UNIVERSITY OF GHANA

COLLEGE OF HUMANITIES

CULTURE, LANGUAGE AND HEALTH:

A LINGUISTIC INVESTIGATION OF COMMUNICATION STRATEGIES IN GYNAECOLOGICAL CONSULTATIONS IN ACCRA, GHANA.

BY

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THIS THESIS IS SUBMITTED TO THE UNIVERSITY OF GHANA, LEGON IN PARTIAL FULFILMENT OF THE REQUIREMENT FOR THE AWARD OF PHD IN ENGLISH DEGREE

DEPARTMENT OF ENGLISH

AUGUST 2022

DECLARATION

I do hereby declare that this thesis is the result of my original research. This thesis has not been submitted either in whole or in part for another degree at the University of Ghana or elsewhere. I also declare that references to other sources of information used in this study have all been duly acknowledged.

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DEDICATION

I am dedicating this thesis first to the memories of my 'beloved people' – my mother's parents - John Kweku Opare, aka 'Papa' and Beatrice Adobea Opare aka 'Auntie' as we affectionately called them. Their love for me knew no bounds. They taught me the value of hard work, and how to surround myself with positivity. My grandparents further initiated my faith in God. Although they are no longer part of this world, their memories and heart for humanity continue to regulate my life.

Next, this thesis is dedicated to my husband, Dr Enock Kwame Dankyi, and our priceless gems – Dean and Mya Dankyi for their sacrifices for me. I appreciate you Kwame for challenging my scientific sensibilities and for every sacrifice made paramount to the realisation of this thesis.

To Dean and Mya, for being an integral part of this journey … Despite all the challenges, and both of you being affected in every viable way, you were still selfless towards me despite your young ages – Thank you my Genius 1 and Genius 1.

Finally, this work is dedicated to God – Indeed you have shown me your Mercy, Favour, and unmerited Grace in this quest - TO YOU ALONE BE ALL THE GLORY!

ACKNOWLEDGEMENTS

Foremost, I am very fortunate and grateful to honour my advisors Prof. Nana Aba Appiah Amfo, Prof. Ana Deumert and Prof. Gladys Nyarko Ansah, for their continuous support of my PhD study. They have inspired me through their patience, motivation, enthusiasm, and immense knowledge. The journey was asperous due to the challenges of ill health and other levels of delay, but through it all, I had a strong team to serve as the road map. Indeed, I worked on mighty shoulders who led the way, but allowed me to engage in the process and learn from my mistakes. This level of engagement has enabled my growth wholistically.

Besides my advisors, I would like to thank academic platforms such as the African Linguistics School (ALS), Association of African Universities (AAU), African Science Frontiers Initiative (ASFI), The Pan-African Doctoral Academy (UG-PADA), The Open University's online training in research methods and finally, the ACE Research Network for all the virtual and physical training programmes. These platforms guided my research curve and capacity as I learned, unlearned, and re-learned during this phase of my life.

Essentially, I would like to acknowledge the University Health Services (UHS) and the Korle-Bu Teaching Hospital's OB-GYN departments, especially the Staff - the consultants, the nurses, the house officers, and the bio-statistics departments for contributing to the data. I would like to appreciate the communities of patients within these settings who made this study possible as well as especially thank two leading OB-GYN experts Dr Senunyeme (UGH) and Dr Oppong (KBTH). These doctors initiated an open process for a sensitive data collection technique that was unfamiliar within their contexts.

Also, I cannot, but mention and acknowledge the late Prof. Seffah, Dr Boafo, Dr Takyi, Prof. Beyuo, Dr Thompson, Dr Armah, Dr Akoto-Ampaw, Dr Deen, Dr Kumi, Dr Asante, Dr Brew, Dr,

Cole, Dr Bewuo and Dr Ngman all at KBTH as well as Dr Asamoah, and Dr Frimpong, at UHS. These amazing medical teams showed the way. They informed and facilitated my smooth navigation of their medical contexts as well as modus operandi. Finally, I would like to acknowledge Dr Dorothy Asima Kemevor of blessed memory. Dr Kemevor was another inspiring, selfless and a promising OB-GYN female doctor at KBTH who became a beam of light during the hectic fieldwork process. Nonetheless, she could not live to experience this day, but I know she is in a better place with our Maker.

My sincere thanks also go to Prof. Paul Kerswill (University of York, UK) for all his support and insights into my study. I would like to thank Dr Jerry Joe Harrison (Department of Chemistry, UG) for his relentless efforts in helping me to acquire the NVivo 12.6 PRO software. Special thanks also go to Prof. Daniel Angus (Queensland University of Technology, Australia) for also assisting me online with the use of the Discursis software to complement my qualitative data analysis. These acts of sacrifice and the selfless dedication for others to have helped me to acquire and transmit knowledge despite the odds has been priceless.

I thank the former Heads of the Department of English and Chemistry – Prof. Jemima Anderson, Dr Edem Dzregah and other senior lecturers - Prof. A. B. K Dadzie, and Dr Mawuli Adzei, my 'Fathers' (all at the Department of English) for serving as light on this path. As well, I would like to acknowledge Prof. Duamekpor and the Vice Dean of Graduate School, University of Ghana - Prof. Dorcas Osei-Safo both from the (Department of Chemistry, UG) and Dr Godfred Hagan (Department of Physics, UG) for keeping me in check, offering their support and advice. Finally, I would like to appreciate Prof. Adesanmi (Formerly of Carlton University, Canada / Faculty, UG-PADA) of blessed memory for shaping my academic growth through his unique mentoring abilities.

Furthermore, my profound thanks go to 'special sisters' – Ms Divine Kyerewaa-Owusu, Ms Angela Kumah, Ms Philomena Ode Mintah, and Mrs Abigail Ayiglo Kuwornu. I am grateful to Dr Amissah-Arthur for enlightening me at first glance during my research conceptualisation process. I would like to acknowledge Dr Victoria Osei-Bonsu, Dr Kwame Osei-Poku – (Department of English) Prof. Yennah, and Dr Antwi- Boasiako (Both from the French Department) and finally, Dr Saanchi (Department of Linguistics) all faculty members at the University of Ghana for their words of strength, support, and encouragement. Additionally, I would like to formally acknowledge and appreciate Mr George Boateng, Senior Policy Analyst at the African Centre for Economic Transformation (ACET) for his candid perspectives, expertise, and inspiration that strengthened my resolve to forge ahead. I also honour Mr Grant Alexander for using his own stories and experiences as motivation for my progress.

Finally, I would like to thank my family: my parents, my late father Mr Eric Bruku and Mrs Lydia Oprare- Bruku for giving birth to me; my brothers – Mr Roger Opare-Brooks, Mr Kenneth Ofori, Mr Yaw Addo and Mr Raymond Opare-Addo for all their prayers, encouragement, love, and the streams of laughter they brought along my tears in moments of pain, weakness, and mental exhaustion. Again, I would like to honour my extended family - especially Papa Abraham Kojo Nsiako, Auntie Nancy Opare, Auntie Joy Gifty Amoah, and Uncle Seth Opare-Boadu for their prayers, love, and believe in me throughout my journey. Special thanks also go to Mr Reuben Adjei (Formerly of Balme Library, Research Commons) and Mr Christian Dorledzi, Assistant Security Officer formerly of the Balme Library, and including all the staff at the Balme Library, University of Ghana for their encouragement, spiritual support, technical support, and warmth. I adore and respect my mother for her spiritual and leadership support in moments when the journey seemed impossible. She is dearly honoured for sacrificing herself for this success.

ABSTRACT

The essential role of effective doctor-patient communication in patients' healthcare outcomes is well established in the literature. Numerous studies have shown that language, communication, and cultural barriers can negatively affect patients' health outcomes. However, in many countries in Africa, communication in healthcare has faced neglect and is grossly understudied, likely due to socioeconomic, cultural, and physical hindrances. The need for studies is underscored by the increasingly multiethnic, multicultural, and multilingual societies in many cities in sub-Saharan Africa, including Ghana. Of particular interest is communication in sexual healthcare, given its private and intimate nature and the cultural prohibition on sexual expressions. As a result, gynaecological encounters present a particularly challenging situation for healthcare communication in Ghana. Adding to the apparent discomfort is the overwhelming male dominance of professionals, presenting an even more complex situation from cultural and religious perspectives. Consequently, gynaecological encounters become daunting for most women, a situation heightened by the high sexual and reproductive health needs of most women in Ghana. This study investigated communication strategies female patients and male/female doctors employed during sexual healthcare encounters to overcome possible language and cultural barriers. Furthermore, the study explored doctor-patient communication and doctor-patient perceptions of the communication relationship through their use of English. To achieve this, 35 doctor-patient interactions were recorded from the University of Ghana Health Services (UHS) and Korle-Bu Teaching Hospital in Accra. Audio recordings of doctor-outpatient face-to-face encounters served as the main data sources, augmented by data from individual semi-structured interviews and participant observations that contributed to the triangulation of results. NVivo 12.6 and Discursis were employed as software's used in the analysis of data. The study adopted

Communication Accommodation Theory (CAT) as its theoretical lens. CAT highlighted the doctor-patient gynaecological communicative adjustments being negotiated under culturally sensitive and restrictive health interactions. The findings from the study established the doctors and patients employed several communication strategies in their interactions, such as using medical jargon (M. J), avoidance (AVO), code-switching (C-S), and low – tones (L-T) to promote communication, enhance understanding and in all the interactive processes accommodated bilaterally to each other's communication needs. English only or English with a local language (mostly Twi) were predominantly employed. The local language often utilised was to enhance patients' understanding of technical medical concepts. The results from this study point to paternalism as the dominant model of the doctor-patient relationship, promoted by patients. This was reflected in the overwhelming verbal dominance of doctors during the interactions. Patients' preferences and satisfaction were primarily based on effective communication strategies, choice (s) of language, continuity of care with a doctor, and the doctor's level of expertise. Given the vital role of sexual health, the findings from this study may contribute to policies aimed at enhancing patient experiences in this area of healthcare by promoting access and quality of care. The findings are particularly significant in a country such as Ghana, where language, sexual, and reproductive healthcare needs are compelling.

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ABBREVIATIONS

OB-GYN	– Obstetrics and Gynaecology
UHS	– University Health Services
UG	– University of Ghana
KBTH	– Korle-Bu Teaching Hospital
{>D}}	– Mostly Doctors
{>P}}	– Mostly Patients
{D.P}}	– Doctors and Patients
{D}}	– Only Doctors
AIDS	– Acquired Immune Deficiency Syndrome
As.	– Asante Twi
Mf.	– Mfante
Ak.	– Akan
AVO	– Avoidance
C – S	– Code-Switching
CAT	– Communication Accommodation Theory
CHAG	– Christian Health Association of Ghana
CON	– Convergence
D SS-I	– Doctors Semi-Structured Interviews
Dr	– Doctor
ECH	– Ethical Committee of the Humanities
EMP.	– Empathy
GAMA	– Greater-Accra Metropolitan Area
GDP	– Gross Domestic Product
GPA6	– Gynaecological Patient 6
GSS	– Ghana Statistical Service
HIV	– Human Immunodeficiency Virus

IRR – Inter-Rater Reliability

L – T – Low Tones

L1 – First / Local language

L2 – Second Language

L3 – Foreign or Additional Language

M. J's – Medical jargon

NHIS – National Health Insurance Scheme

NP-E – Noun Phrase (NP) Expressions,

*NUD*IST* – Non-Numerical Unstructured Data Indexing Searching and Theorizing

OB-GYN – Obstetrics and Gynaecology

UTI - Urinary Tract Infection

P SS-I – Patient Semi-Structured Interviews

PAT – Patient

PHC – Population and Housing Census

POL – Politeness

PRN IT – Pronoun IT

REP. – Repetition

RESPECT – Rapport, Empathy, Support, Partnership, Explanation and Cultural Competence

S/R/W – Speak/ Read/ Write

SDG – Sustainable Development Goals

SIL – Silence

STI – Sexually Transmitted Infections

UGMS – University of Ghana Medical School

UNESCO – United Nations Educational Scientific and Cultural Organization

WE – I – We-Inclusivity

WHO – World Health Organisation

{ϕ PAT} – Null/Empty set Patients

SIGNS AND SYMBOLS

*- Inadequate competency and proficiency in a language

≥ / = - At least & Equal to

≤ / = - At most & Equal to

> - More

ϕ - Empty / Null set

↑- Highest/Maximum doctor-patient coded percentage coverage

↓ - Lowest/Minimum doctor-patient coded percentage coverage

CHAPTER ONE

1.0 Chapter Overview

Using a qualitative approach, the study linguistically investigates communication strategies in English employed during doctor-outpatient gynaecological consultations in two health facilities in Ghana. For most women, the first visit to an obstetrician/gynaecologist (OB-GYN) represents an uncomfortable experience due to the personal and intimate nature of the interactions. However, the patient seeking healthcare would have no alternative but to express and discuss the details of their reproductive health challenge(s) with the doctor (gynaecologist). In most situations, the patient would prefer to give as few details as possible due to their unwillingness or difficulty in discussing their private health challenges. Mostly, they possibly rely on the clinical reasoning of the doctor to diagnose the health challenge expressed and therefore, to offer instant medical relief due to the unease of most female patients seeking sexual healthcare within the facilities. Moreso, some of the necessary procedures to aid the process may even involve some level of physical examination depending on the medical history recorded, a procedure dreaded by most patients. The ensuing interaction both illustrates the essential role of communication and the possible barriers that may impede this important process in healthcare. These two aspects of communication are highlighted in this chapter. Also, the chapter discusses the research objectives and questions to be explored, the significance of the study, and its delimitation. Finally, the chapter gives a structural overview of the entire study.

1.1 Background

Communication is pivotal to the health delivery process and it has always been featured as a central theme of medicine (Ha & Longnecker, 2010; Thompson & Parrott, 2002). Over the past few

decades, the increased attention to creating efficient and effective healthcare delivery systems has propelled the development of medical communication as a distinct discipline within the field of communication. Generally, clinical communication has been defined as the study and use of communication strategies to inform and influence decision-making and actions to improve health outcomes. It usually involves an interactive exchange of information, views, techniques, and knowledge between a doctor and a patient, a nurse and a patient or a nurse and a doctor. This exchange is mediated by the nature of information shared, the language used, cultural influences, and the perceptions and experiences of those involved (Street et al., 2009).

The fundamental objective of medical care is established when patients achieve their goals of well-being through technical acts and the art of communication. Although the clinical consultative process may entail history taking, clinical diagnoses, physical examination, clinical investigations, treatment recommendations, the effectiveness of this entire process relies heavily on communication. Hence, the doctor-patient communication encounter is an essential element in the total delivery of healthcare. A doctor's ability to obtain relevant information to facilitate accurate diagnosis, and offer successful health management relies on effective communication, which is considered a core skill in medical practice (Ha & Longnecker, 2010).

Effective doctor-patient communication has been defined as the exchange of messages between a doctor and a patient in which both parties share an understanding (Ge et al., 2009). In this instance, there is agreement in the exchange and the receiving of shared emotions, ideas, and viewpoints. Studies have shown that patients who experience effective communication with their doctors are more likely to share vital information, adhere to treatment regimens, and are more likely to be satisfied with their care (Simpson et al., 1991; Stewart, 1995; Street et al., 2009). On the other hand, the absence of effective communication between a healthcare provider and a patient can lead

to dissatisfaction, misdiagnosis, lack of effective medical care, or even death (Gibson & Zhong, 2005; Hasselkus, 2011). Ample evidence in the literature suggests that poor communication is linked to poor healthcare outcomes (Hasselkus, 2011) and it is one of the leading causes of preventable deaths in healthcare facilities (Taran, 2010). However, doctor-patient communication is a complex and delicate process. At the heart of this process is the exchange between two individuals of "non-equal" positions sharing vital, personal, and often sensitive information. Studies show that several factors including language, culture, race and communication style have an impact on the quality of doctor-patient communication and interpersonal relationship (Adams et al., 2015; Ferguson et al., 2002a; Odebunmi, 2022). Therefore, the nature of the doctor-patient medical discourse employed is hinged on the communicative encounter. As such, intra - or inter-language differences between healthcare providers and patients are likely to constitute a barrier to communication in healthcare delivery. This barrier may be evident in the case of high levels of divergence in the languages used, but less so with varying degrees of proficiency in a common language between a healthcare provider and a patient (Schyve, 2007).

Apart from the above, cultural differences may greatly influence language and its meaning due to the interplay of varied beliefs, values and traditions mirrored through the spoken language predominantly. As a result, a patient's ability to understand a healthcare provider's instructions may be influenced by cultural factors that transcend education and literacy, impacting cross/intra cultural communication. For instance, one's culture may affect one's understanding and perception of a word or phrase leading to the tendency for misunderstanding. Often these misunderstandings are based on differences in beliefs, norms, values and perspectives on diseases and illnesses. Accordingly, research has shown that an understanding of cultural diversity is crucial to effective

communication and the provision of healthcare (Brooks et al., 2019; Williamson & Harrison, 2010).

While numerous studies on language as a barrier to communication in healthcare exist in the literature, they have largely focused on communication between dominant and minority language speakers, particularly immigrants in the global North (De Moissac & Bowen, 2019; Meuter et al., 2015; Zambrana et al., 2000). In multiethnic, multicultural, and multilingual societies as pertains in sub-Saharan Africa, the potential of language as a barrier to healthcare delivery, and communication is pronounced. This is because healthcare systems may lack the availability of an adequate number of medical officers who are proficient in all the existing local languages within a community (Deumert, 2010). This language discordance presents a huge barrier to accessing healthcare. For instance, in Ghana, the English language is the medical language for training doctors and a dominant language used in healthcare, especially in peri-urban healthcare facilities with a predominant educated patient population that is linguistically diverse. For a patient who is less proficient in English in such contexts, language may thus present a challenge, particularly when a patient does not share the same local language with a doctor. Communication within these culturally and linguistically diverse societies presents enormous challenges for health delivery, access, and inclusion.

Culture, as a construct, is seen as a critical factor in healthcare while health communication is recognised as key in developing appropriate and effective strategies to eliminate barriers to good healthcare outcomes (Kreuter & McClure, 2004). Hence, culture and health communication have an interconnected relationship. Accordingly, ideas about health are essentially, cultural (Napier et al., 2014). Nevertheless, research and utilisation of the role of culture in healthcare practice remain low (Kota et al., 2023; Nyande et al., 2022). Given the keen sense of culture and its awareness as

a construct on the African continent, its neglect in healthcare is stark. Nonetheless, with the increasing awareness of terms such as "cultural appropriateness", "cultural acceptability", and "cultural sensitivity", the need for practical implementation of these terms in healthcare practice must be carefully considered and applied.

At the same time, culture is dynamic and highly adaptive to changing trends. This complexity of culture is evident in the literature and often restricts its application in practice. Again, in the literature, there is a wide variation in the term "culture" (Kreuter & McClure, 2004). For instance, culture is often viewed as race, ethnicity, identity, and social behaviour rather than as a complex, dynamic, and highly adaptive construct. In this study, culture is described as the intersection between an individual's world view (experiences, values, beliefs) and that of the society's where they belong. Moreover, the cultural effects on communication in healthcare have been primarily studied as communication between a medical officer of a dominant ethnic origin and a patient from an ethnic minority (Paternotte et al., 2016). Moreover, there is very little focus within the literature on intra/inter-cultural influence and/or the inadequate cultural orientation within the hospital's practices serving as a barrier. Yet, culture may play a direct or indirect role in health status through factors such as food, employment, lifestyle norms, value systems, and healthcare decisions. The impact of cultural norms, practices and taboos for instance may restrict people's communicative ability to seek medical care or mode (such as a traditional form) of medical care. Hence, a society's cultural norms and values have an impact on doctor-patient communication (Siu, 2014). In Ghana, culture permeates several facets of life, and its identity is portrayed in the choice of food, music, clothes, artefacts, and mode of communication. The existing cultural norms and practices also influence value systems, approaches, and judgements.

While the predominant model of doctor-patient communication in Ghana's healthcare system may be largely doctor-dominated, a growing health awareness, greater access to medical information and education, and an improvement in literacy rates is helping to gradually alter this model of communication towards a more participatory model This "collaborative" model of communication employs a participatory style of conversation to ensure an almost equal contribution from patients, thereby increasing patient involvement in healthcare decision-making through negotiation and consensus-building (Makoul & van Dulmen, 2015). This type of interaction has been observed to improve patient care.

In general, patient satisfaction with a healthcare provider is associated with a provider's interpersonal and communication skills. Here, a provider's ability to effectively communicate warmth, compassion, emotional support, and understanding is linked to the provider-patient relationship and patient satisfaction (Goold & Lipkin, 1999). Doctors who encourage open communication are likely to obtain complete information, provide appropriate advice, undertake a more accurate diagnosis, and promote patients' adherence to treatment (Odebunmi, 2021). On the other hand, a lack of interpersonal warmth or friendliness from a doctor and insufficient or lack of clear communication are associated with patient dissatisfaction (Vermeir et al., 2015). At the same time, an additional burden of care for doctors in Ghana and many developing countries is the substantial number of patients seeking medical care. With a current doctor-to-patient population ratio of about 1:9000, an enormous burden is placed on medical personnel and the existing healthcare system (Ghana Health Service, 2017b). This ratio is significantly higher than the recommended 1:1000 set by the WHO. Studies suggest that higher doctor-to-patient ratios are associated with better patient satisfaction and healthcare outcomes, probably arising from longer

consultations, greater provision of information and better care (Bloor et al., 2006). Consequently, insufficient medical personnel may negatively impact the entire process.

The doctor-patient relationship in Ghana is one of high reverence for a medical expert whose views and opinions cannot be questioned or challenged. The cultural context positions and projects the doctor as knowledgeable in their field of practice. Hence, everything they do or say is acceptable and deemed as right. Additionally, the willing patient is highly open to the "dictates" of the "powerful" doctor. Under this socio-cultural context, questioning a medical doctor is generally regarded as unacceptable. On the other hand, the social and educational backgrounds of patients may influence a doctor's need or ability to explain his/her views and reasoning to patients. Consequently, the level of medical engagement is largely dominated by the doctor, who, in many instances, becomes the active communicator while the patient remains a passive listener. This scenario often lends itself to ensuring that medical care is largely biomedical with a focus on the disease instead of the patient.

While the influence of culture on health is not in doubt, its influence on sexual health in Ghana is decidedly profound. Among the several ethnic groups in the country, one of the shared values and practices is the restraint on the open expression of sex and sexuality. As a result, sex, and sexuality (including sexual organs) are taboo topics that often require indirect expressions such as the use of metaphors, euphemisms, and idioms. For instance, the mention of sexual organs in open and frank discussions on sex and sexuality, particularly of and among women is largely forbidden and deeply frowned upon. This is especially the case when persons of the opposite gender are involved, therefore, placing a considerable burden on patients when seeking sexual healthcare.

A great deal of literature is available on doctor-patient communication, which has helped to significantly improve our understanding of communication in healthcare, particularly within the

Western context. However, doctor-patient communication in the African context has received relatively little attention (Sood et al., 2014). Given the diversity and interplay of language and culture in the African context, this thesis adds to the existing knowledge by examining the nature, peculiarity, and linguistic features of the communication strategies employed in doctor-patient communication during gynaecological care and its impact on healthcare delivery in an African setting. The gynaecological area in focus has received little attention within the literature in Africa. The thesis, therefore, seeks to offer a context-based understanding of doctor-patient communication in sexual healthcare and it ultimately seeks to contribute to knowledge in addressing possible barriers (language and culture) that may be encountered in gynaecological healthcare delivery.

1.2 Problem Statement

Ghana's healthcare system has as its core value: inclusion, accessibility, and opportunity (Ghana Health Service, 2017a). These targets are being addressed with the collaborating efforts of both public and private healthcare providers. As well, these efforts have been immensely enhanced by the establishment of a National Health Insurance Scheme (NHIS) that seeks to provide affordable, equitable, and accessible health service delivery to residents of Ghana, particularly among the poor and most vulnerable populations (Blanchet et al., 2012). The NHIS has helped to remove out-of-pocket healthcare payments while significantly reducing health service delivery inequalities.

Research has shown that, in Ghana, the insured poor have greater access to health services and better health outcomes than the non-insured poor (Nguyen et al., 2011). This has led to a tremendous increase in access and healthcare service utilization from an estimated 600 000 in the year 2005 to 30 000 000 in the year 2016 (Ghana Health Service, 2017a), and an NHIS enrollment

of about 40% of the population (Ankrah et al., 2019). Despite the generally poor state of healthcare in developing countries, the health sector is critical to the well-being of the population not just during periods of outbreaks of diseases such as Ebola and COVID-19, but in managing chronic and endemic diseases which are more common in these parts of the world.

Given the significant improvement in access to healthcare arising out of the implementation of the NHIS in Ghana, there has never been a more opportune time to examine the influence of communication on health. With unprecedented levels of access to healthcare, the competing demands of adequate clinical care, paperwork, and record-keeping for the huge patient numbers often discourage the requirement for suitable patient engagement through communication. In this challenging environment, the task of developing effective doctor-patient communication requires significant commitment. While it is possible that creating room for effective communication may be more beneficial in the long term, the magnitude of the task confronting health personnel due to high doctor-patient ratios in seeking healthcare in varied African contexts makes prioritizing health communication a difficult decision. As such, doctors tread a fine line between providing optimal biomedical and social care (Patel et al., 2002; Rocque & Leanza, 2015). Usually, this practice may be due to the belief in mostly the physiological changes in a patient's body. This belief may serve as a major measurable and predictable point of assessment to the doctors due to their medical and biomedical training. The complexity of doctor-patient communication is not in doubt, and it has been discussed in the preceding paragraphs. It is an interaction that involves vital, personal, and often non-voluntary information that may be emotionally draining. Particularly for vulnerable patients, this interaction is critical due to increased dependence on the doctor's skills and competencies (Goold & Lipkin, 1999).

