well as PMDC and PMA to start running CME's on communication skills training given to medical professionals in actual clinical contexts.

## CONCLUSION

Lack of communication skills, linguistic diversity, lack of knowledge and status of doctors and patients lead to difference in communication styles and attitudes of medical professionals and patients, different disease explanation patterns, difference in disease understanding and decision

making attitudes. Variability in individuals and in groups of doctors, nurses and patients is due to acculturation, education and profession that shape the world views, perceptions and attitudes of the individuals/groups. The medical professionals must be trained to listen actively, to reflect on and clarify verbal and non-verbal communication, cross culturally. This can be achieved if standardized communication protocols are observed in actual clinical practices of medical professionals cultivating cultural awareness in them to achieve holistic patient care.

### CONFLICT OF INTEREST

This study has no conflict of interest to be declared by any author.

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