The doctor-patient encounter is a sensitive process which is hinged on communication. Notwithstanding, the advancement in technology to complement healthcare delivery in clinical diagnosis and treatment affirms communication as an integral component in healthcare for the exchange of information between a doctor and a patient (Thompson & Parrott, 2002). Yet, the observed disparities in doctor-patient communication due to varied literacy rates among the patient population may hamper this beneficial process. Communication, which also serves as one of the main lifelines within medical practice could be detrimental to the discharge and adherence to medical diagnosis, prognosis, and treatment options. Consequently, this may have dire consequences for healthcare delivery when it is inefficiently incorporated. To further exacerbate the issue is when communication is exchanged between a doctor and patient in gynaecological settings. These clinical contexts are intimate due to the personal nature of the discussions that ensue. Additionally, in the gynaecological engagements, there seem to be cultural restrictions (cultural/linguistic taboos) on the open discussions of sexual and reproductive health in an interpersonal context where feelings, thoughts and ideas are to be expressed. Nonetheless, while there is increasing research, interpersonal health communication as a field has not yet received the much-needed attention in Ghana, and in several African countries (Abukari & Petrucka, 2020; Amfo et al., 2018).

Within Ghana's multi-ethnic, multi-cultural, and multi-lingual society, language and cultural barriers to healthcare are obvious. This is further complicated by the diversity of sociocultural norms and practices, individual expressions, communication styles by patients and doctors, changing technology, clinical environment, and the evolution of patient needs and goals (Thorne et al., 2013). Some of the few studies conducted on doctor-patient communication in some developing countries point to weak doctor-patient communication and the dominance of doctors

in medical interactions, a challenge which also exists in the West (Odebunmi, 2021). Developing an interpersonal relationship is crucial in this context as it plays a key role in the treatment processes by enabling a patient to share vital information that aids a doctor's understanding of the patient's health needs. This practice is essential for an accurate diagnosis, potentially leading to better healthcare delivery.

Among several reasons for medical visits, gynaecological encounters present a particularly challenging situation for both patients and doctors in healthcare communication. This is because this medical field understands the unique needs of the female reproductive system, a personal and an intimate area which is largely silenced communicatively due to cultural restrictions that inhibit conversations about sex, sexuality and the sexual reproductive system of the female (Kajombo, 2021). The intimate nature of sexual health adds to the complexity, particularly for women who must necessarily communicate their sexual health challenge, but they are unable and unwilling due to mostly the use of erotic expressions to give clarity to their medical issue. For most women, gynaecological care is an essential part of healthcare, and almost every female can never avoid this important medical experience. Complete feminine healthcare is dependent largely on the efficiency of this encounter. Nevertheless, most women are unable to seek this care due to fear, and the unease in communicating personal matters. In fact, experts recommend at least once a year visit to gynaecologists for a well-woman visit. The focus of this consistent check-up is for women to stay healthy (emotionally, psychologically, and physically) at all stages life. Furthermore, the consistent check-up will help to detect early reproductive issues to reduce the rate of these concerns by preventing cervical cancers, endometriosis, infertility, sexual dysfunction, premalignant conditions, congenital abnormalities, and menopause. These preventative challenges can be avoided with early detection through physical examinations which may be performed for several

reasons, including pregnancy, diagnosis, and gynaecological screening. Apart from pressing gynaecological issues, however, visits to gynaecologists are largely abhorred for reasons such as stigma, privacy, discomfort, ignorance, and sociocultural misconceptions of the role of a Gynaecologist. For instance, many view the role of gynaecologists as persons who examine the vagina mainly instead of their multifaceted role in managing women's health. In terms of clinical management, accurate communication must be shared to enable appropriate diagnoses. Yet, this limited knowledge, on the role of the gynaecologists, seem to place immense communicative restrictions on the sexual health-seeking behaviour of patients.

One major area of concern for women assessing gynaecological care in Ghana is the huge dominance of male professionals within the field. In a study of one cohort of obstetricians and gynaecologists trained in Ghana, only 6% of the 80 practitioners were females, with a dominant 94% being male (Anderson et al., 2014). For most women, this huge gender gap removes the choice of access to a female Gynaecologist and presents a source of discomfort in seeking gynaecological care. On the other hand, a patient is expected to provide adequate, appropriate, intimate, and detailed information about their ailment to enable proper diagnosis and care. Thus, the ensuing conversation may be guided by the doctor's ability to elicit the relevant information from a somewhat reticent patient (Ivanova et al., 2020). The nature of this complex and delicate interaction has received low attention in literature. Therefore, the need to do a linguistic investigation into how these encounters are made daily within the study's timeframe is of the essence. Again, these findings will advance new knowledge within Health Communication, especially in gynaecological care in some medical facilities in Accra, Ghana. The study, therefore, examined the nature of communication strategies adapted to negotiate the doctor-patient

gynaecological encounters to overcome possible language and cultural barriers to gynaecological healthcare.

1.3 Research Aim and Objectives

Given the knowledge gap above, the overall aim of the thesis is to explore the communication (linguistic) strategies employed by doctors and patients during doctor-patient interactions in gynaecological care.

The specific objectives underpinning the research are:

1. To examine the communication (linguistic) strategies of doctor-patient communication during the interpersonal dialogue in gynaecological care.
2. To determine the model (s) of doctor-patient relationship communication during the interactions.
3. To assess the perceptions of doctors and patients during their encounters in gynaecological care.

1.4 Research Questions

Based on the study's aim and objective, the following research questions were formulated:

1. What communication strategies are adopted by doctors and patients during gynaecological care to overcome potential language and cultural barriers?
2. What model of communication is being practised in doctor-patient gynaecological interactions?
3. What are the perceptions of doctors and patients regarding interpersonal communication during their gynaecological encounters?

1.5 Significance of the Study

While extensive literature on doctor-patient communication exists, adequate representation from developing nations in sub-Saharan Africa is lacking, especially, in gynaecological health seeking behaviours. A critical examination of doctor-patient gynaecological communication in a significantly different culture, with multiplicity of languages will help to address the gaps in current literature by advancing a context-based understanding of doctor-patient gynaecological communication, to provide new evidence of the influence of culture on gynaecological healthcare communication, its access, and outcomes. Ultimately, the knowledge gained will help to identify potential barriers to gynaecological healthcare access and its utilisation in Ghana and other sub-Saharan African countries.

In addition, this study will contribute knowledge to the improvement in communication in Ghana's gynaecological healthcare delivery by addressing language and cultural barriers. The knowledge gained will improve access, inclusion, and opportunity in healthcare facilities, particularly for females in a largely male-dominated healthcare provision system. Also, the study is expected to contribute to gynaecological health awareness and to help in the formulation of policies on gynaecological health communication in Ghana as an essential component of healthcare, particularly in health training curriculums for medical officers.

1.6 Delimitation

Contextually, this study examined the interplay of culture and language in health communication between gynaecologists (doctors) and their patients on culturally sensitive subjects such as sex, sexuality, and reproductive health in two selected health facilities in Ghana. These medical facilities - University Health Services (UHS) and Korle-Bu Teaching Hospital (KBTH) admit,

consult with, and treat patients from all over Ghana and, in some instances, beyond Ghana. Thus, both hospitals, based on their locations, handle patients who are multi-ethnic, multi-cultural and for that matter, multi-lingual within a predominantly heterogeneous urban environment. The study was limited to two hospitals in Ghana. While Korle-Bu Teaching hospital represents the largest referral hospital in Ghana, the University Health Services represents one of the largest hospitals servicing a highly diverse community; thus, the delimitation in the use of just the two facilities is apparent. As a result, the study was based in Accra, the capital of Ghana. The location presents the highest diversity in terms of culture and ethnicity. The study was restricted to gynaecological doctor-patient dialogues where the participants involved could speak English.

Moreover, the study only focused on female patients due to the paucity of male patients within the settings also seeking sexual healthcare during the period of the study. Finally, the sensitivity in personal discussions during OB-GYN care restricted the research to participants who were willing to discuss their privileged information in the presence of a researcher.

1.7 The Structure of the Thesis

The study is organised into seven chapters, outlined as follows: *Chapter one* provides a general background to the study. It explores the interplay of language, communication, and culture within the health sector worldwide with an emphasis on Ghana. It also provides the lacuna to the study, the objectives of the study, research questions to be addressed and the significance of the study as well as the boundaries that define the study. *Chapter two* provides a review of pertinent literature relevant to the study area. This chapter presents the conceptual, empirical, and theoretical foundations within which the work is situated. *Chapter three* presents the research strategy, methods employed in data gathering processes, and the study's philosophical underpinnings. The

chapter also explains the ethical considerations that guided data elicitation. *Chapter four* presents findings on communication strategies doctors and patients adopt during gynaecological care to overcome potential language and cultural barriers. *Chapter five* discusses the recurring doctor-patient communication relationship model during gynaecological encounters. *Chapter six* presents the perceptions of both doctors and patients regarding their interpersonal gynaecological dialogues. *Chapter seven* presents a summary of the major findings from the study, provides perspectives, draws conclusions, and makes relevant recommendations for future research.

1.8 Chapter Summary

This chapter has discussed the essential role of communication in gynaecological healthcare and the possible barriers encountered. These barriers during the doctor-patient dialogue are influenced by language and cultural restrictions on expressions about sex, sexuality, and reproductive health. Moreso, an African context with high multilingualism and multiculturalism and its possible impact on doctor-patient gynaecological communication has been highlighted, particularly when sexual healthcare is being sought. Finally, the chapter underscores the study's need and urgency in salvaging preventable medical challenges encountered by women and the maintenance of their overall feminine health. The background provides a context that underlines the study as well as serving as a roadmap to the subsequent chapters.

CHAPTER TWO

LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.0 Chapter Overview

The chapter is a synthesis of some of the relevant literature on communication in health, particularly on doctor-patient interactions. The peculiarity of these interactions during sexual healthcare, given possible language and cultural influences, is examined. The review also discusses models of doctor-patient communication, some of the major barriers to healthcare in general and particularly in sexual healthcare, as well as patient satisfaction. Furthermore, the chapter examines the interplay between culture and its impact on healthcare, especially in multilingual settings such as Africa, as well as the concept of sexuality and sexual health and the nature of communication strategies employed. Finally, barriers to healthcare are discussed in detail. Communication Accommodation Theory (CAT) is used to help explore the nature of doctor-patient interactions. The application of the theory's strengths and weaknesses is examined in this regard.

2.1 Doctor-Patient Communication

The doctor-patient relationship remains the foundation of medical practice. This dialogue continues to be perhaps the most important diagnostic and therapeutic tool in healthcare. Doctor-patient communication has been defined as a unique form of interpersonal communication that involves information and emotional exchange between a doctor and a patient through language and behaviour (Bai et al., 2019). Ong et al. (1995) have identified three main purposes for doctor-patient communication within healthcare settings: creating good interpersonal relations; exchanging information; and making treatment-related decisions (Ong et al., 1995).

The crucial role of communication in healthcare is evident as it is the primary means of discovering a patient's problem, making a diagnosis, and recommending treatment. This process is largely dependent on successful communication between a doctor and a patient, and it may be verbal or non-verbal (Kee et al., 2018; Ong et al., 1995). There is extensive evidence showing that the quality of doctor-patient communication influences patient satisfaction, and compliance with medical recommendations, and it leads to better healthcare outcomes (Beach et al., 2004; Hesse & Rauscher, 2019; Larson et al., 2019; Matusitz & Spear, 2014; Petracci et al., 2017; Roter & Hall, 1989). This association buttresses the critical role played by doctor-patient interactions in healthcare. In most studies, patient satisfaction with the healthcare process is primarily based on their assessment of the effectiveness of the doctor-patient interaction (Birhanu et al., 2010; Moore et al., 2009). Nonetheless, doctor-patient communication is one of the most complex interactions involving competence, skills, language, decision-making, health literacy, and often emotions. Research in health communication tends to examine how doctors and patients negotiate this dynamic engagement under varying sets of conditions in diverse contexts. Thus, the field of health communication is increasingly recognised as a crucial component for improving healthcare and it entails the study and use of communication strategies to inform, guide and influence patients, medical practitioners, and community decisions on health.

A growing body of evidence suggests that patients who are appropriately engaged in communication during healthcare are more likely to be active participants in these encounters and are more often satisfied with their healthcare (Burgener, 2017). The active engagement of patients is characterised by patient-focused care through the provision of adequate information, support, and commitment where the engagement of the patients tends to transform patients from passive to active participants. Given the central role of patient participation in the healthcare delivery process,

doctor-patient communication and its contribution to healthcare outcomes have been the subject of growing research in the literature (Roter & Hall, 1991; Roter & Hall, 1989; Street & Millay, 2009). At the same time, the past few decades have witnessed a general trend toward increased information seeking and patient participation in treatment decisions, particularly in developed countries (Kruk et al., 2018; Kugbey et al., 2019; Odebunmi, 2022). This has brought a greater focus on communication and its role and effectiveness in healthcare.

2.1.1 Effective Doctor-Patient Communication and Patient Participation

Effective communication in medical care has been identified as critical and unequivocal for the long-term success of healthcare (Matusitz & Spear, 2014). Studies show that effective communication has a positive influence on emotional health, resolution of symptoms, pain relief, and functional and physiologic status of patients (Anderson & Marlett, 2004; Stewart, 1995). As such, recent studies in the field of health communication have endeavoured to define "effective communication" and its associated elements, such as patient satisfaction (Deledda et al., 2013). As a result, the doctor-patient communication may be conceptualized based on two parties, each with their investment in the process: the patient who is focused on his/her perception of the health challenge, information on the problem and an understanding of the illness. On the other hand, the doctor is focused on identifying [explaining] the illness. Usually, the doctor bears the task of resolving any conflict between both agendas through dialogue, negotiation, and partnership. In sum, effective doctor-patient communication has been defined as the exchange of messages between a doctor and a patient in which the meaning is mutually understood (Ge et al., 2009).

Effective communication in healthcare, therefore, requires the willing and positive cooperation of both doctor and patient towards a shared understanding and goal (Stewart, 1995; Street, 1992;

Street et al., 2009). The process involves exchanging information, knowledge, ideas, and thoughts so that the intended message is successfully delivered, received, and understood. Often, this entails understanding the intentions and emotions behind the information being conveyed, the presentation of the message with clarity, and the full attention of the receiver. Here, both doctor and patient assign similar meanings to the message, listen carefully to each other, and make the other feel heard and understood. In general, effective communication aims to create a good interpersonal relationship, facilitate the exchange of information, and involve the patient in decision-making (Ha & Longnecker, 2010).

A strong, therapeutic, and effective relationship is crucial for effective doctor-patient communication (Makoul, 2001). Studies suggest that good medical care and positive treatment outcomes are underpinned by the quality of interaction between a doctor and a patient (Griffin et al., 2004; Street & Mazor, 2017). The process of communication becomes effective as an ongoing process of meaning construction where the process is interactive (multidirectional) with mutual understanding of communicative behaviours, enhancing participation and leading to satisfaction.

The communication process is key to relationship-building, information sharing and good decision-making regarding treatment (Makoul & van Dulmen, 2016). Thus, a doctor's ability to communicate effectively with a patient is key to achieving a successful doctor-patient relationship (Burgener, 2017). Effective doctor-patient communication is particularly crucial in the treatment of chronic diseases such as diabetes and cancer, as the disease typically demands regular encounters with a doctor and may involve complex and varying healthcare decisions (Bakker et al., 2001; Koenig et al., 2014; McCormack et al., 2011; Thorne et al., 2013). Nonetheless, developing an effective doctor-patient communication relationship requires skills in communication, empathy, and engagement (Simpson et al., 1991). Often, factors such as privacy,

trust, emotions, perspectives, and power differences may make achieving effective communication challenging and increase the tendency for misunderstanding in doctor-patient communication.

A crucial aspect of effective doctor-patient communication is patient participation, defined as "the extent to which patients produce verbal and non-verbal responses that have the potential to significantly influence the content and structure of the interaction, as well as the health care provider's beliefs and behaviours" (Street & Millay, 2009, p. 62). This relies on a patient-centred approach that prioritises relationship-building and personal connection with patients (Beach et al., 2006). This relation-centred approach is based on four principles: that relationships in health care ought to include the personhood of the participants, which includes the patient's self and all other external factors that contribute to the self; that effect and emotions are important components of these relationships; that all health care relationships occur in the context of reciprocal influence; and that the formation and maintenance of genuine relationships in health care are therapeutically valuable (Beach et al., 2006). Here, a doctor views his or her patient as a person instead of a biomedical defect being addressed. Research shows that patient participation is influenced by several interpersonal parameters on the part of both patient and doctor, including trust, directness/indirectness, an ability to listen, power distance, and personal health beliefs (Ge et al., 2009). Thus, these factors contribute to patients' definition of what constitutes effective communication.

In recent years, patient-centred communication and care have emerged in the literature as an important approach to improving patient responsiveness and addressing patient needs and perspectives, along with providing patient value-guided decision-making.

Patient-centred communication is generally defined as an approach to medical treatment that embraces patients' expectations, experiences, and preferences. According to Epstein and Street (2007), patient-centred communication is primarily aimed at the following: eliciting and understanding patient perspectives (concerns, ideas, expectations, needs, feelings, and functioning), understanding the patient within his or her unique psychosocial and cultural contexts, and reaching a shared understanding of patient problems and the treatments that are concordant with patient values. Street et al. (2003) have observed that doctors can use partnership-building statements (responding to patients probing whether they have or do not have concrete results, using endearing words such as 'my dear', and eliciting patients' feedback) to inspire greater involvement from passive patients. Notwithstanding, the shift toward patient-centred care in doctor-patient communication in healthcare delivery is largely dependent on the educational background and language proficiency of patients (Aelbrecht et al., 2019).

King and Hoppe (2013) posit that successful communication in healthcare should be consistent with basic principles of information transfer, and it should be specific; uncomplicated; employ repetitions; minimize jargon and check for patient understanding (King & Hoppe, 2013). Besides, communication should simultaneously employ a patient-centred approach and interpersonal interaction to promote patient satisfaction. On the other hand, overly directive communication has been shown to have negative consequences on patient satisfaction (King & Hoppe, 2013; Roter et al., 1987). However, Pilnick and Dingwall (2011) have argued that there is a lack of compelling evidence of the positive impact of this model of care distinguishable from patients' perceptions of care (Pilnick & Dingwall, 2011). Instead, empirical studies of doctor-patient communication point to the remarkable persistence of asymmetry in interactions. They posit that medical care is founded on asymmetry, medical authority, and patient reverence for this authority. As such, the training of

doctors should focus on training doctors to exercise their dominance in more civil ways instead of a shared or patient-led form of medical consultation.

The question of how to resolve the ethical tension of patient-centred care as a partnership with the patient or an accommodation of patients' expectations, even when these expectations are for greater doctor control and focus on biomedical health remain unanswered in the literature (Street et al., 2003). Hence, as represented in Figure 1.1, a person-centred measure of quality and responsiveness of healthcare functioning is dependent on a healthy interaction between the type of health system against the patient's needs, expectations and values informing patients experience and therefore, patient satisfaction.

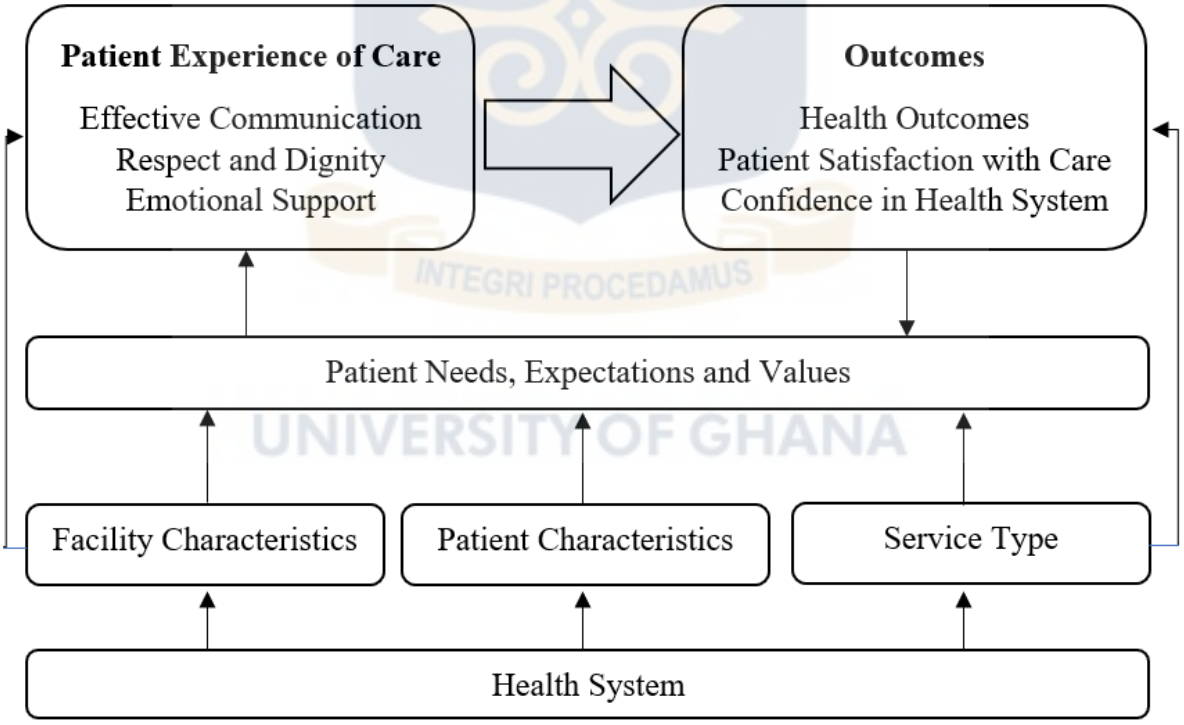

Figure 2. 1: A Framework for Person-Centred Measures of Quality and Responsiveness of Healthcare Functioning. Adapted from (Larson et al., 2019).

Due to the crucial role of communication in medical care, several models have been proposed to describe and improve communication interaction. Examples of these models include the partnership model, AIDET® (acknowledge, introduce, duration, explanation, thank you) model, and the RESPECT (rapport, empathy, support, partnership, explanation, cultural competence, and trust) model (Committee on Patient Safety and Quality Improvement & Committee on Health Care for Underserved Women, 2014). Based on a review and assessment of five major models of doctor-patient communication, Makoul (2001), has proposed an essential set of "communication tasks" needed to achieve effective communication. These tasks include building the doctor-patient relationship; opening the discussion; gathering information; understanding the patient's perspective; sharing information; reaching an agreement on problems and plans; and providing closure (Makoul, 2001).

Given that patients are the recipients of healthcare services, patients' views of doctor-patient communication are essential. As such, knowledge of what patients find relevant from their interactions with healthcare providers is crucial in improving outcomes. Considering the association between anxiety and suffering from illness and the difficulty of seeking care for some types of illnesses, such as sexual illness, a patient-centred approach to communication and care is essential. This approach also considers a patient's view, ideas, thoughts, feelings, and expectations as an integral part of the medical care process. Taken together, there is an impressive body of evidence that supports a positive association between doctor-patient communication behaviours to healthcare outcomes.

Based on patients' views of what constitutes effective doctor-patient communication, Makoul et al (2007) developed a Communication Assessment Tool (CAT) based on 15 statements for evaluating communication effectiveness during medical encounters (Makoul et al., 2007):

1. Greeted me in a way that makes me feel comfortable.
2. Treated me with respect.
3. Showed interest in my ideas about my health.
4. Understood my main health concerns.
5. Paid attention to me (looked at me, listened carefully).
6. Let me talk without interruptions.
7. Gave me as much information as I want.
8. Talked in terms I can understand.
9. Checked to be sure I understand everything.
10. Encouraged me to ask questions.
11. Involved me in decisions as much as I want.
12. Discussed next steps, including any follow-up plans.
13. Showed care and concern.
14. Spent the right amount of time with me.
15. Staff treated me with respect.

The findings from an extensive survey with physicians (38 - physicians) and 950 patients (25 patients per physician) from a variety of specialties and regions within the US were conducted to assess the feasibility of using CAT in everyday practice. The results of the fieldwork showed that doctors were found to be least effective in carrying out tasks "10" (encouraging patients to ask questions) and task "11" (involving patients adequately in decision-making) (Ferranti et al., 2010; Makoul et al., 2007; Mercer et al., 2008; Myerholtz et al., 2010).

2.1.2 Doctor-patient Communication and Patient Satisfaction

Generally defined, patient satisfaction is a measure of the extent to which an individual's experience compares with his or her expectations before, during, and after the course of a medical encounter. Satisfaction represents a positive appraisal by the patient that the goals and expectations regarding healthcare have been achieved (Janicijevic et al., 2013; Lochman, 1983). Currently,

patient satisfaction is by far the most widely recognised measure of healthcare outcome and its quality (Moore et al., 2009; Ong et al., 1995; Street et al., 2009; Van Campen et al., 1995). As such, patient satisfaction has been employed in several initiatives and interventions aimed at improving doctor-patient communication and healthcare in several fields of medicine (Birhanu et al., 2010; Bredart et al., 2005; Burgener, 2017). Generally, surveys based on patient satisfaction are frequently employed to translate largely subjective results into meaningful data.

Patient satisfaction is a multi-dimensional healthcare construct affected by many variables (Carcamo & Lledo, 2001) including access, quality of care, cost, physician role and behaviour, length of treatment, perceived competence of physician, physician emphatic communication; clarity and retention of information, physical facilities and patients' expectations (Birhanu et al., 2010; Hesse & Rauscher, 2019; Lochman, 1983; Naidu, 2009; Shilling et al., 2003). Sorlie et al (2001) have reported that patient satisfaction is influenced by the availability of adequate prospective (rather than retrospective) treatment information and by patients' experience of contact with medical staff (Sorlie et al., 2001). Moreover, long waits during clinical visits have been observed to significantly decrease patient satisfaction (Faezipour & Ferreira, 2013). Evidence from the Joint Commission's Sentinel Event Database confirms communication mishaps as leading sentinel cases in the US and suggests that patients' decisions about doctors, hospitals, and healthcare plans rely largely on satisfaction with the care they receive (Burgener, 2017).

Also, a study which used data from the 2014 Ghana Demographic and Health Survey investigated a total of 12,831 households that were systematically selected with reproductive women aged 15 – 49 years eligible for interview. The data emphasized that the nature of service quality served as a major determinant in patient satisfaction (Wu et al., 2021). However, in South Africa, race and socioeconomic status are major indicators in defining patient satisfaction (Myburgh et al., 2005).

Patient satisfaction is largely based on expectations and personal conditions, which depend on factors such as accessibility, comfort, response capacity, the competence of professionals, staff politeness, information, and continuity of care (Mira et al., 2009). Whether patients are "satisfied" depends on their expectations about different aspects of the healthcare delivery system and process. Moreover, a patient's perception of his or her doctor's interpersonal skills is a key aspect of patient satisfaction and an area widely explored in the literature (Burgener, 2017). A doctor or healthcare provider's ability to communicate clearly and politely, and to connect with the patient on a personal level correlates well with satisfaction (Mira et al., 2009).

Studies show that patient satisfaction leads to patient loyalty; improved patient retention, increased profitability of health systems; increased staff morale and productivity; reduced risk of malpractice suits; and increased personal and professional satisfaction (Moore et al., 2009; Prakash, 2010; Street et al., 2009). Kravitz (1998) has argued that a patient's satisfaction is a distillation of his or her perceptions and values and reflects the weights patients apply to occurrences in a healthcare setting based on what the patient considers to be desirable, expected, or necessary (Kravitz, 1998). For instance, a patient who receives poor care but has low standards may report the same level of satisfaction as a patient who receives good care but has unreasonably high standards.

The literature points to the observation that, the patient experience in healthcare chiefly reflects the interpersonal aspects of the care received and is largely composed of three domains: effective communication; respect and dignity; and emotional support (Larson et al., 2019; Tunçalp et al., 2015). According to Larson et al (2019), these domains may be influenced by factors such as the number of patients seen, waiting time, the ratio of healthcare providers to patients, availability of services and resources, socio-demographic characteristics of the patient, clinical history, prior healthcare-seeking behaviour, and the type of service such as non-emergency care versus

emergency care being sought. Alternatively, these factors can impact a patient's experience indirectly by shaping a patient's needs and expectations which are generally dynamic and may evolve based on the care received and the patient's awareness of healthcare outcomes.

A critical variable that has been found to influence a patient's interpersonal interaction with a doctor or healthcare provider is the wait time. This has been found to have a profound impact on patient satisfaction, particularly during emergencies (Cassidy-Smith et al., 2007; Conner-Spady et al., 2011; Davenport et al., 2017; Thompson et al., 1996).

According to Moore et al. (2009), a significant inverse relationship exists between wait time and physician credibility, and by association, a predictor of healthcare system satisfaction is also confirmed (Abbasi-Moghaddam et al., 2019; Chandra et al., 2018). As has been argued by Street (2003), several important factors influencing the perceptions of patients within healthcare settings are interrelated and often interact with each other to influence perceptions of the healthcare system as a whole and the satisfaction of the patient (Moore et al., 2009; Street, 2003).

Although patient satisfaction may be attributed to factors other than communication, there is compelling evidence in the literature that points to a strong association between communication behaviour during doctor-patient interactions and patient satisfaction with healthcare (King & Hoppe, 2013). Several studies focused on communication and patient satisfaction in medical care have shown that specific behaviours such as eliciting patients' communication with active listening responses, providing detailed information, caring, showing empathy, and addressing the patient's main concerns are highly associated with patient satisfaction. Thus, patients' satisfaction with their healthcare experiences is dependent to a large extent on good communication skills demonstrated by their providers (Kee et al., 2018).

Most studies in the literature demonstrate a correlation between effective physician-patient communication and improved patient health outcomes (Stewart, 1995). However, patient satisfaction ratings lack standards and are largely subjective and depend on patient perceptions relative to their expectations. For instance, a patient's satisfaction with the healthcare delivery process is influenced by his or her perception of what constitutes a successful interaction with the process in meeting the goals and expectations of the healthcare (Moore et al., 2009). Thus, two or more patients experiencing similar health encounters with the same health conditions may provide different satisfaction ratings. In general, where a patient's expectations are high, the likelihood of good satisfaction ratings will be low and vice versa, irrespective of the treatment received. While there may be disagreement on the usefulness or otherwise of patient satisfaction surveys for various purposes, researchers generally agree on the fact that patient satisfaction surveys can reliably differentiate between doctors who are good communicators and those who lack good interpersonal skills (Kravitz, 1998; Lochman, 1983).

2.2 Doctor-Patient Relationship Models

The theory of doctor-patient communication has been framed by Ong et al. (1995) as an interaction that relates background variables, including culture, language, the demeanour of both doctor and patient, and disease characteristics; with the communication process; and patient outcome (Ong et al., 1995). This interaction is largely aimed at developing a positive interpersonal relationship, the exchange of information, and ultimately helping to make treatment-related decisions. One of the earliest models of doctor-patient relationships was proposed by Szasz and Hollender (1956). They defined three basic models as follows: Activity-passivity; guidance-cooperation; and mutual participation (Szasz & Hollender, 1956). These models are described as follows:

i. *The model of Activity-Passivity* is viewed as less of an interaction and more of an effect of a doctor on a patient such that the patient is unable to actively contribute to the interaction. Here the doctor is viewed as active, and the patient is passive. This model is particularly applicable under circumstances where a patient may be helpless such as in emergencies where a patient may be severely injured, delirious, or unconscious. The doctor thus acts in the capacity of trust and acts in the patient's best interest.

ii. *The model of Guidance-Cooperation* is considered the model which underlies much of the medical practice and is applied in situations where a vulnerable patient seeks help from a doctor in a position of power such that, the patient is willing to "cooperate". In this model, the doctor is seen as possessing knowledge about the ailment that the patient does not have. While this model is like the activity-passivity model, the apparent "inactivity" of the patient is "actively" negotiated based on the patient's regard for the doctor and willingness to obey the doctor's guidance without question or argument.

iii. *The model of Mutual Participation* thrives on the assumption that both doctor and patient have approximately equal power; are mutually dependent on each other and are engaged in an activity that will be mutually satisfying to both. This model is particularly beneficial in managing chronic diseases, where a patient's experiences are crucial in recommending treatment.

According to Szasz and Hollender (1956), the various types of doctor-patient relationships may be required for varying circumstances. As such, if changes occur during treatment, a new relationship may be required to replace the old (Szasz & Hollender, 1956). Of the three models proposed, the first two are considered paternalistic and hence, doctor centred. Hellin (2002) argues that paternalism is a principle of hard-line beneficence where patients are treated in the same way

parents treat their children irrespective of the patient's desires and even against their will (Hellin, 2002). The rationale behind paternalism is the belief that the deficiency of the patient is not only biological but moral. This model of the doctor-patient communication relationship can be defined as a process in which the doctor makes all the treatment decisions while the patient is expected to adhere to the treatment plan (Mira et al., 2012). The relationship represents the most traditional model of healthcare and served as the predominant model of healthcare before the 1980s (Ballard-Reisch, 1990). Nevertheless, the creation of the doctrine of informed consent in the early 1980s has witnessed the gradual phase-out of this model of care in many jurisdictions. Informed consent aims to protect patients' rights to agree to or refuse medical treatments, procedures, or interventions based on knowledge of potential complications or risks and benefits (Goldberg, 2009).

Worldwide, healthcare systems are changing, and so are doctor-patient relationships. The extent of change, however, varies considerably between health systems in different nations (Figueras et al., 2010; Ghana Health Service, 2017b; Kruk et al., 2018; Volkman, 2020; WHO & WORLD BANK GROUP, 2018). While the relationship remains largely paternalistic in many developing nations, the literature in developed nations points to a significant evolution of doctor-patient communication from a relationship between a predominantly authoritative doctor and a silent and compliant patient, to that between an empowered and autonomous patient and a doctor fully open to suggestions (Kaba & Sooriakumaran, 2007). For instance, patients may now require more information, ask more questions during doctor-patient consultations, and play a more active role in treatment. The desire of patients to appreciate their medical condition and to understand the treatment prescribed by a doctor has gradually seen a shift away from the paternalistic model to a patient-focused model. In many advanced economies, this is partly a result of disagreement with

a doctor's advice, the availability of choices, patients' rights, and the fear of lawsuits. In the shared decision-making model, both doctor and patient duly participate in the treatment decision-making process, openly share information, and agree on the treatment option to be implemented. Thus, the model tends to encourage more open communication between the patient and provider, facilitate decision-making and increase the quality of care.

According to Hellin (2002), the significant changes in healthcare delivery are largely attributed to the increase in patients' rights emancipation; the rise in ethical issues in medicine; and the influence of economics and healthcare policies. Although changing healthcare systems in African countries remain largely paternalistic in their model of care. In recent years, there has been increased attention on the need to alter the model of care relationship due to the heightened awareness of the beneficial role of social care and patients' contribution to the biomedical treatment process. As healthcare systems in many developing economies gradually shift focus from affordability and accessibility of healthcare to quality of healthcare, the role of doctor-patient communication cannot be overemphasized. However, this will rely on an adequate understanding of the nature and attributes of communication employed in this interaction. While language and communication have been critical to healthcare, research on health communication points to a conspicuous absence of theoretical frameworks in the literature (Beck et al., 2004; Street, 1991). However, this trend is changing, with current literature providing language approaches and theoretical frameworks to illustrate the dynamics of doctor-patient communication (Bylund et al., 2012).

By its very nature, a doctor-patient encounter is interpersonal communication. However, while most studies have considered the nature of doctor-patient communication as an interpersonal relationship, several researchers have argued against this strict view. The argument is that the

practice and conduct of doctor-patient interactions are governed by a set of norms, rules, beliefs, and dynamics that influence not just a particular doctor-patient relationship but the *intergroup* relationship (Gallois & Giles, 2015). For instance, although communication between a doctor and a patient may be driven mainly by personal attributes, patients' personhood and identities, their communicative interaction is also shaped by social and cultural identities as doctor and patient, respectively. As such, several theoretical approaches have been employed to explain doctor-patient communicative interactions. These theories are essential in describing and explaining attributes, practices, beliefs, and behaviours; and furthering our understanding of communication in the context of healthcare. In a comprehensive review of interpersonal models and theories in healthcare, Bylund et al. (2012) identified nine theories that are in use or have potential application in doctor-patient communication. These theories are placed in three broad categories (see Table 2. 1).

Table 2. 1: Interpersonal Communication Theories Applied in Provider-Patient Communication (Bylund et al., 2012)

Theoretical Approach	Theories
Individually centred theories	Goals-Plans-Action Theory
	Uncertainty Reduction Theory
	Uncertainty Management Theory
	Action Assembly Theory
Interaction-centred theories	Communication Accommodation Theory
	Facework and Politeness Theory
	Speech Codes Theory
Relationship-centred theories	Social Penetration Theory and the norm of reciprocity
	Communication Privacy Management Theory

Interaction-centred theories examine how doctors and patients affect each other and are affected during their interactions. Collectively, these theories aid in a better understanding of aspects of the doctor-patient interaction. For instance, how a doctor may request information may influence the amount and the nature of feedback obtained. Similarly, the way a patient's request is made to a doctor may have an impact on the response (s) obtained. This thesis is focused on the interaction-centred approach to communication between doctors and patients. Furthermore, Communication Accommodation Theory (CAT) theory was chosen as the theory that offered the most compelling and comprehensive assessment of this interaction as discussed in sections 2. 7. 1 and of this chapter. CAT has been demonstrated to be an effective approach to the understanding of dynamics and sociolinguistics of doctor-patient communicative interactions in healthcare (Ahmed & Bates, 2016; Farzadnia & Giles, 2015; Street, 1991; 2003).

2.3 Culture, Health, and Doctor-Patient Communication

Health is inseparable from culturally accepted views of wellbeing. This situates culture at the core of health and healthcare practices worldwide. However, the literature points to the systematic neglect of culture in health, which has been recognized as a significant barrier to effective healthcare delivery worldwide (Kagawa Singer et al., 2016; Napier et al., 2014; Stefanovska-Petkovska & Alarcão, 2022; Zbranca et al., 2022). Part of the challenge has been the systemic focus on the individual patient without accounting for the influence of the larger social, historical, and environmental context of the group (s) to which the patient belongs. Although their influences may be pervasive in daily practices, cultural norms and systems may not always be overtly expressed. The covert and subtle influence of culture may have led to its neglect of health. For instance, the influence of culture may not be obvious when a doctor and a patient of the same

nationality albeit with different ethnic backgrounds encounter each other in a healthcare setting in a country, given the assumed culture of the healthcare system itself. Where studies on the influence of culture in healthcare exist in the literature, the focus has largely been across cultures, where the expression of culture and cultural differences are generally overt. These studies include the cultural influence of immigrants and minority populations within a bigger and more homogenous society, usually located in the global north. In contrast, within cultures, differences may appear subtle, unnoticed, or largely ignored but may have profound effects on healthcare outcomes. For instance, within the existing multi-and intra-cultural settings in several African countries, including Ghana, the influence of culture in a doctor-patient healthcare encounter involving two nationals may be taken for granted. Nonetheless, large differences may exist in individuals' views, perceptions, and norms due to the different languages, ethnic and social backgrounds.

In recent years, there has been a compelling need to explore ways in which the complex and dynamic nature of culture and its manifestations in particular settings, including healthcare, can be deeply understood.

Culture as a concept has been particularly challenging to define and has received varied definitions in the literature (Goddard, 2005). This is due to the availability of varied and often divergent views of culture, hindering progress in its study and application in different contexts such as healthcare. Culture has been commonly defined as a dynamic concept that comprises diverse variables, behaviours and practices that may be openly or covertly expressed by a group of people. Generally, culture refers to a set of values, practices and behaviours defined by customs, habits, language, and geography that groups of individuals share. Often, these values may be subjective, unexamined, or taken for granted. One of the earliest and most useful definitions of culture was given by Robert Redfield as "conventional understandings, manifest in act and artefact" (Redfield,

1941, p. 132). This definition is useful in the fact that it does not solely equate to ethnic identity or racial heritage but focuses on shared understandings and practices that are based on those understandings. Also, premised on this definition is the implication that, not all members of a group that share languages, beliefs, and practices, share a given value or norm.

The United Nations Educational Scientific and Cultural Organization (UNESCO) defines culture as "the set of distinctive spiritual, material, intellectual and emotional features of society or a social group, and that it encompasses, in addition to art and literature, lifestyles, ways of living together, value systems, traditions and beliefs." (UNESCO, 2001, p. 2). This definition embodies the creative diversity embedded in the culture as a construct with unique traditions and expressions. One of the most comprehensive definitions of culture has been given by the Lancet Commission on Culture and Health (Napier et al., 2014). They define culture as *"the shared, overt and covert understandings that constitute conventions and practices, and the ideas, symbols, and concrete artefacts that sustain conventions and practices, and make them meaningful"*. This definition attempts to revise the common views of culture as overtly shared and expressed, and as largely unscientific ideas and practices. In perhaps a broader definition, Kagawa-Singer et al. (2016) define culture as "*an internalized and shared schema or framework that is used by members of a group (or subgroup) as a refracted lens to "see" reality, and in which both the individual and the collective experience the world"*. They argue that this framework is created by, exists in, and adapts to the cognitive, emotional, and material resources and constraints of the group's ecologic system to ensure the survival and well-being of its members.

Quite clearly, current definitions of culture highlight the subjectivity, complexity, and evolving nature of the construct. Kagawa-Singer et al. (2016) posit that the construct is inadequately conceptualized and inconsistently applied. They argue that several published studies fail to account

for the complex and dynamic nature of culture which involves the consideration of multiple variables simultaneously. Instead, demographic variables such as ethnicity, race, language, and education are often used and deemed to be universally applicable to culture (Kreuter & McClure, 2004). However, the use of these variables such as race, ethnicity, and ancestry to represent culture has been deemed as simplistic, inaccurate and an inadequate reflection of culture (Goddard, 2005). To date, several studies have demonstrated the crucial role played by culture and cultural competence in doctor-patient interpersonal communication and in improving patient healthcare outcomes (Kreuter & McClure, 2004; Paternotte et al., 2015). The importance of culture is underscored in its influence on several aspects of human interactions, including language. In investigating language, the best way linguistically is through culture due to their interdependent relationship. Every language is embedded and evolves within a culture. This means people from various backgrounds could communicate effectively with each other. Hence, language becomes a feature of social exchange where the interactions are dependent on the actions of the participants involved, and these interdependent interactions could result in quality relationships (Cropanzano & Mitchell, 2005). For instance, culture shapes beliefs, expectations, and attitudes, and these, in turn, have a significant influence on the dynamics of doctor-patient interactions. For instance, Ndidi and Oseremen (2011) have reported that pregnant women in the Niger Delta region of Nigeria tend to report for their first appointments late because clinical care is viewed as largely curative and offers no advantages for healthy mothers (Ndidi & Oseremen, 2011). Here, participation in health care was mediated by ideas about the cultural meaning of care.

Cultural and contextual factors may also play an important role in the doctor-patient communication process (van den Brink-Muinen et al., 2003). This is because culture influences language, style of communication, values and access to healthcare (Claramita et al., 2013; Schinkel

et al., 2019). In cross-cultural communication, the tendency for misunderstanding is high and may result in inappropriate diagnosis and low adherence to treatment. As such, linguistic barriers pose huge challenges for healthcare workers, especially in multicultural settings (Pino-Postigo, 2017). With increasing global migration and multiculturalism, cross-cultural impacts on healthcare are projected to increase.

For effective communication to occur, doctors and patients need to understand each other. As a result, language becomes an important factor in negotiating congruence in doctor-patient communication. As well, language becomes significant when the doctor and patient are from varied cultures and/or use and understand different health terminologies. Differing languages or styles of communication are often associated with misunderstandings and frustration in communication and decision-making. Nonetheless, cultural effects transcend language use. Misunderstandings are common even among patients and doctors who speak the same language but with different ethnic backgrounds (Brooks et al., 2019; Paternotte et al., 2015, 2016). This is often due to different cultural paradigms which are largely influenced by norms, values, religion etc. These may have an impact on perceptions of illness, health, and healthcare.

The cultural background of persons has been shown to influence access to, and effectiveness of healthcare received (Schinkel et al., 2019). Culture is also found to inhibit the disclosure of information as patients may consider that doctors of a different cultural background may not understand their concerns (Ge et al., 2009). As such, culture has a significant influence on perceptions and expectations of the doctor-patient relationship, leading to pronounced differences in the expectations of patients of different cultural groups. It has been shown that dissimilarities in cultural values may impair the development of congruence between a doctor and a patient in

discussions on healthcare resulting in low effectiveness in communication and reduced patient healthcare outcomes (Paternotte et al., 2015).

Consequently, cultural competency research and training are considered critical remedies for addressing cultural challenges (vom Lehn, 2013). Cultural competence has several definitions in the literature, but it often refers to the set of acquired skills that allow for increased insights into and understanding cultural differences (Wachtler & Troein, 2003). As a result, cultural competence in medicine is a complex, multi-layered accomplishment that requires knowledge, skills and attitudes whose acquisition is needed for effective cross-cultural negotiation in clinical settings (Surbone, 2004). The rapport, empathy, support, partnership, explanation and cultural competence (RESPECT) model of communication has been developed to help increase cultural awareness and competence in patient care, particularly during interactions where the patient and the doctor belong to different cultural settings (Mostow et al., 2010). The model comprises a set of action-oriented communication and relational skills and behaviour designed to help build trust in patients, particularly across different races, ethnicity, and culture. This model attempts to go beyond the conventional information-gathering function of interviews by providing a relational building guide that addresses potential distrust, and racial, ethnic, class and economic inequities.

2.3.1 Doctor-Patient Communication in African and Multicultural Settings

Successful healthcare outcome is underpinned by a meaningful two-way communication process between a doctor and a patient. During the process, there can be instances where there is doctor-dominance, patient dominance, or mutual participation during the engagement. However, the communication process in many African and multicultural settings tends to be predominantly doctor-dominated and primarily aimed at facilitating the doctors' task of medical care (Herselman,

1996). The process results in minimal feedback from patients. This form of communication is reinforced by the existing socio-cultural characteristics of the society, including language, norms, beliefs, and practices.

A study by Herselman (1996) between Xhosa-speaking patients and Western medical practitioners in South Africa showed that both doctors and patients attempt to overcome communication barriers by developing communication strategies in ways that are mutually acceptable to accommodate sociocultural differences (Herselman, 1996). Here, doctors strive to communicate with patients at a level and in a style that they can understand, primarily by expressing health issues in culturally accepted ways in which they are perceived by patients (Williamson & Harrison, 2010). This is because, in some cases, patients lack the appropriate vocabulary, and linguistic competence or are culturally inhibited in their communication of health problems (Komaric et al., 2012; Timmins, 2002; Zambrana et al., 2000).

In addition, communication may be hampered by a lack of understanding based on the use of technical language and jargon that a patient may not be familiar with (Thomas et al., 2014). On the other hand, patients may suffer from excessive detail and information overload in a doctor's effort to help him/her understand health conditions and the treatment being carried out. Moreover, doctors may occasionally fail to provide adequate information based on the view that the patient may not fully understand or that the information may not be deemed essential (Coulter et al., 1999).

The literature suggests that patients from less affluent socio-economic backgrounds are generally reticent and reluctant to communicate with their doctors and are less likely to provide the required information or ask questions during healthcare encounters (Hellin, 2002; Pilnick & Dingwall, 2011). However, this information varies in different contexts. For instance, within multicultural African contexts, language barriers may contribute to difficulty in interactions (Hardavella et al.,

2017). This situation is quite prevalent in men, the majority of whom are said to be uncomfortable about talking about their health concerns, particularly those of a sexual nature (Metz & Seifert, 1990). In some cases, patients may not engage in communication out of concern for the volume of work of the doctor and their unwillingness to "burden" the healthcare system or have accepted their condition as recurring (Basu & Duckett, 2009). The behaviour of restraint and unwillingness to communicate is generally viewed as submissiveness, and polite and is highly regarded in rural and conservative communities and among older people (Herselman, 1996; Savundranayagam & Ryan, 2008).

Healthcare is highly influenced by the beliefs of both provider and patient. In several African settings, an important factor that may be at play in health and healthcare is the attribution of illness to spiritual and religious meanings, including activities of witchcraft, wizards, ancestors, and sorcerers. This perspective on health is in direct contrast to modern healthcare and often that of doctors. Frequently, the beliefs that are not shared by doctors are considered superstitions and are often completely ignored or labelled as false. Nevertheless, spirituality and religion are commonly used as coping measures in illness (Amfo et al., 2018; Palmer Kelly et al., 2020; Reinert et al., 2015).

The medical encounter in African societies tends to reflect the tenacious retention of beliefs and traditions that mirror the traditional medicine practitioner-patient relationship in which the practitioner predicts the illness of the patient and prescribes treatment without the participation or questioning of the patient (Herselman, 1996). As a result, patients might withhold information believing it is the doctor's responsibility to know and address them. In some scenarios, however, the withholding of information may be out of the belief that a doctor may not understand the patient's perspective of illness, often borne out of her/his spiritual or religious beliefs. Patient

hesitancy in providing detailed information or engaging in spontaneous communication, particularly about sensitive subjects such as sex, is largely reflected in circumlocution and meandering communication characteristics, often out of embarrassment (Ge et al., 2009).

In many African communities, such as a study conducted in the largest public healthcare facility in Malawi emphasised time constraints (Makwero et al., 2022) as a considerable hindrance to effective communication and healthcare delivery due to the high ratio of patients to doctors, contextual and individual factors. Studies show that outpatient clinics are characterised by long waiting times, which constraints the duration of the doctor-patient interaction and ensures that communication between a doctor and a patient is rapid and straight to the point without room for other related discussions irrespective of their importance to the therapeutic outcome (Umar et al., 2011).

2.4 Sexuality and Sexual Health

Human sexuality is a complex phenomenon resulting from an interaction of biological, psychological, relational, and sociocultural factors (Bancroft, 2009). In addition, economic, political, ethical, legal, historical, religious, and spiritual factors are believed to influence sexuality (WHO, 2002.). The World Health Organization (WHO) defines human sexuality as "a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction". Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships, although not all of these are always experienced or expressed (WHO, 2002).

Conventionally, sexual scientists have attributed sexual reality to a biological basis. This initial construct has shifted beyond the restricting dichotomy of sex/gender and has evolved to reflect a

broader paradigm, which attaches appropriate importance to non-reproductive sex (Abramson & Pinkerton, 1997). Nonetheless, the constructions of sex as a physical act, defined within a narrow coital need, where sex represents vagina/penis intercourse, are the most predominantly applied in medical care (Hordern & Street, 2007). Similarly, research publications mirror the construction of sex as a heterocentric biomedical discourse; hence, it tends to marginalise the sexual needs and concerns of individuals whose disease or treatment does not directly affect the reproductive organs (Ussher et al., 2013). This position also reinforces the narrow interpretation of sex within coitally focused constructions of sexual 'functioning' and performance and neglects the diverse ways in which individuals can negotiate sex and intimacy within healthcare (Hordern & Street, 2007; Perz et al., 2014; Traa et al., 2012; Ussher et al., 2013). However, the past few decades have witnessed dramatic changes in our understanding of human sexuality and sexual behaviour. Of critical significance has been the role of sexuality in human health, a construct referred to as sexual health. The WHO provides a comprehensive definition of sexual health as follows:

> *"Sexual health is a state of physical, emotional, mental, and social well-being about sexuality; it is not merely the absence of disease, dysfunction, or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships and the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination, and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected, and fulfilled"* (World Health Organization, 2006a).

The importance of sexual health is manifested in the fact that several diseases and challenges such as HIV/AIDS, diabetes, cancer, heart diseases, and depression may have an impact on sexual health (Hordern & Street, 2007; O'Connor et al., 2019; Ussher et al., 2013; Vos et al., 2016). These

conditions have drawn much-needed attention to sexual health. In contrast to sexual health, sexual dysfunction has been described as the feeling of distress stemming from difficulties and disruptions in sexual life. Sexual dysfunction is found to have a major impact on the quality of life, interpersonal relationships, and physical and mental health (Basson, 2005; Sarkadi & Rosenqvist, 2001). For instance, research shows that an increase in satisfaction with sexual life ratings is accompanied by a parallel increase in the quality of life ratings in persons with epilepsy (Owczarek et al., 2015).

Sexual health communication is widely recognised as essential to sexual healthcare. In several studies, both patients and healthcare providers acknowledge the critical role and the need for communication on sexual health (Krouwel et al., 2015; Mellor et al., 2013; Sarkadi & Rosenqvist, 2001; Southard & Keller, 2009). However, the literature shows that patients' need for communication during sexual healthcare is largely unfulfilled (Zhang et al., 2020). Often the lack of sexual health communication results in the absence of sexual healthcare during treatments of other diseases that directly impact sexual healthcare (O'Connor et al., 2019; Perz et al., 2014).

There is substantial evidence that patients with sexual health problems want to discuss them with their healthcare providers (Baker et al., 2013; Gott & Hinchliff, 2003; Ussher et al., 2013; Wendt et al., 2007). More crucially, patients wish for their healthcare providers to initiate the conversation on sexual health (Clark & Williams, 2014; Lin et al., 2017). Nonetheless, a lack of knowledge, confidence, and comfort on the part of healthcare professionals in initiating and continuing discussions on sexual health represents a significant obstacle to sexual health communication (Stead et al., 2003; Ussher et al., 2013).

Over the past few decades, there has been a steady increase in sexual health concerns, including unwanted pregnancy, abortion, sexual dysfunction, sexually transmitted diseases and sexual

violence, particularly among women (Shifren et al., 2008; Wendt et al., 2007). However, sexual health-seeking behaviour is considerably low for several reasons on the part of the patient, doctor and society (Kottmel et al., 2014; Stead et al., 2003). These behaviours are linked to the health status of a nation and, thus, country-specific (Latunji & Akinyemi, 2018). Gynaecological visits and examinations provide a good platform for sexual health functioning, reproductive healthcare, sexual problems, and an opportunity for sharing sexual concerns, asking questions and receiving feedback from gynaecologists (Wendt et al., 2007). Nevertheless, gynaecological visits are particularly challenging in many African societies due to cultural norms and behaviour that constrains discussions on sexual health. As a result, gynaecological visits tend to be limited to serious, urgent, and unavoidable causes of sexual health due to the fear, and difficulty in communicating sexual health challenges.

2.4.1 Communication Strategies in Sexual Healthcare

Globally, there is an increasing focus on sexual health as a result of the growing contribution of sexual issues to the global burden of diseases and risks arising from unsafe sexual and reproductive health practices (WHO, 2015). Consequently, matters related to sexual and reproductive health have been enshrined within goal 3 of the UN's sustainable development goals (SDG). Under this goal, sexual health concern is a major focus and includes targets such as improving the quality of childbirth, maternal health, and combating HIV. A pertinent concern for both doctors and patients are how to communicate sexual and reproductive healthcare information and services effectively to enhance accessibility and inclusivity. This process would enable early warning, risk deductions, and reduce global health risks and emergencies. Hence, the situation represents an even bigger concern during first-time doctor-patient meetings. While medical information is confidential and subject to doctor-patient privileges, communication about sexual health is particularly challenging

and intimidating due to the additional privacy burden. Adding to the complexity are culture-induced limitations on sexual communication, which is prevalent among many cultures in Africa. These restrictions on sexual communication are prevalent in many societies and often begin within households and among family members (Bushaija et al., 2013; Manu et al., 2015; Motsomi et al., 2016; Wamoyi et al., 2010).

In communicating with patients with sexual health challenges, doctors are often confronted with the difficulty of eliciting private and intimate but vital information needed for diagnosis and treatment. On the other hand, patients are faced with the challenging task of divulging sensitive personal information to a stranger while hoping for appropriate treatment without judgement. Such consultations pose many difficulties as both doctors and patients are faced with the pressure of time constraints, trust, and privacy. For a patient, illness may present difficulty in communication due to pain, uncertainty, discomfort, and a potentially distressing outlook. The doctor faces a similarly challenging situation. This is especially when communicating unpleasant news or requesting information that may elicit very private responses. This situation is further complicated by the social and cultural contexts of both doctor and patient. Given that how a doctor and patient communicate about sexual health can significantly impact a patient's overall treatment and level of satisfaction, gynaecological care remains severely challenged in many societies on the African continent. Studies show that doctor-patient communication on sexual health is thorny and awkward and often requires complex communicative strategies different from other kinds of medical interactions (Hordern & Street, 2007).

It has been argued that, under these communicative settings, the burden of the level of information a patient provides or receives lies with the doctor (Komaric et al., 2012; Politi & Street, 2011). As such, it is the doctor's responsibility to elicit the required information in an amount needed to

provide relevant care while also ensuring that the patient receives an adequate level of information to ensure participation and satisfaction (Aronsson & Sätterlund-Larsson, 1987). Nonetheless, under sexual healthcare, disclosure of the information is unnerving and largely constrained. Although patients are often desirous of appropriate knowledge of their healthcare, including diagnosis and treatment, the requirement of disclosure on sexual matters remains a challenge and often renders the care-seeking a daunting task (Berman et al., 2003).

In the literature, several reasons have been suggested for the difficulty of communication in sexual health matters. Some of these include how a patient will be perceived; age difference; religious restrictions and perceptions; cultural restrictions and perceptions; and the demeanour of doctors. Speer (2013) argues that the difficulty in communicating about sex may not necessarily be about the delicateness of the topic of sex, as there is general hesitancy and interactional difficulty when discussing intimate features of our lives. Rather, individuals may not be too keen to talk about sex due to social perception, communication settings, and the demeanour of medical officers (Speer, 2013). Given the hesitancy of patients, doctors often take advantage of easier-to-discuss topics to initiate conversations about sex. That notwithstanding, doctors tend to elicit information from patients rather than patients volunteering information about their sexual health. While this approach tends to constrain the conversation and limit the topics a doctor can cover, it appears to be generally more responsive (Speer, 2013). The communication process may be characterized by a range of interactional features such as hesitation, trepidation, few words, euphemisms, non-verbal cues, and self-repair (Aronsson & Sätterlund-Larsson, 1987; Politi et al., 2009; Tomlinson, 1998). Doctors may employ several convergence strategies that may be verbal, such as repetition and slowly speaking; non-verbal such as nodding, making eye contact and showing emotions, including touching (Jain & Krieger, 2011). Often, doctors tend to transition from asking questions

about easier, but related topics to a more challenging talk about sex (Speer, 2013). This strategy helps to avoid the abrupt introduction of sensitive topics and helps patients ease into the conversation with less difficulty. Generally, patients' opposition, as evidenced by evasive strategies and minimal feedback, results in vague and ambiguous medical decisions.

Facial expressions and paralinguistics have been highlighted as crucial aspects of non-verbal communication techniques and especially during doctor-patient engagements (Kee et al., 2018). For instance, non-verbal communication strategies, including gestures, facial expressions, posture and paralinguistics such as tone of voice, eye contact, loudness and body language, are widely acknowledged as integral components of affective communication (Kee et al., 2018). As an example, during a doctor-patient dialogue, a doctor or patient's facial expression, tone of voice or body language may convey interest, approval, disapproval, boredom, or indifference based on the information being relayed. These expressions and their perceived interpretation may have a huge impact on the scope of communication. For instance, a doctor's communicative behaviour during a medical meeting has a major influence on a patient's level of participation (Kaba & Sooriakumaran, 2007; Schinkel et al., 2019). Studies show that minority groups and migrants are often negatively impacted by doctor's communicative behaviour due to their low language proficiency and hence, lower encouragement of discourse by doctors (Ferguson et al., 2002; Schinkel et al., 2019; Schouten et al., 2007; Schouten & Meeuwesen, 2006).

As a remedy, the development of asexuality counselling guideline for healthcare providers that integrates counselling into health services has been recommended. This has the goal of ensuring that healthcare providers integrate sexuality-related communication into sexual and reproductive health services (WHO, 2015). It is envisaged that, through such discussions, healthcare providers may promote sexual healthcare, especially in gynaecological care by promoting and enhancing

effective communication instead of merely treating sexually related diseases or addressing other negative health outcomes due to communication difficulty.

2.5 Barriers to Health Communication

The provision of appropriate care for sexual health problems by healthcare professionals relies on adequate knowledge underpinned by effective engagement with patients. This is because the treatment a patient receives can be greatly affected by what the patient chooses to disclose to his or her doctor. However, there is widespread recognition of several barriers encountered by doctors and patients during discussions on matters related to sexual healthcare. Studies show that these obstacles to sexual health communication restrict healthcare-seeking behaviour by patients. As a result, seeking medical care on matters related to sexual health is generally low, and it is often associated with significant delay and severity of symptoms (Adelowo et al., 2014; Bhan et al., 2020). Evidence suggests that inherent barriers to sexual healthcare may involve personal impediments of both doctor and patient, as well as institutional and societal barriers. In studies on sexuality and health, barriers such as ignorance of symptoms, lack of knowledge about the disease, difficulty in accessing treatment, beliefs about disease, a feeling of embarrassment, and difficulty in discussing symptoms have been identified (Basu & Duckett, 2009; Gott & Hinchliff, 2003; Moore et al., 2013).

Furthermore, Pakbaz et al. (2010) have identified six main obstacles that restrain women from seeking sexual health care "absence of information, blaming oneself, feeling ignored by the doctor, having a covert condition, adapting to successive impairment, and trivializing the symptoms and de-prioritizing own health" (Pakbaz et al., 2010), which are all expressed through language, hence making language a critical barrier in these contexts. For many patients, the experience of

significant symptoms of sexual health is not associated with seeking healthcare treatment (Basu & Duckett, 2009). This is principally a result of their own beliefs and attitudes about health, healthcare, and ageing. Often, these persons develop coping strategies to deal with their symptoms and tend to trivialise symptoms, viewing them as not as crucial compared with other health challenges (Pakbaz et al., 2010).

Again, research shows that patients are more likely to consult a doctor about sexual health problems if their symptoms are severe and have an impact on their quality of life (Adelowo et al., 2014; Basu & Duckett, 2009; Gott et al., 2004; Gott & Hinchliff, 2003; Pakbaz et al., 2010). Research has consistently identified a wide range of barriers to healthcare provisioning and communication about sexuality (O'Connor et al., 2019). Some of the most frequently encountered barriers reported in the literature have been described below:

2.5.1 Time Constraint

Several studies have identified a lack of clinical time to address the sexual aspects of a patient's illness as a key constraint in sexual health and one of the major reasons for the low profile given to sexual concerns in medical practice (Gott et al., 2004; Moore et al., 2013; Strada et al., 2016). Interestingly, time constraint appears to be a barrier for both doctors and patients. A lack of time is considered a barrier across several professional groups in healthcare systems in several studies (Strada et al., 2016). In a survey of 1, 946 physicians and other health professionals attending the 2004 annual meetings of four major specialty societies, time constraint was indicated as the most predominant barrier to communication on sexual health (Bachmann, 2006).

Evidence also points to the fact that quite often, healthcare professionals consider that talking about sexuality and sexual health will take too much time and may constrain more pressing health

challenges (Brandenburg & Bitzer, 2009; Byrne et al., 2010; Helland et al., 2013). This is especially when sexual health is not considered to be the major health concern, but a consequence of the problem. Doctors' perceived time pressure was found to be more prominent among doctors who attend to many patients within a specific time duration, as is common among doctors in many developing countries (Do et al., 2014). Similarly, studies have reported a lack of time or patients' readiness to seek sexual healthcare as a result of the commitment to other duties (Adelowo et al., 2014; Basu & Duckett, 2009). In healthcare settings, time constraint was perceived to stand in the way of patients bringing up sexual-related issues due to the feeling that doctors may not have enough time to deal with them (Brandenburg & Bitzer, 2009; Sarkadi & Rosenqvist, 2001).

2.5.2 Experience and Training

The ability of a doctor to communicate with patients about sexual health practices and problems is fundamental to sexual healthcare and patients' well-being. Nonetheless, this dialogue can be challenging for many doctors (and patients), as doctors often feel inadequately trained and ill-prepared for discussions on sex (Speer, 2013). Inadequate training among doctors has been identified as a critical barrier to sexual health and one of the major means of addressing sexual health challenges (Krouwel et al., 2015; Strada et al., 2016). The literature is replete with studies on patients desirous of discussing issues on sexual health, and often preferring their doctors would bring up the subject (Ussher et al., 2013; Wendt et al., 2007). Largely, these desires are unmet. An important reason cited in the literature is limited training and competence by doctors in communicating issues about sexual health (Finley, 2018).

Not all problems presented by patients visiting healthcare settings may be sexual. Nonetheless, several ailments are indirectly linked to sexual health. As such, sexual health history is increasingly

being viewed as an indispensable part of the medical history-taking process, which is performed by doctors. The sexual history of patients is a necessary first step toward providing sexually related care and also helps to screen for high-risk sexual behaviours, activities and diseases that may impact sexual health (Pakpreo, 2005). At the same time, doctors seem to underestimate the prevalence and need for sexual concerns among patients or are uncomfortable bringing up the subject of sexual health (Reese et al., 2017). Improving communication skills training is widely regarded as the solution to these problems (Criniti et al., 2014; Speer, 2013). The education and training of doctors in communication skills have been identified as central to sexual healthcare, including sexual history-taking and the management of sexual problems. This helps to improve doctors' psychological orientation, exposure, attitudes, and levels of comfort and promotes their involvement in sexual healthcare (Tsimtsiou et al., 2006).

While several studies have shown that patients want to receive sexual health services, generally, most doctors are ill-equipped with the knowledge and skills to discuss sexual health with their patients (Criniti et al., 2014). Often doctors lack the requisite knowledge, communication skills and assuredness that their patients expect from them in discussing sexual health. Nevertheless, Criniti et al. (2014) have reported the dearth of published literature on structured, systematic education and training experiences aimed at preparing doctors to address the sexual health concerns of their patients. This lack of education and training in sexual health communication helps to widen the gap between a patient's desire for a discussion on sexual health and a doctor's ability and the likelihood of discussing the topic of sexual health during medical care (Criniti et al., 2014).

In medical curriculums where training on sexual health exists, it often, they are deemed insufficient. For instance, in a survey of 379 final-year medical students in Malaysia, less than half

(46%) felt that the training they received adequately prepared them to take sexual histories of patients - highlighting gaps in sexual training among medical students (Ariffin et al., 2015). To address the inherent deficiencies in the current approach, it has been argued that communication skills training and clinical practice should be grounded empirically in recordings of actual consultations rather than theory (Speer, 2013).

Evidence from the literature confirms that previous training in communication skills is the strongest predictor for sexual history taking among doctors (Tsimtsiou et al., 2006). The level of communication skills training received by a doctor appears to be central to sexual history taking and the management of sexual problems as it helps to improve doctors' level of comfort in dealing with sexual health issues (Helland et al., 2013; Tsimtsiou et al., 2006). As a result of the significant impact of patients' sexual health on the quality of life, investments in training programmes that build doctors' knowledge in dealing with patients' sexuality are not only seen as essential, but urgent.

2.5.3 Privacy & Embarrassment

For most people, sexuality is private and touches upon intimate aspects of their lives. As such, patients have the right not to be compelled to share information or to have information about them divulged to others (WHO, 2006). Consequently, the privacy of sexual health or the lack of it has been noted as a major barrier in sexual healthcare. Several studies have shown that most patients do not trust their privacy would be maintained (Boekeloo, 2014; Boekeloo et al., 1996; A. Moore et al., 2013; Tsimtsiou et al., 2006). From a doctor's perspective, issues on sexuality are often avoided for fear that patients may be reluctant, feel embarrassed or offended by discussions on sex and sexuality (Brandenburg & Bitzer, 2009). This concern for privacy and feeling of discomfort

or embarrassment appears to be a barrier that prevents patients from initiating discussions (Byrne et al., 2010; Reese et al., 2017).

Again, the feeling of embarrassment or shame by patients suffering from sexual difficulties, particularly older women, has been highlighted in the literature as a major barrier (Gott & Hinchliff, 2003; Pakbaz et al., 2010; Sarkadi & Rosenqvist, 2001). For some patients, disclosing sexual difficulties may be embarrassing due to the belief about how a doctor may perceive them. This feeling of shame may be worsened by the feeling of negative judgment of the healthcare system and society (Brandenburg & Bitzer, 2009; Do et al., 2014). In a large survey of women with female sexual dysfunction, the feeling of embarrassment was identified as the second greatest obstacle to discussing sexual health (Bachmann, 2006). However, the feeling of embarrassment was not considered a factor among women seeking treatment for persistent or recurrent sexual conditions (Basu & Duckett, 2009).

Several studies report that doctors may find discussions on sexuality uncomfortable and embarrassing, and thus avoid raising them (Gott et al., 2004; Verhoeven et al., 2003). For instance, a survey of 647 health professionals involved in the management of sexual care in rheumatology revealed that the feeling of embarrassment was the greatest barrier to raising disease-related sexual issues during healthcare (Helland et al., 2013). Yet, older health professionals have been observed to show less embarrassment in discussing sexual health issues, being less affected by patients' age, compared to younger professionals (Haboubi & Lincoln, 2003).

For some doctors, addressing sexual issues may create too close a bond with patients in non-medical aspects of patient's life that may increase vulnerability or embarrassment or may open a "pandora's box" (Gott et al., 2004; Hordern & Street, 2007; Stead et al., 2003). Moreover, healthcare professionals consider patients' sexual lives as too personal and intimate to ask about

or may feel ill-prepared to sufficiently deal with sexual issues once raised (Richards et al., 2016; Stead et al., 2003; Strada et al., 2016). In several studies, healthcare professionals have identified a lack of privacy as an important barrier to sexual healthcare (Mellor et al., 2013; O'Connor et al., 2019). In many clinical settings in developing economies, there may be a lack of private space, with doctors sharing a consulting room with other health professionals during doctor-patient consultations (Gilbert et al., 2016; Ussher et al., 2013). This often makes the bringing up of sex talk appear inappropriate for both doctor and patient.

2.5.4 Gender & Age

The construction of sexuality is highly influenced by gender. As such, gender has a huge impact on sexual well-being and may influence the complexity of sexual functions, particularly in women (Mellor et al., 2013). Several studies have revealed that the gender and age similarities or differences between doctors and patients may constitute an important barrier to sexual healthcare and a source of discomfort during doctor-patient discussions on sexual health (Bertakis, 2009; Boekeloo, 2014; Burd et al., 2006; Tsimtsiou et al., 2006) (Bertakis, 2009; Boekeloo, 2014; Burd et al., 2006; Tsimtsiou et al., 2006). Based on self-reported levels of discomfort of both patients and doctors, gender congruence was reported to produce less discomfort compared to gender discordance. A study by Burd et al. (2006), reports that doctors perceive their comfort level and that of their patients as best during same-gender interactions on sexual health. Similar findings on gender concordance have been reported in the literature (Politi et al., 2009).

A patient's definition of sexuality and their preferences for a conversation on sexual problems may vary across gender and age (Southard & Keller, 2009; Strada et al., 2016). This outlook of gender rather than concordance or discordance may influence the preference of gender in sexual health

communication. For instance, male healthcare professionals are believed to be less likely than females to discuss the sexual history of patients. Similarly, male doctors may be less comfortable performing breast and gynaecological exams with their female patients (Politi et al., 2009; Temple-Smith et al., 1999). Likewise, men have been described as less likely to open up to their doctors about sexual health problems compared to women (Ussher et al., 2013). In addition, doctors are reported to show a high level of discomfort when interacting with patients of the opposite gender or patients of extreme age discordance, particularly involving older patients (Burd et al., 2006). For many healthcare professionals, the challenge of raising matters related to sex is worsened by gender and age, particularly when a patient is significantly older. It has been observed that, during medical consultations, a patient may opt for a particular health professional based on age and/or gender (Hordern & Street, 2007).

Overall, reported sexual problems tend to increase with age (Shifren et al., 2008). The literature points to the fact that sexual problems are greatest in elderly women and men, although the severity of sexual problems may be more prevalent among younger age groups (Brandenburg & Bitzer, 2009; Shifren et al., 2008). In recent years, there has been general concern about the huge negative influence of age discordance on sexual health discussions reported in most studies. This is due to the higher vulnerability of patients at an older age and their general description of being "asexual" and hence less caring about sexually related matters (Burd et al., 2006; Ussher et al., 2013). Thus, old age represents a barrier to sexual healthcare-seeking (Gott & Hinchliff, 2003). At the same time, other studies have reported no significant correlation between the gender of doctor and patient in initiating and continuing a discussion on sexual health and, as such, its lack of consideration as a barrier (Baker et al., 2013).

2.5.5 Culture

When properly defined, culture appears to be the predominant barrier to sexual health, considering its effect on several other barriers discussed. Culture and its influence on factors such as language, belief, practices and religion constitute a key barrier to sexual health (Ho & Fernández, 2006; Moore et al., 2013). This is because a patient's definition of sexuality and sexual health is shaped by factors including religious and cultural beliefs (Southard & Keller, 2009). These beliefs can be very strong and limited to sexual health in some societies. For instance, in many African and developing societies, culture constrains and censors discussions on sex, sexuality and individuals' views on these topics (Abramson & Pinkerton, 1997; Finley, 2018).

Sexuality is often viewed beyond a set of sexual behaviours to include an individual's sense of femininity or masculinity and a body image rooted in cultural and social norms (Owczarek et al., 2015). Besides its influence on language, culture impacts communication styles and the understanding, attitude and perception of diseases and health. Cultural background is also known to influence a patient's choice and participation in decision-making in healthcare (Gaston & Mitchell, 2005; Ndidi & Oseremen, 2011). Generally, silence about sexuality tends to reflect a broader cultural view of sex as a 'private' subject. As a result, health professionals are often concerned about raising issues on sex with patients of a different culture for fear of offending them. Often, there is a feeling of uncertainty about what may be acceptable and the fear of misunderstanding, promoting discomfort and a feeling of ignorance about sexual communication with patients from different cultures (Hordern & Street, 2007). As well, cultural differences may result in a lack of awareness of topics that may be sensitive to patients (Julliard et al., 2008). This makes raising issues of sex challenging for most health professionals and thus is often avoided altogether (Ussher et al., 2013).

In multicultural societies, the impact of culture on sexual healthcare can be substantial (Ariffin et al., 2015). This is because culture and ethnicity play a key role in what patients disclose about sexuality and how they discuss these topics (Julliard et al., 2008; Nguyen et al., 2007). In a study by Julliard et al (2008), all participants who discussed sensitive issues on sexuality indicated the impact of culture in limiting their discussion with doctors (Julliard et al., 2008). Other studies also showed that cultural differences have the potential to impact patients' willingness to consult with their doctors about sexual dysfunction (Yulevitch et al., 2013).

The available literature on sexual health in Africa is generally low, perhaps due to the strong influence of culture as discussed above. The few publications available are dominated by the Southern Africa region and are largely focused on human immunodeficiency virus (HIV), a sexually transmitted infection (WHO, 2002). In several African societies, including Ghana, the discourse around sexuality is underscored by silence, taboos and a repressive culture that emphasises the suppression of sexuality. As a result, sexual health problems are often suffered in silence and viewed with embarrassment and shame. This is particularly troubling in a region where a high premium is placed on childbirth, placing millions of women at risk.

Cultural competence training has been suggested as an approach to overcome culture as a barrier in sexual healthcare and healthcare in general. This approach aims to help health professionals to acquire the skills needed for an increased understanding of cultural differences. Beach et al. (2005) have argued that cultural competence training shows huge potential for improving the knowledge, attitudes, and skills of health professionals as well as improving patient adherence to therapy and healthcare outcomes across racial and ethnic groups (Beach et al., 2005). Nonetheless, a clear definition of the concept, its associated terms and instructional pathways appear to be lacking and need to be addressed to help to overcome this barrier (Wachtler & Troein, 2003).

2.6 Conclusion

An extensive body of literature points to a huge gap in sexual health perspectives between patients and healthcare providers (O'Connor et al., 2019). These diverse views constitute substantial barriers to healthcare. These barriers may be individual (personal), societal, structural, or institutional. Several of these barriers have been identified in the literature and discussed in sections 2.4 and 2.4.1. However, many of these barriers are closely linked with individual and social views in both patients and healthcare professionals. Largely, these barriers appear to be associated with the greater focus on biomedical models of healthcare to the neglect of the social and psychological aspects (Paternotte et al., 2015, 2016). The emphasis on biomedical models of healthcare seems to reflect the belief that sexual issues are largely physiological and can be managed through pharmacological or medical care (Eldridge & Giraldi, 2017; Gilbert et al., 2016; Hordern & Street, 2007; Stead et al., 2003).

Based on a review of barriers to sexual healthcare, O'Connor et al. (2019) have proposed the following as a means of overcoming barriers in sexual health communication within healthcare settings: patient-centred care that makes room for a well-structured means of obtaining biomedical and psychosocial data; proactively addressing intimate issues without being too invasive; allowing for enough space and time for adequate communication while respecting the time limits of medical consultations; and effective combination of biomedical, diagnostic, and therapeutic procedures with verbal communication. With the introduction and expanding use of technology in healthcare, the doctor-patient encounter has become unquestionably more complex, strengthening the need for education and training in communication. As a result, the task of overcoming the barriers to sexual healthcare can be addressed beginning with the recognition of their impacts on quality of life. While being conscious of cultural sensitivities, careful integration of strategies that encourage

trust, comfort, and open communication on issues of sexual concern in healthcare settings would be key in improving sexual communication. This would be enhanced by the education and training of healthcare professionals to develop and improve engagement and communication skills particularly related to sexual healthcare.

Also, health education in society will help to enhance the public awareness of the importance and need for health and healthcare in general and sexual healthcare.

2.7 Theoretical Framework

2.7.1 Communication Accommodation Theory

Communication accommodation theory (CAT) provides a broad framework for exploring both interpersonal and intergroup communication dynamics under various contexts. The theory focuses on the ways individuals modify their communicative behaviour because of their communication with each other. CAT examines attitudes, behaviour, motivations, strategies, approaches, and tactics that communicators employ to adjust their language and non-verbal patterns to each other (Gallois & Giles, 2015). The main assumptions of the theory are that interactants have motivations for adapting their communication relative to their perceptions of the communicative styles of interlocutors; and interactants form impressions and evaluations of each other concerning their expectations for the other's communicative style relative to their own (Street, 1991). According to Giles and Ogay (2007), CAT is premised on four main principles:

a) Communication is influenced by the immediate context, participants' initial orientations, and the socio-historical context in which the interaction is embedded.

b) Communication involves the exchange of information about facts, ideas, emotions, and the negotiation of relevant social categories during an interaction through the process of accommodation.

c) Interactants have expectations regarding optimal levels of accommodation based on stereotypes about intergroup members within the prevailing social context and situational norms.

d) Interactants employ specific communication strategies such as convergence and divergence to signal their attitudes towards each other and their respective social groups.

The term accommodation refers to the continual movement toward and away from a person by changing one's communicative behaviour. Gallois and Giles (2005) define communication accommodation as "the adjustments made in speech and communication (whether perceived or actual) resulting from attempts to take positive (or negative) account of an interlocutor's behaviour, group memberships, motivation, and needs, in an interpersonal (face-to-face or mediated) encounter, and their impact on the relationship and future encounters with the interlocutor or other members of his or her group" (Gallois & Giles, 2015). The construct of accommodation has been examined in two major terms: convergence and divergence. Whereas convergence refers to the process of matching another's communication style and is indicative of perceived similarity, divergence refers to the process of accentuating the differences in communication styles.

Among the accommodative strategies that speakers use to achieve these goals, convergence has been the most extensively studied. It has been defined as a strategy whereby individuals adapt their communicative behaviours in terms of a wide range of linguistic and paralinguistic features such as accent, speech rate, nature of utterance, as well as nonverbal features such as nodding, smiling,

and eye contact in such a way as to become more like their interlocutor's behaviour. On the other hand, the strategy of divergence leads to an accentuation of differences in speech and nonverbal behaviour between oneself and the other person.

Divergence has been defined as the modifying of one's communication to move away from the other's communicative behaviour (Giles et al., 2010). Under the approaches of divergence, there is maintenance. Maintenance is the absence of communicative adjustments by a person, thus maintaining their "default" way of communicating irrespective of the other person's communicative behaviour. Similar to divergence, the construct of "maintenance", whereby a person persists in his or her original style, regardless of the communication behaviour of the interlocutor has been defined (Giles & Ogay, 2007). Maintenance has also been viewed as a strategic means of preserving one's social identity in certain intergroup contexts and the desire not to accommodate.

The theory posits that the communicator accommodates those they admire, like, respect, and trust by adjusting to any differences in social and communicative attributes. This accommodative behaviour may occur by using (or adjusting to) the other person's language, speaking style, or accent, or paying attention to the person's needs and desires in the conversation. CAT contends that one may converge – make one's speech more like that of the partner, diverge – make one's speech more different from the partner, or maintain – not make any changes in the communication. Convergence, divergence, and maintenance involve specific changes made for one's speech and communication to be like that of the conversational partner and are referred to as "approximation" strategies. Approximation refers to the process of making one's language and communication patterns more similar or dissimilar to another. Approximation strategies pertain to the ways

interlocutors adjust their messages in response to each other and can be observed in convergence across a range of phonetic, lexical, and morphological features.

CAT also suggests that speakers come to interactions with an initial orientation, which is informed by such factors as relevant interpersonal and intergroup histories, as well as the prevailing sociohistorical context. In interaction, speakers adjust their communicative behaviour based on the evaluations of their fellow interactants' communicative characteristics in context, as well as their desire to establish and maintain a positive personal and social identity (Gallois & Giles, 2015). Each speaker evaluates and makes attributions about the encounter as well as the other speaker based on their perceptions of that other speaker's behaviour (i.e., adjustments). These attributions and evaluations then affect the quality and nature of the present interaction between these speakers, as well as the speakers' intent to engage in future interactions with each other.

CAT was first developed out of studies of interactions of persons with different linguistic indicators such as language, accent, dialect, and fluency, which are often defined by members of similar ethnic and cultural groups. As such, the theory is well suited for studies in an intercultural context. In recent years, CAT has been extensively applied in the study of communication in healthcare, particularly between health providers and patients (Burns et al., 2017; D'Agostino & Bylund, 2014; Farzadnia & Giles, 2015). The theory has gradually evolved and expanded from its roots in interpersonal communication to a strong intergroup context of intercultural communication. The context specificity of CAT enables its wide application under varying circumstances such as different languages, ethnicity, culture, and a context such as healthcare.

Currently, CAT has been transformed into one of the most influential behavioural theories of communication with enormous scope and potential for valuable application in any context where people from different groups or cultures interact with each other (Pitts & Harwood, 2015; Soliz &

Giles, 2014). Consequently, the theory has received widespread empirical support based on its applicability to a wide array of qualitative analyses in healthcare (D'Agostino & Bylund, 2014; Street, 1991).

Several studies have also shown that both healthcare providers and patients face language discordance as a primary source of difficulty in intercultural settings. Nonetheless, both doctors and patients employ approximation strategies to help overcome language barriers. These may include phonetic, paralinguistic, and semantic features such as using colloquial vocabulary, slang, simple vocabulary, and codeswitching (Herselman, 1996; Jain & Krieger, 2011). Others include modifying accent, exaggerated intonations, reduced speech rate, careful pronunciation, repetitions or the use of analogies and nonverbal cues such as the use of gestures, images, and exaggerated facial expressions, including smiling and frowning (D'Agostino & Bylund, 2014; Gasiorek et al., 2015; Jain & Krieger, 2011; Karuthan et al., 2020). On the other hand, approximation strategies may not only occur in terms of language and expressions. The literature suggests that patients and doctors often have conflicting beliefs, expectations, needs and preferences (Gasiorek et al., 2015; Herselman, 1996). These differences may not only be expressed at the individual level but the intergroup level (Baker et al., 2011).

In essence, the doctor-patient encounter is fundamentally one that involves approximation. In most studies on provider-patient communication in the literature, approximation has been studied mainly in geriatrics, communication disability, and intercultural/language-discordant settings. These studies point to difficulties of approximation or non-accommodative stance, particularly in intercultural contexts where the provider and patient are from different ethnic, religious, or national backgrounds (Kee et al., 2018; Paternotte et al., 2015, 2016).

While approximation is generally positive, the strategy may be employed negatively, as interlocutors may diverge to maintain or accentuate their differences (Jones et al., 1999). Correspondingly, while it may be positively intended, the concept of "over-accommodation" involving the overuse of approximation strategies, as may occur in geriatrics and with patients with communication disabilities, may be linguistically assessed as non-accommodative behaviour by others. This incongruence highlights the gaps and lack of sufficient understanding between linguistic and psychological accommodation in doctor-patient interactions (Hemsley et al., 2012; Jain & Krieger, 2011). Besides, Giles and Coupland (1991) argue that approximation is only concerned with the interlocutor's response to the linguistic performance of the other, and thus, may not be an appropriate criterion for explaining communicative behaviour. This is because doctor-patient communicative behaviour toward each other may go beyond the mere approximation of each other's communicative behaviour and may include other strategies such as emotional expression, discourse management, and interpersonal control (Farzadnia & Giles, 2015b).

While several works using CAT consider actions and outcomes in terms of accommodation versus non-accommodation, "non-accommodation" may describe a variety of perceived behaviours such as divergence, maintenance, overaccommodation, and underaccommodation (Giles & Ogay, 2007). Overaccommodation has been defined as exceeding or overextending one's communicative behaviour beyond what is necessary for a successful interaction. On the other hand, under-accommodation is defined as one not doing enough to fulfil a given communication behaviour needed to achieve the desired level of communicative interaction. Thus far, overaccommodation has been the most researched non-accommodative behaviour in the literature. This has been largely based on the phenomenon of patronizing talk and so-called "elderspeak", which involves the use

of overly simplified speech in interactions with older adults, often in a condescending manner (Hummert & Mazloff, 2001; Savundranayagam & Ryan, 2008). As well, studies show that, often, overaccommodative behaviour between persons of wide ages is evaluated as less patronizing by the participants compared to outside observers (Hummert & Mazloff, 2001; Savundranayagam & Ryan, 2008). While little attention has been given to under-accommodation, some evidence suggests it may be more prevalent, particularly among young people. Remarkably, underaccommodation is largely viewed more negatively than overaccommodation under comparable situations (Gasiorek & Dragojevic, 2017).

Non-accommodative behaviours may occur for a variety of reasons. For instance, a person engaged in interpersonal communication may not be aware of his/her tone of language or may be unwilling to adjust due to social status, power, and roles. In the non-accommodative setting, a doctor may not adequately attend to or listen to a patient's needs and may rather focus on their knowledge of what a patient needs, often resulting in an egotistic agenda being carried out via this communication (Giles, 2008). Based on the literature, subjectivity serves as the critical distinction between forms of non-accommodative behaviour and is largely based on a listener's inferences about a speaker's motives (Gasiorek & Giles, 2015). For instance, it is the listener's perception of a speaker's communicative behaviour, rather than the objective qualities of the behaviour, that determines whether the behaviour is evaluated as under-accommodative or over-accommodative. This evaluation completely disregards the real motives of the speaker and instead focuses on the perceived motives as adjudged by the recipient. This raises the potential for misjudgment and overlap between these two types of non-accommodation. For instance, communication that is planned to be appropriate and accommodating may be deemed as non-accommodative and vice versa.

Moreover, the perception of accommodative or non-accommodative behaviour is largely based on social behaviour, and hence it may be highly dependent on social context, roles, and experiences (Jones et al., 1994). In contrast to over-accommodation and under-accommodation, which are inherently subjective phenomena, divergence and maintenance are based on speech variables such as dialect, accent, tone, and speech rate and accordingly they are less subjective.

Communication accommodation theory offers an effective means for the evaluation of communication behaviour in doctor-patient relationships. The theory can be applied to predict and explain communication behaviour during doctor-patient interactions and its possible impact on patient health outcomes. In healthcare communication, CAT examines the behavioural adjustments that providers and patients engage in to create, maintain, or decrease social distance during interactions (Giles & Ogay, 2007).

The theory helps to explain how behavioural strategies such as speech rate, eye contact, and gestures are employed to accommodate, or not accommodate speech and nonverbal behaviour. The literature on the use of CAT in healthcare generally points to difficulties of approximation by both doctors and patients in an attempt to account for the other's knowledge (Bylund et al., 2012). This often results in a struggle for control by doctors in managing communication interaction. Often doctors and patients have a huge challenge in accommodating each other's communication styles and personal preferences, particularly within intercultural or language-discordant settings (Baker & Watson, 2015; Chevalier et al., 2018). As a result of the peculiar nature of the doctor-patient relationship, accommodation is not expected in all matters of healthcare interaction. While some behaviours, such as history-taking by the doctor, are expected to be complementary, other behaviours aimed at fostering rapport between doctor and patient are expected to follow the

principles of CAT. In this regard, nonverbal behaviour, including the use of gestures, speech rate, and smiling, plays a crucial role in doctor-patient interactions (Bylund et al., 2012).

According to the theory, communication is influenced by the context and socio-historical framework in which the situation is embedded (Giles & Ogay, 2007). In many African countries, healthcare settings revolve around the paternalistic model of care where patients have little say in treatment decisions. Instead, providers make all the healthcare decisions for the patient, presumably due to their higher knowledge and belief that they will make better decisions for patients (Mira et al., 2012; Ong et al., 1995). At the same time, patients believe that the relationship is one where they completely rely on the doctor to make the decisions. Doctors thus control the interaction. The interaction is often limited to what a doctor wants to know from the patient and the information he/she wants to give to the patient. Nevertheless, increasing literature shows that the use of CAT strategies and accommodating behaviours have been associated with more positive healthcare outcomes (Baker & Watson, 2015). Often, patients who feel able to speak freely, ask questions, listen in, or provide adequate information tend to show increased satisfaction and improved healthcare experience (Baker et al., 2011). Notwithstanding the value of quality communication in healthcare, research suggests that doctors often adopt non-accommodative communication attributes, including the use of medical jargon that they fail to explain to patients (Hagihara & Tarumi, 2006; Thomas et al., 2014). The lack of explanation may result in patients feeling uninformed, confused, unsure of their treatment, and unsatisfied with their experience (Politi & Street, 2011).

2.7.2 Strengths and Weaknesses of Communication Accommodation Theory

CAT has several advantages that enable its use in clinical encounters. The theory supports the dynamic nature of communication which is necessary when evaluating encounters with people with different expectations and experiences. Besides, the theory may be applied not only to speech styles but also to non-verbal communication (D'Agostino & Bylund, 2014). CAT has been particularly helpful in the care of chronic diseases and distressing medical contexts such as neonatal care, oncology, neonatal care, disabilities care, and hospice care, where the sociolinguistic strategies of CAT are often employed (Bylund et al., 2012).

The sociolinguistic approaches of the theory together with its social-psychological features serve to provide great insights into the communication approaches and strategies employed by both doctors and patients during healthcare interactions. Giles (2008) argues that social stereotypes in the provider-patient relationship may lead to flawed expectations about the other's competence in the conversation. For instance, a doctor may assume a patient does not understand what is being said and may overaccommodate in his or her communication behaviour. While this may be helpful in situations where the patient is confused, a well-informed patient may evaluate this as condescending. CAT, therefore, provides a strong theoretical approach for studying the linguistic and socio-psychological characteristics of doctor-patient interactions by providing a dynamic framework that helps to determine and analyze both interpersonal and intergroup features of the interactions. The theory recognizes the mutuality of the doctor-patient interaction and accounts for both contributions.

Another huge advantage of CAT is its reflection of the basic assumption that in doctor-patient interactions, communication serves the dual function of serving as a medium of information exchange and as relationship nurturing. CAT offers a broad range of applications and can be

applied to a variety of different communication scenarios. The theory has found great success in its application not only in interpersonal communication and also in intergroup communication but being applied in health communication, cross-gender communication, cross-cultural communication and non-verbal communication (Soliz & Giles, 2014). The theory helps to describe and explain how individuals accommodate or adjust their communication styles when they interact with others for different motivations, such as gaining approval or improving perceptions of themselves. The theory holds great practical value in aiding the understanding of various motivations and communication strategies being employed. Furthermore, CAT displays heurism and appears to offer room for expansion and even greater applicability in the future.

CAT has proven to be a valuable resource when studying human interactions. However, CAT does have limitations. There is little understanding regarding which communication features will be accommodated during an interaction. It is also important to note that non-accommodative patterns and whether they are consciously or subconsciously used has yet to be studied (Giles, 2008). Nonetheless, CAT has weaknesses. While the theory offers a broad means of describing and explaining communication behaviour, the complex nature of communication, which ensures that information is not only conveyed through words, but gestures, facial expressions, eye contact, etc, makes it challenging to ascribe constructs such as convergence and divergence. Again, this also means that the approaches within the same conversation taking place between two interactants may continually vary, making it difficult to explain using CAT. Again, emotions may play a crucial role in communication and may influence words used that may not be meant. This communication process is not properly accounted for by the CAT.

In conclusion, given that a significant number of patients seeking healthcare in Ghana have sexual and reproductive care-related problems, the nature of the relationship providers maintain with their

patients is crucial. This is especially due to the social and cultural contexts under which this communication relationship is built. Here, CAT offers a strong theoretical approach in helping to describe and explain several adjustments in communicative behaviour.

2.8 Chapter Summary

The chapter has examined some of the pertinent literature on health communication with a focus on doctor-patient interactions. While not exhaustive, a synthesis of relevant literature on communication in health within and outside of sub-Saharan Africa has been performed. The dynamics of health communication within the African context based on the strong influence of factors such as culture, language and religion have been examined. In this regard, major barriers to communication in healthcare in general and sexual healthcare have been investigated in this chapter. Finally, the application of the communication accommodation theory to health communication in the literature and how it may help to explain the doctor-patient interaction has been discussed.

CHAPTER THREE

RESEARCH METHODOLOGY

3.0 General Overview

The focus of this chapter is to describe the broad philosophical fundamentals of the selected research's methodological approaches. This is a cross-sectional study that assumes a qualitative perspective. Also, the chapter details the approaches used in collecting data from the field. Thus, the use of emergent designs such as semi-structured interviews, doctor-patient audio-recordings and direct participation (ethnography) and their justification for this specific study within the socio-cultural context of Ghana. The research methods used sought to eschew any predetermined findings in the production of knowledge with the use of regulated and well-controlled methods. Despite the non-routinised structure of the qualitative method, it offers multiple sources of evidence which are verifiable as the researcher engaged with the context in a personalised and socially constructed manner.

Although there are several criticisms levelled against the qualitative research paradigm, it was still selected as the most appropriate method for the study. The qualitative method explored a deeper understanding of health-related issues in doctor-patient gynaecological medical settings. This research perspective, therefore, provided the necessary tools to study health-related phenomena from the social worlds of the participants (doctors and patients) experiencing and receiving gynaecological care. Apart from ascertaining the ontology of the study, the approach further explored how relationships were built within the social contexts of the health facilities studied. Hence, an elaboration on the ethical foundations appropriated for the nature of the study was obtained and included.

3.1 Design Philosophy: Qualitative Research Methods

According to Weaver and Olson (2006), a research paradigm is a pattern of beliefs and practices that guides inquiry procedures of research by providing lenses, frames, and processes through which investigation is achieved. This definition of paradigm reveals how research could be affected and guided towards the attainment of its goal. Thus, the research paradigm could be quantitative, qualitative, or mixed methods in approach.

Quantitative methods have their philosophical orientation founded on positivism which views reality as simple, quantifiable, and objective (Creswell, 2009), whereas the qualitative methodological approach founded on an interpretivism philosophical background perceives reality as multiple and subjective where meaning evolves in a socially constructed paradigm. Interpretivism sharply differs from positivism. Interpretivist theorists as opposed to positivists do not share the belief that there is one reality that is objectifiable and measurable. The challenge as to whether to adopt either a quantitative or a qualitative approach or both has become a topic for debate. Methodological pragmatists, such as (Tashakkori et al., 1998) and Johnson and Onwuegbuzie (2004) accept that researchers should adopt the two paradigms if this leads to an optimal level of understanding and complete analysis. Nonetheless, they also note that the difference between quantitative and qualitative methods is not always as great as researchers are made to believe. However, both in an interdependent way, can be used to effectively augment each other. On the other hand, methodological purists take serious exception to this view of methodological pragmatists and argue that the two methods cannot be merged as the two methods are founded on mutually exclusive archetypal assumptions (for example, positivism vs interpretivism) and are, therefore, dissimilar (Guba & Lincoln, 1985). Leininger (1994) argues against the use of both quantitative and qualitative research methods as the dissimilarities in the

two paradigms make them incompatible. In supporting the view of methodological purists, this study adopted a qualitative research approach that inadeptly studied a phenomenon (Quinn, 1990), and applied rigour to its data collation processes and analysis in addition to logical reasoning. Indeed, Suter also, reiterates that there are no compact rubrics for making sense of it all (Suter, 2014).

The qualitative dimension attempts to broaden and deepen the understanding of human behaviour within varied social worlds. Hence, it is explorative. Also, it employs an in-depth, interpretative model that allows varied research insights into how people interpret and make meaning out of their realities and inquire into the social phenomena within their natural contexts. This approach attempted to achieve the depth of the research objective being explored. Hence, its selected samples of inquiry are purposeful in ascertaining cases that were rich in data (Patton, 2002, 2014). From the perspective of Patton, these information-rich cases are studied in detail to yield insights and understanding (Patton, 2014, p. 265).

Also, the procedure can neither be measured nor quantified since it deals with quality. Thus, the procedure is descriptive and interpretative rather than numerical. In contrast, the procedure is arduous, time-consuming, and expensive. Equally important is Patton's (2015, p. 13) view on qualitative work, which regards the world as "complex, dynamic, interdependent, textured, nuanced, unpredictable, and understood through stories […] distrusting generalisations, but rather an immersion into the details of a specific time and place". This perspective highlights the study of behaviour in natural settings, using people's real-life accounts as data. In emphasis, (Malterud, 2001, p. 398) asserts -

> *"Qualitative research also called naturalistic inquiry is developed within the social and human sciences, and it refers to theories on interpretation (hermeneutics) and human*

> *experience (phenomenology). They include various strategies for systematic collection, organisation and interpretation of textual material obtained while talking with people or through observation. Such research aims to investigate the meaning of social phenomena as experienced by the people themselves."*

According to Christians and Carey (1989), poetic resonance in a story is what each qualitative researcher strives to achieve. The rigorous processes undertaken lead to no manipulation of variables (Hancock et al., 2009). While the methodology employs an emergent and flexible process, it follows a systematic process making it more scientific and focused. Albeit the laborious procedure, the process demands a high degree of interpretive ability to augment the research analyses and interpretation (Hammarberg et al., 2016; Lekas et al., 2006; vom Lehn, 2013).

Moreover, criticisms made about the strengths of qualitative research are concerned with the generalisation of the findings. Yet, most qualitative studies do not focus on the generalisation of the findings. Alternatively, other sceptics describe the qualitative approach as a 'personal experiment' that cannot be reproduced; nonetheless, scientific methods could be employed to have the results of the fieldwork reproduced, verified, and falsified (Kamwendo, 2004).

Moreso, qualitative research is thorough with its primary objective of achieving validity and reliability and generalisability (Busetto et al., 2020; Golafshani, 2015; Leung, 2015). The use of qualitative analysis does not render the facts of the work questionable due to its detailed procedure. However, other scholars still challenge the nature of its approaches. Hence, the approach is viewed with skepticism as being subjective and lacking facts. Similarly, scholars such as Snider (2010), also argue that although numbers impress, they do not reveal details of phenomena or an occurrence as acknowledged in qualitative studies.

Contrary to the above arguments, Tesch's (1992) principles were adopted under the work's methodological scope. This model treats data analysis as an ongoing process with no time schedules slotted for data collation. Although selected data under the qualitative paradigm avoids rigidity, its analysis is systematically collated, organised, and comprehensively maintained in the process of interpreting data into its textual form. Therefore, the qualitative perspective examined the objectives of the work, thus, the complex realities of the sociolinguistic situation of the hospitals' communicative practices. Besides, data on doctor-patient interaction was subjected to a thorough thematic analysis. The qualitative paradigm engaged with the context, thereby serving as appropriate and significant in exploring research within healthcare, especially in most cases where medical interventions cannot be measured. Thus, a thorough approach in impacting and improving health-related phenomena. In this procedure, Ceña et al. (2012) notes the relevance of the social world of people and not their disease(s). Thus, they acknowledged an increased understanding of the meaning of certain conditions for health professionals and patients, and how their relationships are built in a particular social context.

According to Strydom et al. (2005), a research design is a plan or blueprint guiding the conduct of research. In Yin's (2003) perspective, the best research design for a study depends on the purpose of the study and the research questions. In addition, the purpose of research can be exploratory, descriptive, or explanatory, depending on the nature of the problem being examined.

The current research is both exploratory and descriptive. Exploratory studies examine the existence of a phenomenon. This study is exploratory because it sought to explore the communication strategies adopted during gynaecological interactions, as well as describe the nature of research phenomena with accurate observations. As a result, the research design focused on the validity and reliability of the observations (Blanche et al., 2006). Likewise, a description of the influence of

socio-cultural and demographic characteristics of the patients and doctors in the adoption of a communication strategy is ascertained. Again, the research paradigm was descriptive, with the representation of the demographic classification of the participants being highlighted (Bogdan & Biklen, 1997). Nonetheless, the study gathered empirical data using participant observation, audio recordings, and semi-structured interviewing procedures. The methodological outlook not only obtained the perceptions of the doctors, and the patients engaged in the gynaecological consultation processes, but also focused on how language was used in such contexts. Consequently, the type of method employed by this study addressed the following: The researcher contributed significantly to the investigative site since she brought along her positionality (identity/history) along with her expertise in observing the natural context, recording data when appropriate and coding data systematically (Busetto et al., 2020). In all, the philosophical angle of the study sought to capture participants' realities (ontology) and to understand their communication phenomenon in gynaecological encounters (epistemology) in two selected hospital sites in Accra, Ghana.

3.2 Ghana: Brief Country Profile

Ghana, which also means *Warrior King* in the Soninke language, sits on the Atlantic Ocean, towards the West of Africa, with Togo, Cote d'Ivoire, and Burkina Faso delineating its borders to the East, West, and North, respectively. The Southern borders of Ghana have the Atlantic Ocean and the Gulf of Guinea. Ghana is the first country, south of the Sahara to gain political independence in 1957 (Benneh & Dickson 1988; Obeng 1997) from British colonial rule under the leadership of its first President, Dr Kwame Nkrumah. Ghana is a unitary state where significant power is controlled by the presidency and currently, Nana Addo Dankwa Akufo-Addo who is her

ruling president. The country is constitutionally secular, but with a Christian dominating South and Islam dominating North. Nonetheless, Christianity is the largest religious group in the entire country. Thus, religious beliefs and practices serve as core to her definition as a nation. The current population of Ghana, according to *World Population Review* 2022' report is estimated at 32,244,805, with a current growth rate of 2.15%. Ghana is observed as one of the most peaceful countries in the world with a land area of 227,540km ^{2}. It has Greater-Accra as its largest city (1,963, 264), followed by Kumasi (1,468, 609) and Tamale (360, 579). Its urban population is estimated at 57.3% (Bertelsmann Stiftung, 2022) with Accra serving as its political and administrative hub.

Moreso, Ghana prides itself on universal education through primary school, and a tuition free public Senior High school educational system currently. The general literacy rate stands at 79% (WHO & WORLD BANK GROUP, 2018), but males are more educated (83.5%) than females (74.4%). Ghana's healthcare system comprises a universal healthcare scheme under the National Health Insurance Scheme (NHIS) and private health insurance schemes. These diverse schemes being grouped into private, traditional, and public ownership are all being regulated by the Ministry of Health. According to the 2021 Housing and Population Census, about 68.6% of the population is managed under either the NHIS or the private health scheme system (Ghana Statistical Service, 2021). However, most of the population have subscribed to the NHIS scheme due to its affordability because of government subsidy. Additionally, the private providers of healthcare complement the public healthcare system by being able to provide healthcare services to about half of the Ghanaian population dwelling within either the rural or urban areas. As compared to public healthcare system, the private healthcare system is expensive, and it benefits those who can afford it. Notedly, the religious institutions in Ghana perform an invaluable role in

providing preventive and curative healthcare support to especially the rural population in Ghana. Also, medical supplies, devices, equipment, and pharmaceuticals are mostly imported for healthcare practices within the country.

3.2.1 Brief Socio-Economic Profile of Ghana

Ghana is ranked 138 out of 189 countries represented in the 2019 human development index (HDI), positioning the country within a score of 0.611 among countries with medium human development (Gatune et al., 2021). Although its Southern areas are better developed than its Northern parts, there is also infrastructural disparity that exists between its rural and urban settings, especially with healthcare and sanitation inadequately managed in its rural areas, the country remains advanced per the sub-Saharan African measurement parameters. According to Bertelsmann Stiftung (2022), its status index is 6.79, number 24 on a scale of 1 – 10 out of 137 countries; its political transformation is 8.00 and number 17; governance index is 6.23 on a scale of 1-10 and number 19 out of 137 countries; Finally, its economic transformation index (BTI) is 5.57 making the country number 67 among 137 countries studied.

3.2.2 Language Profile in Ghana

Ghana is predominantly a Black-African multi-ethnic and multilingual country linguistically categorised under three main language families: Kur, Kwa, and Mande, under the Niger-Congo language family. These languages have been identified as mostly tonal. The major ethnic groups that exist in Ghana include Akan (47.5%), Dagbani (17%), Ewe (14%), Ga-Adangbe (7%), Gurma (6%), Guan (4%), Gurunsi (2.5%), and Bissa (1%). The representation of data identifies Akan as demographically large, with about 20 sub-ethnic groups. But due to the cultural, political, and

social similarities of the Akan ethnic group, they have categorised under one ethnic group (Langer, 2007; Owusu & Agyei-Mensah, 2011). Again, some of its other common languages include Ewe 14%, Dagomba 4.4%, Dangme 4.2%, Dagarte (Dagaba) 3.9%, Kokomba 3.5%, Ga 3.1% and all others at 31.2%. Varied scholars still argue about the exact number of languages spoken in Ghana. Scholars continue to quote different numbers (Agbedor, 1994; Dolphyne & Dakubu, 1988; Duthie, 1988; Lewis, 2009; Simons & Fennig, 2018). To date, these language controversies still abound in the literature. The reason could be because of the varied linguistic backgrounds that exist, some of which are lumber and splitters. Whereas the lumbers categorise all the dialects of a language as one, the splitters identify all the dialects of a language as variants of that language. Thus, the range established for the number of languages used in Ghana is usually between 40 to approximately 90 languages. Ethnologue establishes 81 languages spoken in Ghana today (Simons & Fennig, 2018). There are about 81 living languages recorded according to {{ethnologue, 19}}, 73 of these languages are indigenous, while eight are non-indigenous. A total of 13 of these languages have been categorised as institutional, thus, being used beyond the home and the community. While about 46 of these languages are developing, 14 are dominant, six are endangered, and two are on the brink of extinction. Due to Ghana's multicultural set-up, varied languages can be perceived as being spoken within the hospital's environments and amongst the healthcare workers. Some of these commonly used languages were profiled according to how they were being used during the fieldwork as follows: English, Twi, Ga, Ewe, Hausa. Nevertheless, in most contexts, English was used in addition to the preferred local language (s) of those involved in the communicative engagement.

3.2.3 The Status of English in Ghana

English is the de facto official language of Ghana. The status of English in Ghana stems from its source as the language of Ghana's former colonial masters. English, according to (Adika, 2012; Adjaye, 2005; Simo Bobda, 2000), became a part of the languages in Ghana in the 16th century. The language dominates varied discourses in Ghana, with its rise noted to be unstoppable due to its varied functions. Apart from English, there exist other languages of wider communication, such as Akan, Hausa, and Ghanaian Pidgin English. For instance, Hausa, a Chadic language spoken predominantly in Niger and Nigeria, is a major lingua franca widely spoken in the northern parts of Ghana (Northern region, Upper East, and Upper West) in addition to the dominant indigenous languages spoken in these areas. It also serves as a second language in the Zongo communities with high linguistic diversity. In parts of Accra, especially in Nima, Mamobi, New Town, and Pig farm, known as the 'projects', where these Zongo communities also exist, Hausa is the contact language. These areas are located within the metropolitan districts of Accra. Among the three widely used languages in Ghana, Akan is the most widely studied and documented with large volumes of written creative artistic works (Obeng, 1997). Nonetheless, Obeng highlights Pidgin English as also a lingua franca in Ghana yet, its communication reach is limited. For instance, the identified contexts where Ghanaian Pidgin English is mostly used informally and orally are predominantly among male university students, among prisoners, military, manual workers, police barracks and the dormitories of senior high school students with levels of variation due to especially context, age, and level of education. Besides, English is used as a second language with high levels of multilingualism and cultural diversity in all aspects of its life. Despite the high levels of linguistic heterogeneity, English still penetrates unofficial and traditional functions. For instance, in some of Ghana's health sectors, English is observed to dominate medical

consultations. Within this field, English serves as the most preferred language of choice or the [1]automatic language of use in all forms of communication, such as in speech, writing, medical records, and in the hospitals' linguistic landscaping. This is because English is the language of instruction in formal education in Ghana. Therefore, it is not out of place for the language to serve as the medium of instruction during medical school and in its literacy materials. Thus, it is the first language to be experienced visually, orthographically, and orally within the hospital's environments. In the Ghana Living Standards Survey's 2019 report, the results established that 51.8 % of the population, which is 15 years and older cannot read and write. Only 15.8 % can read and write in English, with 29.4 % being literate in English and any of the Ghanaian language (s). For the French language, less than 1 % (0.2) can read and write. Also, less than two % (1.7) are literate in any Ghanaian language. Literacy is substantially higher in Accra (AMA) and other urban areas such as Kumasi than in its rural areas. Whereas seven out of every ten persons (69.6 %) 15 years and older in the urban areas is literate, only about two out of every five (41.7 %) of their rural counterparts are literate. Whereas males have a higher literacy rate than females, and a little over two-fifths (43.7 %) of males are not literate, nearly six out of ten (59.0 %) of females cannot read and write (Ghana Statistical Service, 2019). The language need necessitated an investigation within University of Ghana Health Services and the Korle-Bu Teaching hospital. These sites allowed an investigation to ascertain the role of the English language in terms of how it is being used to navigate doctor-patient gynaecological consultations.

Yet, should the literacy pattern continue, then communication which also serves as one of the main lifelines within medical practice could be detrimental to the discharge and adherence to medical diagnosis or prognosis. Consequently, this may likely impact gynaecological engagements where

[1] The use of English in such contexts was observed as spontaneous. There was no question as to its dominance and therefore its wider communication *(Field work language observational data – 2018/2019).*

there seem to be cultural restrictions (cultural/linguistic taboos) on the open discussions on sexual and reproductive health. Therefore, the need to do a linguistic investigation into how these encounters are made daily within the study's timeframe to advance new knowledge within Health Communication, especially in gynaecological care in some medical facilities in Accra, Ghana is of the essence. The study, therefore, examined the nature of communication, thus, the strategies adapted to negotiate the doctor-patient gynaecological encounters.

It was further observed by the researcher that the location/status of the Korle- Bu Teaching Hospital (KBTH), as well as the University Health Services (UHS) as Regional (Ecowas)/National referral/tertiary medical facilities, also warrant linguistic insights for such investigation. The contexts would naturally place the onus on health professionals to adopt the official language and some or most of the indigenous languages in their healthcare management and treatment services. Accra, which served as the research's data site, is observed to function as a melting pot for varied cultures and languages. The selection of the sites contributed to multilingualism and its impact on communication between health practitioners and their patients. Figure 2.1 is the linguistics map of Ghana showing the diversity of languages, their location across the country, the sparsely populated areas marked in white, and the languages predominantly used in its communicative life, which include Akan, Ewe, Ghanaian Pidgin English, Ghanaian sign languages, Hausa, Fulfulde. The map establishes the high levels of linguistic variation in terms of the varied languages used, regions and places of use, as well as the specific languages used for wider communicative functions.

Figure 3. 1: The Linguistics Map of Ghana: SIL International

3.3 Greater-Accra Region: Catchment Area

Accra is a coastal city in the Greater-Accra Region of Ghana. This region has the smallest land size as compared to the other 15 administrative regions in the country. Nonetheless, it serves as the administrative capital of the Greater-Accra region as well as the whole of Ghana. As the Greater-Accra region's economic and administrative hub, Accra serves as the cornerstone of the larger Greater-Accra Metropolitan Area (GAMA). Its total surface area is estimated at 3, 245 kilometres, thus, about 1.4% of the entire surface area of Ghana. The region is observed as the fastest-growing region with significant cultural and ethnic heterogeneity. Owusu and Agyei-Mensah (2011) further assert that there is rapid internal migration in Accra.

The merit of Accra's instantaneous internal migration, as confirmed by Owusu & Agyei-Mensah, significantly contributes to high levels of urbanisation that Accra constantly experiences. Due to its critical role, position in Ghana's development, and connecting Ghana internationally, Accra is the heart of Ghana and the most densely populated with the highest proportion of Ghana's urban population. Accra has over two million inhabitants. In contrast, the remaining 14 regions are predominantly rural, with the level of urbanisation stated as below the national average. This could be attributed to the industrialisation and commercialisation of activities centred in Accra, fuelling higher levels of influx of people from all over Ghana.

Additionally, major institutions in education, administration, health, transportation, and governance are all centred in Accra. For instance, Accra has about 90 health facilities, and among them are the Korle-Bu Teaching hospital (KBTH) and the University Health Services (UHS), which served as the study's data collation sites.

3.4 Research Sites

Data collation was focused on two main hospital sites within Accra - University Health Services (UHS) and Korle- Bu Teaching Hospital (KBTH). The justification for these site selections was because of the following merits: The statistical information discussed on Accra establishes Accra as linguistically heterogeneous and culturally diverse, thereby making it a significant area to be considered for language research. Accra serves as the first largest multilingual city in Ghana, where medical services are heavily concentrated within Ghana. For instance, the University of Ghana medical school, partners with KBTH's medical school both located in Accra to enhance medical training and collaboration in research and medical capacity building. KBTH is Ghana's tertiary care centre with an innovative medical outlook in care giving, whereas, UHS has its core mandate of enhancing the health status of the communities within the University of Ghana, its immediate environs and by providing affordable world-class medical services, client focused, and excellent healthcare delivery services of the highest quality.

Moreover, these sites served as an opportunity for the researcher to obtain relevant data which would assist in documenting and examining communication strategies employed during doctor-patient gynaecological interactional dynamics at play within a cosmopolitan area. The field observations also established clear structural differences within the settings of both hospitals. As well, the administrative procedures and the doctor-patient population size varied. In addition, there were multifaceted medical applications in both hospitals regarding each of the gynaecological encounters experienced. UHS served as the first data site and KBTH as the second data site.

3.4.1 The University Health Services (UHS)

UHS is a quasi-government hospital established and commissioned in 1957. It serves as a primary health care facility located in the Southern part of Ghana, specifically, East Legon which is about 12 kilometres Northeast of the centre of Accra. Its referral cases are managed at KBTH and the 37 Military Hospital, also in Accra. In UHS, the system privatises members of the university community who are neither staff nor their dependents as well as patients from the university's environs - (Madina, Adenta, Oyibi, Dodowa). Thus, although most hospitals in Accra including KBTH still allow the use of the NHIS scheme, at UHS, the scheme was dysfunctional during the period for data collation.

During the data observation and collection phase, its gynaecological unit had about five doctors (one consultant, two OB-GYN specialists, one OB-GYN general doctor and one part-time OB-GYN general doctor) managing all the general and specialised cases that were reported and presented within its department with the assistance of medical students on their annual rotational schedules. These five OB-GYN doctors present were all male with no female OB-GYN doctors present. The female doctors observed to be working within the gynaecological units at that time were either house officers or medical students. Nevertheless, the researcher had the privilege of working with only three of the male OB-GYN doctors since the fourth doctor was on official work leave and the fifth doctor was a part-timer with a time slot that conflicted with the fieldwork schedule.

3.4.1.1 General Protocol to Service Delivery at the University Health Services

UHS is an urban hospital, with most of its patients being staff and their dependents within and beyond the university of Ghana. The hospital serves as a private clinic to all members who are not

staff or their dependents within the University of Ghana community. Its medical services satisfy a larger intellectual, younger, and more educated class. To these members, the hospital provides them with free medical services, whereas all others outside its healthcare design are privately managed through 'payout of pockets'. UHS has also set up an internalised electronic system (patients-electronic folder) since 2015 that keeps the medical records of its patients intact, protected and accessed on-site by assigned doctors only. The position of nurses and house officers in the consulting rooms and sometimes the presence of medical students was mandatory as they served as medical assistants, witnesses, and mentees to the consultations that evolved.

Furthermore, UHS has an average daily attendance of about 160 out-patients being attended to by two to three consultants in a week, although the number of patients fluctuates. Despite the human capacity systems in place, the facility still felt overwhelmed by the number of daily cases in OB-GYN. Out of this figure, the 2018 bio-statistical data (*January-May*) on the OB-GYN department, also obtained at the end of May 2019 established that the average median age of patients attended to within the period was 45.6 years, with a predominantly female patient population within their reproductive years.

3.4.1.2 The Interplay of Languages at the University Health Services

The medical environment encourages the use of English in most of its activities. Although the hospitals are in Accra, and Ga and Dangme languages are grouped as an ethnolinguistic group (Ameka & Dakubu, 2008), who primarily live in Accra, one would likely associate the language of the indigenes as being the primary language with wider communicative functions within the hospitals environment; unfortunately, that is not the situation. Twi (Akan) rather than Ga was used as the language of inter-ethnic communication as established by (Bibiebome et al., 2019).

Twi, according to Batibo is ascribed with area significance (Batibo, 2005). This situation has become an established norm (Mesthrie et al., 2000: 248) previously acknowledged as an increase in social interactions between people from varied ethnic backgrounds leading to language contact. To further expand the argument, Batibo (2005) and Myers-Scotton (2006) also ascertained that in the language contact situation, the communicators might decide to maintain their respective languages in all domains, maintain their first languages (L1), and their new languages in certain specific environments or solely rely on their new language in all contexts. Nonetheless, in this communicative environment, one would envisage Ga, an indigenous urban language to maintain its status as the most attractive and dominant language with wider communicative functions among the immigrants in Accra. But the position of Ga seemed to be threatened by Akan thereby making Akan obtain wider communicative functions after the English language.

Surprisingly, the displacement of Ga by Akan makes its status questionable, as articulated by (Akpanglo-Nartey & Akpanglo-Nartey, 2012). It was detected that most workers and patients hardly subscribed to the use of Ga, although Ga served as their first local language (L1) or (mother-tongue). Instead, Akan (Twi) was accommodated as the most widely used local language, although the patients were also proficient in Ewe, Krobo, and Hausa as their main languages. However, if the doctors lacked competency in the patient's language in situations where the patient lacked proficiency in English, the process became cumbersome, prolonging consultation time, making the process uncomfortable as third parties (other medical staff) competent in the patient's language were called upon to assist in the communicative encounter. Hence, English dominated the medical discussions on varied communicative platforms identified.

The common languages observed in wider use in order of preference included English, Akan (Twi), Ga, Ewe. Interestingly, all archival information (medical folders, hospital cards, laboratory

forms, consent forms, pharmaceutical inscriptions, hospital receipts) as well as the linguistic landscaping of the hospital (wall posters, signposts, notices, directional signs, departmental locations, hospital boards) were all inscribed in English. However, there was only an old inscription adjacent to the hospital's former pharmacy sitting place for patients which had the following inscription: *'Keep this place clean', written in the following local language chronology - English, Ewe, Ga, and Twi* showcasing some level of multilingualism observed as observed below but, generally, all medical presentations, reports, and discussions among the staff of the facility was done in English to the detriment of the other languages as showcased. The general appearance of the hospital is predominantly white.

Figure 3. 2: Only Inscription on English, Ewe, Ga, and Akan (Twi) at the UHS Old Pharmacy Area - *(Fieldwork, 2018/2019)*

3.4.2 Korle-Bu Teaching Hospital (KBTH)

Korle-Bu which means 'the valley of the Korle Lagoon, was established in 1923 as a general hospital to address the health challenges of the Ghanaian populace. The hospital is regarded as the premier healthcare facility and a leading public tertiary hospital located in the southern part of Ghana. In addition, it is the largest referral government teaching hospital in Ghana serving a wider Ghanaian population as well as other nationals within sub-Saharan Africa. KBTH operates on the national universal medical insurance scheme as introduced by the Ministry of Health in Ghana. Nonetheless, patients who are not registered on the scheme enjoy a pay-as-you-go medical service. The hospital is currently the third-largest hospital in Africa and the leading national referral centre in Ghana. This facility had comprehensive structures, thus, operating within five main OB-GYN teams, with about 20 team members ranking from medical consultants to house officers. This hospital is part of the hospitals under the Ghana Health Services which comprises government (university) hospitals that belong to the Christian Health Association of Ghana (CHAG), and private facilities. The medical staff, nurses, and house officers under CHAG are all paid by the President of Ghana.

An increase in Ghana's population and an upsurge in KBTH's hospital-based treatment led to an increase in its hospital attendance. By 1953, the maternity, medical, surgical and child health blocks were built to expand the health services of the hospital. The clinical and diagnostic departments such as medicine, child health, obstetrics, and gynaecology, pathology, laboratories, radiology, anaesthesia, polyclinic, accident center and the surgical, or medical emergency became functional as well as pharmacy, finance, engineering, and their general administration.

The facility attained teaching hospital status in 1962 when the University of Ghana Medical School (UGMS) was established and affiliated with it. The UGMS and five other constituent schools have currently been subsumed under the College of Health Sciences to train health professionals across the country. Presently, the hospital has more than 2,000 beds and more than seventeen (17) clinical and diagnostic departments *(fieldwork observations 2018/2019)*. It has an average daily attendance of more than 1, 500 patients. Out of this figure, the 2018 bio-statistical data (*January-May)* on the OB-GYN department established that every week, the Gynaecological unit consults about 273 (in and out) patients whereas in Obstetrics, a total of about 304 patients consult. In all, about 515 cases are managed at its OB-GYN unit. However, the hospital also provides sophisticated and scientific investigative procedures and specialist care in various specialised medical fields. It is one of the few hospitals in Africa where sophisticated laboratory investigations are being conducted. Despite its technologically advanced medical services, the hospital still operated on a paper system for recording and saving medical records. Nonetheless, this medical facility aims at becoming the hub of health tourism within the West African sub-region, making it another significant data site.

3.4.2.1. General Protocol to Service Delivery at the Korle-Bu Teaching Hospital

The hospital attends to and offers services to the entire Ghanaian populace and patients from the West African sub-region. Most of the cases that are received are emergency cases, referrals, and cases based on recommendations from other medical facilities: primary health centres (either private or government), and district hospitals in Ghana. The numerous cases from all other hospitals in Ghana make the hospital heavily populated daily. So, the hospital runs a 24-hour, seven days a week schedule. During national holidays, the medical teams still follow a shift system; thus, every day is a working day except for leave days (this structure also applies to the

UHS medical facility). Despite this medical scheme, expensive medical challenges and their treatment procedures such as HIV, thoracic, neuro or plastic surgery (except after trauma), other elective surgeries, infertility evaluations, transplant medication or surgery and hemodialysis are not covered under the scheme as also reported in (Drislane et al., 2014). In the hospital's environment, there is an interplay of languages between the indigenous ones and the only official language, English which predominated in most interactions.

3.4.2.2 The Interplay of Languages at the Korle-Bu Teaching Hospital

English serves as a lingua-franca within its medical environment as well. It is the predominant language among the medical staff, especially between the medical students, the house officers, the specialists, and the consultants. However, among the nurses, conversations are commonly heard in both English and Akan, or English and any other common local language or just the local language (s) of their choice. Nevertheless, the use of Ga and Ewe could also be heard. Depending on the type of relationship between the nurse and the doctor, the language use differs. Interactions are strictly and predominantly in English, or the frequent mixing of codes between English and Akan (mainly), English, and Ga, English and Ewe, and English and Hausa. Besides the level and nature of interactions between doctors and nurses, English always served as the base language. Interestingly, English and/or Akan served as the most preferred language when the health workers communicated with other non-health workers or either English/Akan (Twi) was used depending on the educational status of the patient.

It was also observed that Akan was mostly used by the patients of the facility. In cases where the doctors were not proficient in the patient's local language, they relied on other medical staff (especially nurses) competent in the local language to assist as interpreters. Nonetheless, this

system was practised as most doctors also identified language interpretation as a hindrance to their relationship with patients. In addition, interpretation, according to them, wasted consultation time with regard to the high number of patients in queues that needed to be seen daily (Wolz, 2015).

Although the hospital is in Accra, and along the coast, specifically in the context of its native inhabitants, the Ga people, one would naturally expect the frequent and dominant use of Ga. Yet, Ga is preceded by Akan (Twi) under these health contexts. The same striking observation was made within the medical context of UHS. In fact, in instances where the patients' used Ga, almost all doctors observed from both hospitals had minimal understanding of its usage. Therefore, patients with competency in Akan (Twi) could freely, competently, and flexibly interact with most doctors much more than in any other local language.

The languages of wider communication within the hospital's setting included English (official), Akan, Ga, Ewe, Krobo, and in some cases, Hausa. Among these languages, Akan was the most widely used. Interestingly, patients who sought medical care services, but were non-nationals of Ghana, such as those from Benin, Mali, Niger, La Cote D'Ivoire, always brought along someone close or a family member who mostly spoke Akan (Twi) or had some level of literacy in English to serve as the interpreter. It was noted that whereas patients who were literate in English were open, relaxed, comfortable, and interactive, those who were non-literate in English struggled to communicate their intimate concerns, especially when the doctors involved lacked understanding of patients local language or their language of self-expression *(field observation - 2018/2019).*

In KBTH, the OB-GYN doctors were of varied nationalities, whereas all the OB-GYN doctors at the UHS facility were all of Ghanaian origin. The doctors at KBTH were predominantly of Ghanaian origin, whereas few were of Nigerian and Sierra Leonean nationalities at the time of the data collation. Those from Nigeria and Sierra Leone had only English as their official and

functional language. In other situations, a few of the doctors observed enhanced patient explanations by using a customised graphical aid to enhance their patient's understanding, awareness, and appreciation of their conditions.

The general presentation of medical cases was in English. All archival materials, bill hoardings, directional maps/inscriptions, and medical flyers observed within the gynaecological units at the time of data collation were all inscribed in English. Generally, the facility also had a predominant white, cream and a touch of green. The Obstetrics and Gynaecological (OB-GYN) team departments had a few hanging artworks at the entry points of the various team blocks, and in-patient wards.

3.5 Fieldwork

Although the fieldwork was scheduled to commence from January 1, 2018, to July 31st, 2018, different structural occurrences affected the time slated, nonetheless, the field work could not take off as scheduled. Again, when the fieldwork had officially commenced, there were no research assistants co-opted into the data collection phase due to the privacy, confidentiality, and sensitive nature of gynaecological healthcare delivery services. From several observations made in the field, issues about ill-health were a confidential affair between the patient and the health practitioner. Within a specialised and focused domain such as OB-GYN care, health concern is largely associated with stigma, belief systems, spirituality, and other cultural rather than scientific approaches *(field observations 2018/2019)*. Culturally, it is difficult to break through this domain. Naturally, within the multilingual context, most people confided in people they trusted and felt comfortable with, and in this respect, it was mostly the doctors who enjoyed this privilege. Due to the confined consulting room area and the privacy concerns which guided OB-GYN care, it was a

requirement for only the main researcher to take data samples. Consequently, two research assistants were added after the data sampling phase.

A period of about six months was allocated for data collation and exploration at the two hospitals (UHS and KBTH). The researcher employed an ethnographic approach after seeking ethical clearance from the Ethical Committee of the Humanities (ECH) at the University of Ghana at the end of 2018. A minimum of eight hours a day, in five days of the week was spent at each selected site to enhance the researcher's understanding of the data sites, their modus operandi, and the building of relationships that allowed the doctors and patients to become comfortable with the researcher's presence before data collation. The approach allowed the researcher to observe the gynaecological care processes to acquaint herself with the basic medical registers, the norms, protocols, requirements, and medical etiquette practiced within the Obstetrics and Gynaecological units.

It was noted that the medical team at the gynaecological units at both data sites operated and understood the quantitative approach to data collection more than the qualitative approach as part of their training. Hence, most of them opted out of the study due to their unease in my presence in their consulting room. Nonetheless, other gynaecological doctors had no objection to the field methods and therefore, signed onto the study as participants. As a result, I scheduled with the gynaecological doctors who were willing to allow my presence during their consultations. Besides, there were instances where the patients rather than the doctors were uncomfortable with my presence in the consulting room and vice versa. Some of these challenges stalled the data process as I needed to find new gynaecological consultations where both doctor and patient had to grant their approval for my presence despite institutional clearance. Hence, the sampling of data within the shortest time became impossible. This strategy allowed the researcher to be present from

Monday to Friday to be able to meet consultants, collate adequate and useful data sets in English interactions, although Akan (Twi) data could be perceived within some of the English interactions due to the language dynamics within the context.

There were several days when data collection activities had to be truncated due to other emergency assignments to be managed by the consultants who served as participants in the study. As a result, data collation had to be stopped and rescheduled to other possible dates based on the availability of gynaecologists. In other instances, no data was gathered since the consultants selected were also assigned to medical students to train, mentor and coach; thus, they had hectic schedules with fully booked in/out-patients, students, and medical trainees.

Moreover, the researcher had time, about a month in both cases, to acquaint herself with her new context before data collection began. This opportunity allowed the researcher to observe the linguistic landscapes of the research sites in terms of language practices and the functional language (s) used in documenting information in the patient's hospital cards or e-folder, prescription of drugs, hospital signage and language (s) of wider communication. The use of participant observation enabled the researcher to note the language choice (s) of the participants in order of importance, their representation, frequency, and therefore, the one (s) commonly used during the gynaecological interactions.

Furthermore, in each case, the researcher had to conduct pilot investigations on the preferred language (s) used and the best methodology to apply within the selected sites. This exercise allowed the researcher to verbally introduce the nature of the research and its topic primarily to the directors of both hospitals, the gynaecological units faculty, patients as well as the medical students. This was an opportunity for the gynaecological units to be informed about the nature of the study and their decision to be participants to the study or not

The researcher adhered to all rules, protocols, and regulations concerning research in the two medical facilities during fieldwork. Some of the adhered to rules included: the researcher being present and punctual before the interactions between the doctors and patients began. Again, it was the responsibility of the researcher to make sure that nothing about the data collection process disrupting the gynaecological engagement. Overall, the researcher allocated time to discuss the project with the professional gynaecological consultants who served as guides within the OB-GYN facility for their inputs to the data collection. Equally important, due to the incorporation of ethnography as one of the methods to the study, the researcher gained credibility, trust, and confidence over time among the participants involved within the gynaecological facilities selected. The fieldwork as an interdisciplinary approach aided in triangulating how different data sets could be garnered as well as aid in reducing possible errors (Jakob, 2001; Yevoo et al., 2018).

The researcher added OB-GYN specialists as a backup to the inadequate consultant samples to make up for the hectic schedules of the consultants and therefore, their inability to be present always. There were several days when data collation had to end due to the difficulty in recording gynaecologists who had signed onto the study, but who were sharing a consulting room with other gynaecologists who were not participants to the study. Although, in few instances, there was a gynaecologist (consultant) in the consulting room with his or her patient, there were also several uncountable situations where there were about four to six persons in a consulting room (two gynaecologists, two patients, and an assisting nurse). Sometimes, within such multi-consultation situations, some other patient (s) from other gynaecological consultation rooms are led by the doctors to the next available consultation room to perform physical examination on them in cases where the examination bed is well-equipped and available. The multi-consultation processes impacted the audio recordings due to the challenge of not being able to record any data most of

the time due to non-consensual responses from some of the gynaecologists and patients sharing the consulting room. This setback further prolonged the time spent on the field. But the time allocated for the study enabled the researcher to purposively gather data that occurred mostly in English, although data on doctor-patient gynaecological interactions also occurred concurrently in some local languages such as Akan, Ga, and Ewe. The sampled interactions mostly happened between gynaecologists (primarily male) and mostly female patients within their reproductive years.

3.6 Sampling Procedure

There have been several approaches to research into patient-physician communication. Some studies have used direct observations of a limited number of consultations, or structured patient interviews (Stewart, 1984), while others have used questionnaires (Cantwell & Ramirez, 1997; Detmar et al., 2002). Nonetheless, this study adopted a combination of direct observation, semi-structured interviews, and audio-recordings as its main data collection instruments. Information obtained from direct observation complemented the audio-recordings and the semi-structured interviews using triangulation. The triangulation approach to data collation is meant to enhance the validation and credibility of the study and its findings (Jakob, 2001). This system aided in data corroboration and the convergence of the data patterns ascertained.

3.6.1 Triangulation of Qualitative Research Methods

Triangulation, as an approach to the collection of data, served as the main focus of the work since the design could be argued as complementary (Saville-Troike, 2003). The approach selected enhanced an in-depth discussion of the inductive mode of data analysis. It must be emphasised that

the research questions were extracted from the objectives of the work; hence, no laid-down hypothesis was followed. The triangulated methodological approach for data collection was time-consuming and arduous. Nonetheless, the approaches offered the participants an opportunity to provide their unique, but real-life experiences, despite their varied socio-cultural backgrounds.

3.7 Data Sampling Techniques

3.7.1 Ethnography

Accordingly, studies within the health environment (Sarangi, 2002) will demand that the researcher who is an outsider will in an ethnographic way observe the way the new communities of practice (Wenger, 2010; Wenger et al., 2002) operate within their real environment. Based on the in-situ observation of the interactions that ensued, the researcher gained a deeper understanding of the critical issues that were otherwise less apparent. To this end, the researcher had to immerse herself fully in her study's context at the initial phase to erase any form of researcher bias, or a false representation of data. Likewise, the adoption of the face-to-face approach as a communication management tool necessitated the researcher's presence. This approach was significant for the researcher to document interactions that could rarely be explained in simple terms. Moreso, the number of medical practitioners usually involved in consultation within the consulting room and the gaps likely to occur in the data enabled the researcher to be fully immersed in that set-up. The ethnographic dimension provided the researcher with a way to approach data from an emic perspective (Copland & Creese, 2015). In this approach, the researcher emphasised observing the realities of the insiders' (OB / GYN doctors and patients), after which she developed an analytical stance from an unfamiliar setting. This approach was strictly adhered to positively impact the researcher's critical observation within her research context. Rampton asserts that

integration between insider knowledge and an ethnographic observation permits a "from-inside-outwards trajectory that enhances analytic sensibilities" (Rampton, 2007, p. 591).

Again, this stance allowed an exploration of the researcher's historical insights (positionality) (see discussion on researcher positionality in section (*3.13*) into the local setting while establishing a balance between the reliance on insider knowledge and doubting that same knowledge. Significantly, the ethnographic observation design involved the observation of language use within the selected study sites. This process aided in the validation and reliability of the study as it focused on derived data from both the OB-GYN specialists/consultants and their patients. As a result, the researcher applied the concept of obtrusive observation, where participants at the data sites were aware of her presence. The trust established through the approach resulted in less inhibited behaviour and an efficient way of observing people in their natural environment. It must also be noted that the choice of language and its use observed around the pharmacy departments, queues in front of, and outside of the consulting rooms, front desks of the departments, [2]Outpatient Departments (OPD), interactions on the corridors, a careful survey of the wall posters within the hospitals and signposts were all relevant in identifying the pattern of language use and the most frequently used within the gynaecological units.

Also, the researcher had a diary (memo) that detailed reactions, comments, innovative ideas, daily reflections, notes on the quantum of work done, and the contact information of some respondents likely to assist in the collection of data. The diary aided the researcher in reflecting on the data gathering process (es) and revising strategies daily in dealing with different doctors and patients within the unit. The nature of the current study avoided contact with the intensive care units and

[2] In all medical facilities, the Outpatient Department (OPD) serves as the department where basic medical conditions that require optimum medical care is treated as well as other allied services provided. At this department, all medical charges are paid, patients vital science (Temperature, Blood Pressure (BP)) are checked as they wait in front of different numbered consulting rooms to meet their doctors or an available doctor.

patients on admission (in-patients). This researcher incorporated participant observation to eliminate all forms of observer bias (Kamwendo, 2004). Again, as part of the process, the health environment including the gynaecologists, nature of patients being consulted, and the consultation styles were observed to determine whether the language (s) used within the environment reflected the language (s) used during the doctor-patient gynaecological encounters and to note the most preferred. This approach was used to add validity to the observations experienced. As part of the method, it was ascertained that a consent letter in addition to an invitation letter was needed to assure participants of their confidentiality in their given data. The invitation letter was a technique employed to further give a brief focus to the research and to make the willing participants feel significant and secure in the study. (See Copy of Document in *Appendix D*).

3.7.2 Respondent Semi-Structured Interviews

The use of interviews also falls within the methodological paradigm of ethnographic methods. This approach aided in capturing in-depth qualitative information through an open-ended and closed-ended interviewing format. As a result, its conservative nature did not follow any specific format since questions and answers sparked other questions and answers within a maximum time limit of about one hour. It must be noted that although it is labour intensive, it was worth the effort in terms of the extra data insights discovered.

In the process of data elicitation, some consultants and specialists voluntarily offered to grant interviews, whereas others objected to being a part of the process. These participatory concerns expressed were taken into consideration and respected by the researcher. Due to the study's qualitative nature, participants who were contacted and agreed to be a part of the work were contacted within the hospital's environment as a matter of their preference. Time constraints

around the hospitals' set-up allowed the doctors some minutes to be interviewed after their clinical duty periods, thus, from 2:00 pm to about 3:30 pm GMT, or early in the morning between the hours of 6:00 am to about 7:30 am GMT depending on their availability. The earlier interview schedules in the mornings with the doctors were unsuccessful in most cases. Nevertheless, the doctors suggested various times after several failed interview appointments due to their hectic routines. Although the new schedules produced the same challenges, different times had to be reset and re-negotiated until a convenient time was obtained. These convenient times were relaxed moments immediately after the doctors daily consultations and sometimes after their theatre sessions or when they had not yet started consultation with patients. It must be noted that having interviews with the doctors, hours before their daily consultation was rare due to other clinical responsibilities.

With regards to the doctors' timing, the volunteered patients preferred being actively engaged in the interviews between the hours of 8:30 am to about 10 am GMT, (hours when patients were waiting for their doctors to return from their [3]clinical ward 'rounds'). The patients immediately refused any interviews as soon as doctors entered the consulting rooms, and immediately after, they (patients) left the consulting rooms. The period after leaving the consulting rooms was when they had to either run some medical labs and get back to their doctors before they ended their outpatient consultancy, queued for drugs, or be in a hurry to get home.

[3] Clinical Ward Rounds - These were observed to be an important part of especially the in-patient care process. It adopted a multidisciplinary approach as various medical disciplines discussed their cases (patients) and coordinated care. The consultants or the medical leads among the groups facilitated the process. It was usually the first thing done before anything else, thus, from 7 am to 9:00 am or 9:30 am or from 8 am - 9:30 / 10:00 am depending on the medical facility and the number of in-patients on admission. Here, the doctors visited their patients, discussed their diagnoses, test results, and approved or disapproved the medical plans of management. Moreover, this is the period when patients showed they had followed all medical procedures, showed they are in good shape, negotiated their discharge and base on the doctors' medical findings approved, or not. It was a period when trainees (medical students, residents) were also trained practically with the medical theories (*field observations -2018/2019*).

The study sampled data using purposive sampling technique due to the specialised unit of gynaecological care. Therefore, the respondents who granted their time and permission to be interviewed were willing participants (Gynaecologists and out-patients) receiving care at the OB-GYN care delivery units in each hospital. Under these circumstances, four doctors (two male; two female) were interviewed at KBTH as well as five out-patients each seeking gynaecological care at the same unit were interviewed. The interviews encouraged perspectives from both the gynaecologists and patients on their interactions, and it allowed flexibility for additional insights on the data to be collated.

Also, the researcher conducted semi-structured interview sessions with the selected and willing participants with the use of the non-random sampling technique. The interview sessions were between the researcher and one of the participants (doctors or patients) at any point in time due to their availability and willingness, specifically in the OB-GYN units of both hospitals. Most of the interviews with the respondents were audio-recorded and transcribed. Thus, the work focused on the transcripts of doctor-patient interactions which dominated in English. Although the analyses identified emerging themes that were categorised under the study's objectives, the process also established the credibility, reliability, and validity of the study. In addition, a patient information sheet (see Copy in *Appendix E*) was made available to participants in case they should opt for an interview session outside the hospital's premises. This sheet requested the location, address, and contact information of the patients against unforeseen time changes. Notwithstanding, all the participants gave their interviews at various locations within the OB-GYN department. (The interview guides that aided the semi-structured interviews with both OB-GYN doctors and the patient participants are attached to *Appendix F, and G* of the study).

3.7.3 Audio-Recordings of Doctor-Patient Interactions

The data on doctor-patient interactions were audio-recorded after permission and clearance had been sought from the University of Ghana's Ethics Committee for the Humanities (ECH) (refer to section *3.9* for a detailed discussion). Apart from this clearance, the human subjects involved also willingly gave their consent by appending their signatures to the consent forms before the audio-recordings were made. Once consent was obtained from participants, they were not informed of the exact time the recordings were going to be done. This was a strategy observed to be efficient in the field. As a result, the researcher worked within a natural environment devoid of anything that could interrupt the natural flow of the interactive exchange between the doctors and the patients involved. This technique was included to enable spontaneous data to be taken without any manipulations, interference, or disruptions during personal encounters.

Moreso, the approach was relevant to the work as its analyses satisfied and answered the objectives of the study. This sampling process was sensitive as the researcher needed to be in the consulting room as the interactions proceeded to note the exchanges in their full entirety. As a result, all the necessary documents that qualified for the sampling exercise had to be compiled. In fact, in the process, or after the process, some participants still requested to see the complied documents on ethics. (Refer to *Appendices A, B, and C* of the study for the ethical consent form, the introductory letter, and the letter of support from her Department (English), under the School of Languages, University of Ghana, Legon).

3.8 Sampled Participants

The researcher sampled four different data sets from each data site. The samples from each site included fieldwork observations, doctor-patient audio-recordings, doctors' semi-structured

interviews, and patients' semi-structured interviews as discussed above (refer to *Section 3.7.1*). 52 cases of doctor-patient gynaecological encounters were recorded between doctors and patients from July 2018 through to February 2019, and then May 2019 from the UHS and KBTH for linguistic analysis of which 26 were identified as regular patients with nine being first timers to the hospitals. In all, a total of 35 doctor-patient gynaecological audio-recorded samples were collected in addition to seven individual semi-structured interviews obtained from the sampled doctors and ten semi-structured interviews obtained from five patients from each hospital. The qualitative nature of the study makes the sampled data adequate for an in-depth analysis on the doctor-patient interactions. Contrastingly, about ten doctors, sampled could not be a part of the study due to their compressed schedules, sudden ill-health, institutional rotational demands, medical leave periods and a few, their discomfort with the methodological (qualitative) approach employed.

Again, about 14 patients sampled at the KBTH were disinterested because of fear, inadequate understanding about research, lack of adequate time to fully participate in the study as well as their general misconceptions about research. The researcher strictly following the ethical protocols also used the opportunity presented to educate participants on the relevance of research for them to allay all fears, doubts, and discomforts. The researcher refused to take any data samples from participants in such confused, emotional, and psychological state of mental shifts. Nonetheless, the researcher allowed participants to learn and appreciate the data process for future projects.

Interestingly, the participants sampled at UHS were enthusiastic about the study, although five participants exempted from the study also due to similar concerns expressed at KBTH as follows: fear, inadequate time to fully engage in the study, limited knowledge, and misconceptions about research. It must be noted that although some of the patients declined from the research, these

patients were still treated and medically managed under the most effective care in both institutions. Their reason for not participating did not affect their medical management in any way.

Furthermore, due to the number of patients in queues waiting to see doctors, and the doctor's insistence on no further delay in their consultations, detailed demographic details on the patients during the audio-recording sessions became impossible in both hospitals. Table 3.1 gives a summarised representation of the overall sampled participants during the semi-structured interviews, type of hospitals (UHS and KBTH) and the type of data taken. Also, (Find attached the consent form for the doctors and patients sampled from UHS and KBTH in *Appendix H* of the study).

Table 3. 1: Overview of Sampled Population

Number	Type of Participant	Type of Hospital	Total number sampled	Type of data
1.	OB-GYN doctors	University Health Services (UHS)	Three male doctors	15 audio-recorded doctor-patient interactions. Three semi-structured interviews
2.	Patients	University Health Services (UHS)	Five female patients	Five semi-structured interviews
3.	OB-GYN doctors	Korle-Bu Teaching Hospital (KBTH)	Four doctors – (two males; two females)	20 doctor-patient audio-recorded interactions. Four doctor semi-structured interviews
4.	Patients	Korle-Bu Teaching Hospital (KBTH)	Five female patients	Five semi-structured interviews

Accordingly, Table 3.2 also details the nature of the fieldwork, the identification of specific data sites, and the assigned time schedules used in accomplishing each task towards the entire data collation process in 2018/2019.

Table 3. 2: Overview of the Fieldwork Procedure

Step	Procedure	Time duration
1.	Institutional Clearance: University Health Services (UHS)/ Korle-Bu Teaching Hospital (KBTH)	June 2018 / Dec. 2018.
2.	Participant Observation at the UHS	June – July 2018.
3.	Participant Observation at KBTH	25th Nov. 2018 – Dec. 2018.
4.	Introducing the nature of the study to participants	Study's Pilot [June-July 2018; 28th Nov.-23rd Dec. 2018] at UGHS and KBTH.
5.	Completed Consent (Written & Oral)	Before obtaining semi-structured interviews, and audio recordings.
6.	Demographic surveys of participants- (UHS / KBTH)	During data sampling: [July – Sept. 2018 at UGHS and End of Dec. 2018 – Feb. 10th, 2019].
7.	Audio-recordings – (UHS)	July-Sept. 2018 / May 2019
8.	Audio-recordings – (KBTH)	Jan - Feb. then May 2019.
9.	OB-GYN patient interviews/Follow-up (UHS)	Follow-Up: May 2019.
10.	OB-GYN doctor interviews – (UHS)	July 2019, August 2019, Follow-Up: May 2019.

11.	OB-GYN doctor interviews – (KBTH)	Dec. – Jan. 2019 / Follow-Up: May 2019.
12	OB-GYN patient interviews – (KBTH)	Jan. – Feb. 2019 / Follow-Up: May 2019.

3.9 Ethical Approval.

Almost all human research studies are required by law to obtain ethical approval before they can begin. As part of the University of Ghana's research requirement standards especially on human subjects, ethical approval was needed for the study. Hence, a protocol was prepared and submitted to that effect. The submitted protocol was cleared with protocol number *ECH 169/17*. Nevertheless, the researcher needed to seek institutional clearance from both medical facilities as well as consent from each voluntary participant. All consent forms were signed by the participants before any data was obtained. The document aimed to assure participants of their privacy, anonymity, protection, rights, and confidentiality during and after the process of data gathering. Oral consent was also obtained during the fieldwork in an oral text format which was audio-recorded and transcribed. This approach was added as some patients expressed their apprehension and discomfort in signing any document for research, yet they felt comfortable and preferred giving their oral consent through the audio-recorder. The use of written texts provided by the researcher also included the written consent of the voluntary participants and their signatures. Not only were the participants who voluntarily participated assured of the powers they wanted, but also, they were informed they could either stay or leave the study at any point in time if they felt uncomfortable with the approach.

3.9.1 Consent Procedure: Medical Institutions

Primarily, before the commencement of the data collation exercise, institutional consent was obtained from the selected institutions, the healthcare providers, and other staff members who constituted the entire OB-GYN units. Institutional approval was granted after the researcher was scheduled on different dates to make official presentations of the study to the members of the medical staff (Consultants, Specialists, Residents, House Officers, Medical students, Nurses) of the data sites. Whereas approval was granted for actual data to be commenced on the 28th of November 2018 at KBTH, complete data sets began in December 2018 as five of the initial doctors who willingly accepted to be a part of the study had to go on their annual leave. The annual leave period preferred by most doctors was usually in December. Considering the timing, new doctors had to accept to be a part of the study, which meant that the researcher had to re-inform the new participants, book new schedules and plan around unforeseen circumstances.

Before the fieldwork period, there was an initial data exploration period (pilot study) at the UHS from June 2018 to July 2018. On the field, the researcher garnered ethnographic data on the (written and oral) languages mostly used by the doctors and their patients within the OB-GYN units of both hospitals. Besides, individual semi-structured interviews were garnered from both doctors and patients. Additionally, audio-recordings of the doctor-patient gynaecological interactions were also collated.

Institutional clearance within both units was granted for participant observation only before the issuance of the ethical approval document, letters of introduction and support from the researcher's institution and a letter of invitation to each voluntary participant. The challenge was that although institutional clearance was granted, the ethical approval document had not been issued to facilitate an interview and audio-recorded data from the participants within the shortest possible time.

Actual data collection commenced at the end of November 2018 to February 2019, with final follow-up in both hospitals in May 2019.

Moreover, two medical doctors from both data sites willingly accepted to serve as mentors on the project. Although data initially targeted only consultants within the units, the nature of the institutional structures and emergency demands on the consultants inhibited the researcher from using only consultants, but rather adding some OB-GYN specialists to the field. The consultants served as the primary and final voice in managing the patients through their diseases. They were the main medical experts in managing the OB-GYN cases. All OB-GYN reports on patients were reported to them for their immediate and final plan of action. The consultants served as the lead in medical delivery, performance of surgeries, organising, supervising, coordinating the daily input of the teams working under them daily. Teams worked with different time schedules and rotate to present on their inputs and outputs to the OB-GYN units through early morning presentations. During the early morning OB-GYN medical unit presentations, there was a thorough review and medical assessment of each team's 24-hour progress report on the clinical management of cases admitted to the department on duty's ward. The process has been instituted to enhance medical checks and balances. The consultants, specialists, housemasters, nurses, and all other medical teams within the unit are required to be present, punctual and to contribute to the process. The other teams are required to learn from the presentation and help to address the medical gaps if any by giving feasible suggestions. In situations where the medical management were well coordinated, the team on duty were appreciated and encouraged.

The OB-GYN medical care giving follows a hierarchical structure. This structure focuses on the care of patients as well as the proper functioning of the various units under the OB-GYN department. The medical consultants (who are highly experienced serve as the heads of the various

medical teams), followed by the specialists (those pursuing their medical fellowship programmes), and then the house officers in their residency programmes (physician-in-training). Figure 3. 1 represents the hierarchical flow of the healthcare management process in terms of medical leadership in OB-GYN within the hospitals observed.

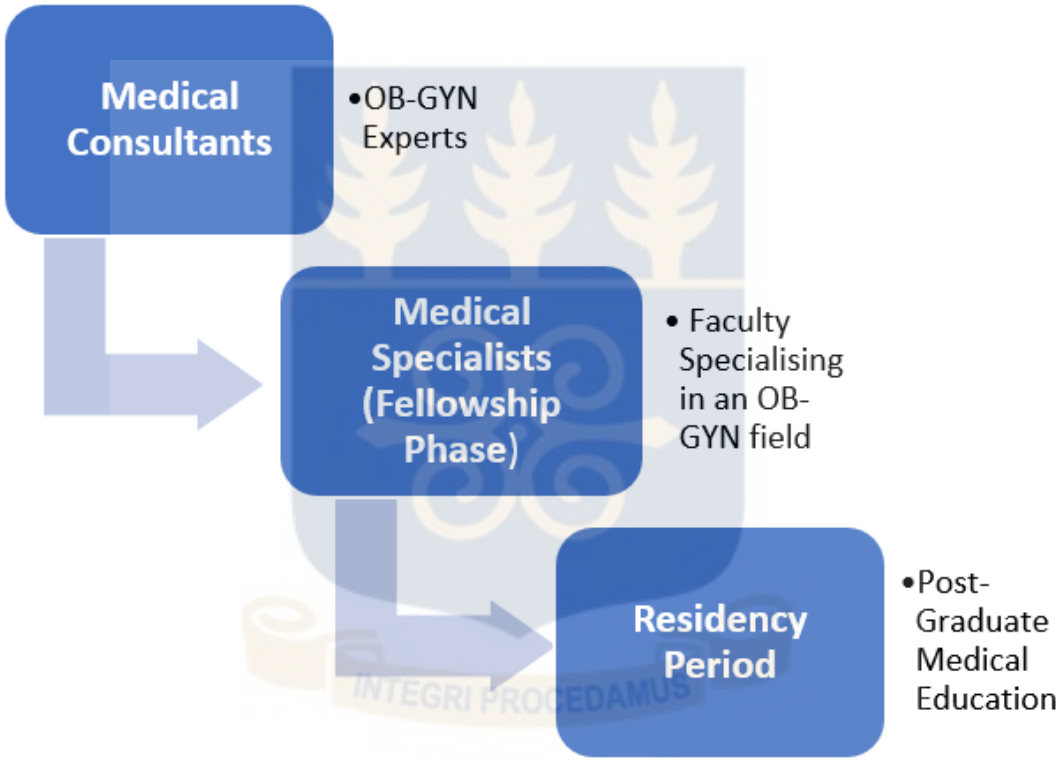

Figure 3. 3: An Illustration of the Medical Hierarchy of Workflow in OB-GYN

(Author's construct, 2019)

3.9.2 Consent Procedure: Participants

Given the voluntary participants used, the consent documents were sent to the OB-GYN units of both the KBTH and the UHS. Before any information could be obtained from voluntary participants, face-to-face interactions were held on the study, its objectives, and its significance,

to the overall medical management process. The process of informing the participants about the study before the commencement of data collation was mandatory. The researcher had to assure the participants of their confidentiality and the protection of their data for research as both parties raised concerns as regards to the data sampling procedures. After establishing trust, some patients freely permitted an audio-recording of their interactions with the doctors in addition to offering semi-structured interview sessions. Although a lot of participants (doctors and patients) were approached and introduced to the study, in total, seven doctors and ten patients from both hospitals agreed to serve as participants for the semi-structured interviews (SS-I). A total of five doctors and about ten patients had to opt out during the initial phase of the data collection due to changes made to their medical schedules. On the other hand, participants asked for more time to identify the researcher as credible within that environment.

Some patients showed interest and therefore wanted to serve as participants in the study. However, they asked me (researcher) to obtain consent for participation from their husbands and partners through phone calls. In all cases, the husbands, and partners ungranted the requests. Others were also disinterested, and some indicated they had "no time" since they lived farther away from the hospital. In some aspects of data elicitation, thus, during the semi-structured interviews, both verbal (oral) and written consents from the patients and doctors were obtained after an explanation of the study's objectives.

Moreover, the voluntary patients were assured of their anonymity, a proven zero harm which was thoroughly explained to them and followed by the researcher. Also, the doctors and the patients (participants) were given an extra copy of the consent forms. Whereas the doctors were interested in keeping their copies of the consent forms, many of the patients thought it was not important to keep the document despite the insistence of the researcher; rather, their words were as follows

"*they had confidence in the process and the researcher*". (See Copy attached to *Appendix D* of study). Nonetheless, they were still given their copies. Subsequently, Tables (3.3 –3.6) highlight the detailed demographic information derived from the 17 participants (seven doctors and ten patients) in total during the semi-structured individual interview sessions from both medical facilities.

The demographic information on doctors highlighted the following: age, gender, nationality, number of languages spoken, primary consultation language (s) used, qualification, years of practice, information on medical rotation, and each participant's interview duration. On the other hand, the patient participants had additional information for the derived samples - Official language, area of upbringing, marital status, and languages (Foreign/local) spoken, read, and written (S/R/W). [4]The order of the languages spoken, read, and written by the data participants was according to the order of their competence and proficiency.

Table 3. 3: Demographic Information – UHS Doctors

The demographic variables on the gynaecologists can be observed in Table 3. 3. The three gynaecologists sampled were all male, full-time, and were aged between 35 – 55 years. They were all Ghanaian, with Asante Twi, Ewe, and Akuapem Twi as their [5]mother tongue/First Language (L1). Although one doctor had an indigenous language, all three had Akan (Twi) serving as their second language and an additional local language, including Ga. Surprisingly, one of the doctors was proficient in German as an extra international language. All three doctors – the Two

[4] The order of the languages above was listed in order of competency by the patients involved. The participants insisted on that order since it was indicative of a language cline with their most proficient languages beginning.

[5] Mother- Tongue / L1 – This language serves as an irreplaceable and an indispensable first language (L1) of any individual. It is the foundational language which is so vital to one's self-expression. It serves as one's personal, social, and cultural identity. According to UNESCO (2017) "Local languages, especially minority and indigenous, transmit cultures, values and traditional knowledge, thus playing an important role in promoting sustainable futures." (n. p.).

consultants and one general OB-GYN specialist consulted primarily in English, which is their official language. Their years of professional medical practice ranged from ten to 17 years. The doctors had been on medical rotations as a requirement and as part of their medical practice, and growth as shown in Tables 3. 3 and 3. 5 respectively. The interview time slots varied due to doctor's availability and easy accessibility. The demographic information is essential in providing a basis for understanding the nature of gynaecologists and the patients being used in the study. These variables on participant demographics are independent and can never be manipulated. Hence, they contribute towards the validity of the study considering the sensitive area under study

Table 3. 3: Demographic Information - UHS Doctors

Doctor	Age	Gender	Nationality	L1	L2	L3	Primary Consultation Language	Qualification	Years of Practice	Rotation	Interview Duration (Minutes)/ Date
Dr 1	40 - 55	M	Ghanaian	Ewe	Asante Twi	Ga	English	Consultant	17	YES	1:04:06 20/05/2019
Dr 2	40 - 55	M	Ghanaian	Akuapem Twi	Asante Twi	German	English	Consultant	10	YES	28:16 30/05/2019
Dr 3	35-45	M	Ghanaian	Asante Twi	Asante Twi	Asante Twi	English	General OB-GYN Specialist	12	YES	14:02 04/12/2018

Table 3. 4: Demographic information - UHS Patients

The patients used were five in total. Four were married and one unmarried. Their ages ranged from 30 – 35 years. While three of the patients were older i.e., they had been visiting the health facility with their health concerns for more than three months whereas the other two who were fairly new were on their 2nd and 3rd visit. All the patients identified as female and Ghanaian. Two of the participants had a mother tongue and an extra local language, while the other three had a mother tongue and two auxiliary local languages.

Again, all the patients had English as their official language, they are educated and they grew up in different parts of Ghana. Their educational background ranged from 1st degree – to Masters / Mphil. Although patient one was proficient in Ga (L1) and Asante Twi, she could speak / read / write (S/R/W) English and Ga; patient two had Buem (L1), with Ewe and Asante Twi, but she could only speak (S) Buem and Ewe and speak / read / write English, and Asante Twi; patient three had Asante Twi (L1) with Fante, yet she could speak (S) Asante Twi, and Fante, and speak / read / write only English; patient four had Asante (L1), and Akuapem Twi, and she could speak both, but speak / read / write only English; patient five had Ewe (L1), and Fante however, she could only speak Ewe, and Fante and speak / read / write English, and [6]*Fante. Interestingly, apart from patient one, who could speak / read / write in her L1 (Ga), all the rest could neither read, nor write in their L1s – Buem, Asante Twi, and Ewe. In all, their interview time slots ranged from 20 – 33 minutes.

[6] The symbol (*) on the language represents inadequate competency in the language, where the user can speak, but reading and writing proficiency in that language is *average* according to the participants.

Table 3. 4: Demographic information - UHS Patients

Patient	Age	Sex	Nationality	L1	L2	L3	Education	Marital status	Interview Duration (Minutes)/ Date	Languages Spoken (S) /Written (W)/ Read (R)
UHS 5	37	F	Ghanaian	Ga	Asante Twi	-	Mphil	+M	32:12 16/05/2019	*S/R/W=English & Ga* R=As. Twi
UHS 10	32	F	Ghanaian	Buem	Ewe	Asante Twi	Mphil	+M	23:30 23/05/2019	S=Buem /Ewe *S / R /W = Twi & English*
UHS 3	25	F	Ghanaian	Asante Twi	Fante	Fante	1st Degree	+M	21:40 15/05/2019	S = Twi/ Fante *S/ R / W = English*
UHS 4	31	F	Ghanaian	Asante Twi	Akuapem Twi	Akaupe m Twi	1st Degree	+M	20:11 15/05/2019	S = As. Twi/ Ak. Twi *S / R/ W = English*
UHS 8	30	F	Ghanaian	Ewe	Fante	Fante	MBA	-M	26:27 16/05/2019	S = Ewe & Fante *S/ R/ W = English & *Fante*

Table 3. 5: Demographic Information - KBTH Doctors

The doctors in this profile were two males, and two females. Their ages ranged between 35 – 40 years. Whereas in this category, three of them were Ghanaian, one was Nigerian. Although all of them consulted primarily in English, which also served as their official language, they all had their first language (L1) or mother tongue and other local languages. While doctor one had Dagaare (L1), with Ga, Twi, and Krobo; doctor two had only Igbo; doctor three had Siwu, Hausa and [7]*Broken Twi and doctor four had Sehwi and Asante Twi. This data set had two consultants and two general OB-GYN specialists with about ten years of professional practice which involved medical rotations in varied medical facilities as part of their training. It must be noted that all the doctors had lived and worked in Ghana for at least ten years. The individual semi-structured interview schedule within this group lasted between 19 – 43 minutes due to the participants' available time.

[7] *Broken Twi: This is when one with limited knowledge in Twi (Asante Twi) modifies the language in a way to suit or achieve communicative function. Usually, the rules governing the language is not followed. It is observed that the language that becomes *Broken Twi is based on the individual's level of exposure to the language, and how their idiosyncrasies impact on their derived versions. It is a language of survival.

Table 3. 5: Demographic Information - KBTH Doctors

Doctor	Age	Gender	Nationality	LI	L2	L3	Primary Consultation Language	Qualification	Years of Practice	Interview Duration (Minutes)/ Date
Dr B	35-40	M	Ghanaian	Dagaare	Ga	Twi /Krobo	English	Consultant	9	18:39 05/12/2018
Dr F	35-40	F	Nigerian	Igbo	Igbo	Igbo	English	Consultant	9	43:49 14/12/2018
Dr F1	30-35	F	Ghanaian	Siwu	Hausa	*Broken Twi*	English	General OB-GYN Specialist	10	42:44 08/01/2019
Dr M	35-40	M	Ghanaian	Sehwi	Asante Twi	Asante Twi	English	General OB-GYN Specialist	10	29:40 24/01/2019

Table 3. 6: Demographic Information - KBTH Patients

The patients used were five in total. Two were married and three were unmarried. Their ages ranged between 25 – 45 years. While two of the patients were old patients, i.e., they had been with the facility for more than three months, the other three who were fairly new were on their 2nd or 3rd visit. All the patients identified as female, and Ghanaian. Two had a mother tongue and a local language, and three had a mother tongue and two additional local languages. Again, all the participants in this set had English as their official language. They were all educated and grew up in different parts of Ghana. Their educational background ranged from Senior High –Tertiary.

Although patient one had Krobo (L1) with Ewe, Ga, and a foreign language - French, she could only speak / read / write (S/R/W) English and Asante Twi; patient two had Asante Twi (L1), with Ga, but she could only speak (S) Asante Twi, and Ga, and speak / read / write English and Asante Twi; patient three had Ga (L1) with Asante Twi, she could also speak (S) Asante Twi, and Ga and speak / read / write only English; patient four had Mfante (L1) and Nzema, yet, she could speak Nzema, Mfante, and Asante Twi, but she could speak / read / write Mfante, and English; patient five had Ewe (L1), Asante Twi, and Ga, however, she could only speak Ewe, and Fante; speak / read / write in English. Interestingly, apart from Patient two who could speak / read / write in her L1 (Asante Twi), and patient four, who could also write in her L1 (Mfante), patients 1, 3, and, 5 could neither read, nor write in their L1's – Krobo, Ga, and, Ewe. In all, their semi-structured interview time slots ranged from 12 – 24 minutes.

Table 3. 6: Demographic Information - KBTH Patients

Patients	Age	Sex	Nationality	L1	L2	L3	Education	Marital Status	Interview Duration/ (Date)	Languages Spoken/Read/ Written
GPA 7	41	F	Ghanaian	Krobo	Ewe	Ga / French	Senior High School	-M	23:31 11/02/2019	S = Ewe, Ga, As. Twi, English, French *S/R/W = As. Twi & English*
GPA 10	42	F	Ghanaian	Asante Twi	Asante Twi	Ga	Tertiary	+M	13:43 08/02/2019	S = As. Twi & Ga *S/R/W = As. Twi & English*
GPA 9	27	F	Ghanaian	Ga	Asante Twi	Asante Twi	Tertiary	-M	12:02 08/02/2019	S = Ga & As. Twi *S/R/W = English*
GPA 4	36	F	Ghanaian	Mfante	Nzema	Mfante	Tertiary	+M	15:34 11/02/2019	S = Nzema, Mfante, As. Twi *S/R/W= Mfante & English*
GPA6	31	F	Ghanaian	Ewe	Asante Twi	Ga	Tertiary	-M	17:28 11/02/2019	S = Ewe, As. Twi, Ga *S/R/W = English*

3.9.3 Data Protection

A sophisticated android phone with an in-built microphone with 64 Gigabyte space served as the instrument to record all the interactions. After data had been obtained with the use of the recorder, the transcriptions and data analyses strictly adhered to the following format: 1. Manually listening to the tapes on doctor-patient interactions, transcribing verbatim into Microsoft word document, transferring the transcribed document into excel sheets, and finally saving the entire file on the researcher's online One-drive cloud. Participants were anonymised.

The recognition and the acknowledgement of personal data and its multiple breaches over the years on electronic and non-electronic platforms necessitated the formation of the Data Protection *Act 843* in Ghana. This Act was passed by Ghana's parliament and assented to by the President of Ghana on the 10th of May 2012. It was instituted to further guarantee the right to privacy enshrined under Article 18 *(2)* of the 1992 Constitution. It must be noted that this study recognises the sensitive and personal gynaecological interactions and therefore, thoroughly adhered to sections (32, 33, 34 and 35) of the Data Protection Act (see Copy Attached in *Appendix I)* during personal data sampling and archiving. These data resources were all transcribed before use.

3.10 Data Transcription

The collated samples from the doctor-patient audio recordings and the semi-structured interviews were manually transcribed verbatim. This process as well as the analyses phase, was time-consuming. Contrastingly, in the process of transcribing, the transcripts were reviewed to informally modify the prompt guides of the data. The time estimated for transcribing an interview of about 45 minutes – 1 hour was about 24 - 48 hours and sometimes the complexity of the audio

recordings having several voices within a consulting room further impacted the general timelines for the completion of each data transcript on the estimated time plan.

3.10.1 Research Assistants

Two research assistants assisted in the data processing. These assistants were further equipped to appreciate the nature and dynamics of data coding. Data coding was adopted to establish the reliability and validity of themes among the data sets without any form of bias. Importantly, these assistants were selected based on their merits in the following: 1. Fluency in the English language and at least any two of the national languages and 2. Acquisition of their cultural, social, and linguistic intelligence into the research area. These merits guided the coding processes to eschew any researcher bias during data analyses.

3.11 Data Analyses

Communication Accommodation Theory (CAT) served as the theoretical lens for data analyses. CAT as a theory of communication was propounded by Howard Giles in 1973 (Giles, 2008; Ogay et al., 2005) to demonstrate how interactions are managed to minimise social distances based on whom one is engaged with communicatively. CAT aided in the language analysis to answer the study's set objectives.

The study adopted semi-structured interviews, surveys, ethnographic field notes, audio recordings, and direct observations. This approach studied the unique patterns of the observed and recorded interactions to understand their classifications and possible forecasts (Bode et al., 2017). In the process, the themes, categories, and patterns of communication in health delivery emerged naturally by the prevailing conditions during the period of data elicitation, although this approach

could be assessed to be full of bias, and unquantifiable, the use of triangulation as the study's method during data elicitation helped to reduce bias in the study. Triangulation in the methods served as an appropriate approach in the generation of new findings. The perspectives derived from this in-depth method democratised the process by establishing agreement and the validation of results. As a result, this outlook established that figures can only be interpreted with the use of qualitative information. Also, numerous statistics in an entire work would not automatically make such works scientific as there is bound to be errors that still do occur (Brown et al., 2018).

It is interesting to note that the work attained saturation at the phase at which new, but additional data failed to generate insights (Suter, 2014). All data garnered were accessed to ascertain the study's level of quality. Data were therefore examined based on the study's research questions, thus serving as its empirical chapter. The reduction of the text into themes according to the study's objectives was done using *NVivo* 12.6 PRO. Thoroughly, the findings derived were backed with evidence from the qualitative data garnered. Even more, the researcher employed the use of another software termed *Discursis*. This software is a computer-based tool used for investigating human communication. It must be emphasised that the qualitative and quantitative divide must be eschewed since both methods have merits in complementing each other in single and across several studies (Aspers & Corte, 2019).

Also, the participant observation adhered to the above pattern of an in-depth study where (Saville-Troike: 2003, p. 8) opines that since "ethnography has tended to be identified exclusively with qualitative approaches, currently, many scholars are recognising the need to include some level of quantitative data analysis in ethnographic descriptions". In the data analyses, the observational surveys, audio-recordings, and the semi-structured interview data provided a general overview of communication percentage coverages. This served as a curious statistic that queried and therefore

projected the percentage of the data file that the reference coding represented. In this regard, the items coded represented x percentage of characters in the entire data file. This information was obtained by opening a node in NVivo which allowed the percentage of the source coded to nodes. Again, the % in the coverage column represents the intersection found in selected nodes with respect to selected attributes (location). Hence, the results in percentage coverage were a summary of the text coded in a specified way. (Refer to chapter 4 on the percentage coverages of the communication strategies used). It was observed that the coded texts contributed in equal measure to the interactive dynamics the doctors and patients employed to negotiate their gynaecological encounters. Subsequently, the triangulation approach to data collation validated the study and the interpretation of its findings in terms of its reliability, accuracy, adequacy, and relevancy.

3.11.1 Open-Coding

After the original data transcripts were obtained, the first few written versions were read in detail by the researcher and two research assistants. This strategy enhanced familiarity with the text content and the initiation of the process of open coding where conceptual categories from the raw data were formed (Linneberg & Korsgaard, 2019). The process ensured consistency in coding to eschew low consistency and therefore, re-coding. The coding consistency was applied to all data sets. Contents of short sections of the text such as each unit of meaning were summarised in a word (s) until the entire text was reduced into meaningful phrases. After the entire data coding process, its reliability and validity were ascertained between the researcher and the research assistants through a verification process of an exchange of their codes and themes, also known as [8]inter-rater

[8] Inter-rater reliability – The point of congruence between coders. This is a focal process adopted by the researcher and her team of assistants in the establishment of data consistency, precision, accuracy, validity, and reliability through an objective process of review.

reliability (IRR) (Belur et al., 2021) index check. Since there are no absolute methods under which reliability processes should be judged and considering the nature of the study as qualitative, the study therefore adopted the simplest method of 'percentage agreement' to calculate the inter-rater reliability test. During this process, the percentage of agreement, also called 'po' was identified as the proportion of agreement observed by the three independent coders including myself on the codes derived. In this calculation, the data was divided according to the total number of agreements between the three raters by the total number of assessments made on the codes identified and thematised. The figure was then multiplied by 100%. On all accounts, the independent coders agreed on 80% of the assessments made. Additionally, the coding comparison query on NVivo 12 was used to assess the reliability of the coding scheme by comparing all the coding conducted. Since little is known about the research area, the inductive coding approach was adopted to aid in the heuristic or exploratory nature of the study. Hence, inferences were drawn through an exploration of the coding patterns, categories, and dimensions as units of data files created were all examined. At this level, the codebook was generated and built from scratch on the data types collated. The codebook which served as the data analyses blueprint was generated with *NVivo* 12.6 PRO export tool. (See a Copy of the Codebook in *Appendix I*).

3.12 Use of Data Analyses Applicational Software Tools

The study design adopted the use of two analytical packages, *Discursis* and *NVivo 12.6 PRO to* process the data. While the former analysed relational communication data, the latter was used for varied qualitative data explorations.

3.12.1 Discursis

This software is a computational methodology (tool) used for the analysis of communication data. It is motivated by the idea of data visualisation. This form of visualisation assists language analysts to explore, understand and transmit the findings, analyses, and data interpretations to the understanding of others in terms of the nature and pattern of how human communication can transcend information transmission. Hence, despite the complexity in interactions, there are ways to mirror the role (s) of each participant and their unique communicative dynamics (Angus et al., 2012; Baker et al., 2015; Chevalier et al., 2018). To be able to analyse this qualitative part of the data effectively, transcripts from the audio-recordings adopted Discursis, a computer-based tool for analysing human communication. These transcripts were derived using the excel sheet interface to aid the software's easy applicability. It must be noted that the efficient use of Discursis required 200 and more interactive exchanges to be keyed into Excel sheets, then fed into the Discursis programme before the software could generate results. As a textual analysis software programme, it applied modern technology to visualise and identify speaker approximation as supported by Watson et al. (2014). Simultaneously, its application explored a contextual interactive visual inspection of all contributions made by each participant during the medical encounter. Correspondingly, the programme highlighted the interactive dynamics and the nature of the content used by both interactants (doctor-patient), (Holler et al., 2015). The software further established sequential analysis as well as the visual account of the engagement to derive the level of interaction between the participants since behavioural engagement (s) has been identified by other scholars as a crucial factor in a patient's rating (s) of satisfaction. As a result, single visual plots were randomly derived from each doctor-patient audio-recorded interaction. Moreso, representative plots were selected to show moderate to high and low-level speaker engagements.

Details of involvement were investigated for the doctor-patient interactions around their communication accommodation (approximation or not) and the varied levels of dominancy that occurred.

Adopting this programme has been advantageous to the study since the software helped in studying the interactions and sorting themes in all conversations graphically. This feature of the software complemented the analyses of data on (the doctor-patient relationship) by identifying the doctor-patient communication model practised visually with all the data segments being derived from the various classifications attained from the analyses. Under this principle, there was room for the researcher to creatively develop a style for analysis since data analysis was eclectic. Quantitatively, the causal relationships between variables such as age, gender, educational level, languages spoken, and ethnic background were ascertained and established. The software also identified the medical communication techniques used in doctor-patient consultations and the level of relationship established (Angus et al., 2012) within Ghana's socio-cultural context.

3.12.1 NVivo 12.6 PRO

This software is used for advanced qualitative and mixed methods research. As one of the current and popular qualitative data management programmes developed out of the Non-Numerical Unstructured Data Indexing Searching and Theorizing *(NUD*IST),* this software was adopted due to its high capability to research designs. Despite the software being methodologically versatile (mixed methods, ethnography, critical discourse analysis), it was selected in the study to process purely qualitative data. It must be emphasised that NVivo was selected for this study primarily because the software is known to improve data accuracy, reliability, flexibility, and transparency across an eclectic data paradigm (Nowell et al., 2017; Zamawe, 2015) such as being used for varied

data imports from pure text images (Surveys, interviews, websites, focused Groups, news articles and field notes), videos, and social media sites (Twitter, Facebook posts).

NVivo was used to thematically analyse the data on the doctor-patient gynaecological experiences, views, and perceptions. This analysis focused on an inductive process where codes and themes were developed from the data as they were being identified and organised coherently to communicate meaning to the nature of the study. With utility effects, it arranged and explored the qualitative data such as semi-structured interviews and doctor-patient audio-recorded encounters to ascertain insights.

During its application, the software (NVivo 12.6 PRO) was acquired and opened with its unique electronic key. A blank project was created, and the researcher titled it *PhD Journey* to begin the study's analyses in a project file. Due to the purely qualitative paradigm adopted, thematic analyses were done on the entire data set. Hence, the audio-recorded doctor-patient interactions transcribed on word documents were imported into the data files of the software in succession. The software used the node feature to create a 'code' also known as a theme. Saldaña (2015, p. 3) opines that a code is "a short word or phrase that symbolically assigns summative, salient, essence capturing and or evocative attribute for a portion of language based on visual data". An explanation that accentuates data divided into viable segments allows a recap of vital information. This process is analogous to manual coding, which is complex and cumbersome as data is easily lost.

Themes or codes were developed and tagged from the imported data into the software. During this aspect, key data information in descriptive details was added to the un-coded data. The codes/themes were generated from the study's research questions. To establish the trustworthiness and reliability of the themes generated, the themes were moderated between the researcher and the two research assistants consistently in a learning and cross-checking format.

The codes were generated from words, sentences, and paragraphs, all at the researcher's discretion. Thus, the constructivist/interpretivist point of view was adopted to develop the codes on the working theory adopted for the study – Communication Accommodation Theory (CAT). This involved the provision of narrative descriptions to represent the communicative experiences of both the doctors and their patients in the process. The semi-structured interview questionnaires contributed to the development of the themes within the data derived. This thematic synthesis approach allowed conclusions to be collated around multiple and varied data sets which supported the synthesising of key findings in the entire study.

In all, varied codes and references were derived for the data on doctor-patient audio recordings and the semi-structured interviews conducted for both the doctors and the patients. In Tables (3.7-3.11), there are individual passages or references in NVivo that were coded at a given node. In Table 3. 7, the codes of all doctors and the number of references derived were from the consulting room audio-recordings. In the table, we observe doctors M, B, and 1 having the highest codes (36) in each case, followed by Drs F1, 2, and 3. The least codes were derived from Dr F at 31.

Table 3. 7: Doctor-Patient Consultations (audio-recordings) for all sampled doctors

Doctor Label	Codes	References
1. Dr F	31	489
2. Dr M	36	628
3. Dr F1	34	533
4. Dr B	36	760
5. Dr 3	34	766
6. Dr 2	34	534
7. Dr 1	36	483

Moreover, in Table 3.8 we have a summarised Table showcasing the number of codes, and their number of references in the individual semi-structured interview data of the four doctors sampled

from KBTH. In this sample, Dr M had the highest number of codes - 25 codes followed by Dr F1, Dr B, and Dr F who had the lowest number of codes at 16.

Table 3. 8: KBTH Doctors Semi-Structured Interviews

Doctor Label	Codes	References
1. Dr F	16	23
2. Dr M	25	40
3. Dr F1	18	25
4. Dr B	17	21

Following the individual semi-structured interview data from the KBTH doctors, five of their patients were also sampled through a semi-structured interview process. It is observed from Table 3.9 that participant GP7a's data had the most codes (34), with participant GPA4 with (33) codes, then GPA6 (29), GPA10, (26), and the least codes were derived from participant GPA9 at (22).

Table 3. 9: KBTH Patient Semi-Structured Interviews

Patient Label	Codes	References
1. GPA6	29	47
2. GPA4	33	49
3. GPA9	22	30
4. GPA10	26	40
5. GP7a	34	55

However, the semi-structured interviewed data from UHS doctors in Table 3. 10 produced the highest codes as compared to the doctors from KBTH. In this sample, the codes derived from each sample were above 30. As a result, the highest codes were derived from the samples of Dr 1 - (60), followed by Dr 2 – (36) and finally, the least by Dr 3 at (34). These highest codes from UHS may be influenced by the number of patients seeking gynaecological care daily as compared to the number of patients seeking the same care at KBTH daily.

Table 3. 10: UHS Doctor Semi-Structured Interviews

Doctor Label	Codes	References
1. Dr 3	34	39
2. Dr 2	36	43
3. Dr 1	37	60

In Table 3.11 the individual semi-structured interviews data were sampled finally from five patients at UHS. It is observed that the highest codes were derived from the sample of participant UHS 8 at (35), followed by UHS 3 (34), UHS 4 (32), then, UHS 5 (32), then finally, UHS ten with (28) codes. Interestingly the number of codes in this data as compared to the KBTH patient's semi-structured interview codes were high.

Table 3. 11: UHS Patient Semi-Structured Interviews

Patient Label	Codes	References
1. UHS 8	35	56
2. UHS 4	32	44
3. UHS 3	34	50
4. UHS10	28	41
5. UHS 5	32	56

The codes were generated until data reached saturation (Creswell & Creswell, 2018; Sommier, 2014). In this study, some of the core themes also derived were as follows: Avoidance, Empathy, Code-Switching, Repetitions, Pronoun IT, Euphemisms, Low Tones, and Silence. These rich sources of data identified as codes (themes) revealed the human experiences that ensued during the doctor-patient OB-GYN consultations. Lastly, Table 3.12 gives a summary of the research questions being explored, the tools used in sampling the required and the specific data under the specific questions and the modes of data explored to answer each question.

Table 3. 12: Overview of Data Collection Analyses

Research Questions	Data Collection Tool	Data Collection Analysis
1. What communication strategies are adopted by doctors and patients during gynaecological care in overcoming potential language and cultural barriers?	- Participant Observation - Audio-recordings of doctor-patient interactions - Semi-structured interviews	• Transcription of data • Descriptive statistics on participants' demographic variables • First-level data coding • Linguistic Analysis using *NVivo* 12.6 PRO
2. What model of communication is adopted during the doctor-patient interactions?	- Participant Observation - Audio-recordings of doctor-patient interactions	• Transcription of data • First-level data coding • Linguistics Analysis using *NVivo* 12.6 PRO. • Use of *Discursis* software
3. What are the perceptions of doctors and patients regarding the interaction?	- Participant Observation Audio-recordings of doctor-patient interactions - Semi-structured interviews	• Transcription of data • Linguistics Analysis on Open-Ended questions using *NVivo* 12.6 PRO software

3.13 Issues of reflexivity: The Author as an Indigenous Ethnographer

The researcher's "native" status offered both opportunities and limitations for the study (Burke, 2008; Dales, 2015). The researcher approached this study by employing ethnography to further garner more accurate information on her indigenous environment with her native credentials - as a born and bred Ghanaian, an "Akan" (Akuapem Twi) speaker, married with children and had had a personal experience with the general Ghanaian biomedical landscape with specific interest in some OB-GYN care units in Accra. As a result, the researcher was able to co-opt two mentors to

the project: both of whom were consultants in OB-GYN care at each data site. Whereas one OB-GYN expert specialised in infertility, the other was also an OB-GYN consultant who apart from other key duties focused on pregnant women with sickle cell. Through the relationship, other health networks and contacts were also established, thereby enabling easy access to a wider cross-section of the participants in the study.

Upon reflections on how the data collection processes influenced my perceptions as a researcher and how other participants also responded to me, I understood that taking sensitive and private data from participants pursuing OB-GYN care services required a longer time, patience, and trust from the perspective of the willing participants in practice than in theory. This awareness lengthened the data collation phase in both hospitals.

During the initial piloting phase, it was extremely difficult to collate any data samples as participants demanded to make sure the facility approved of my (researcher) presence. In some instances, about five of the participants asked me (researcher) to seek permission from their husbands before they participated in the study, as corroborated with the D SS-1(2018/2019) from Dr 1's response who was privy to this information due to his years of medical practice.

> *So, it means therefore that … you cannot manage to talk about issues about contraception, family planning, without involving an African man… The male partner. It is very, very crucial … Discussions bordering on sexuality, sexual… in relationships, you cannot discuss it without the man … (D SS-I 2018/2019 Field data).*

However, they were unable to participate since their husbands through phone calls disallowed their participation. Furthermore, I had to wear a [9]*white coat* or *doctor's coat* as part of the protocols to

[9] The patients and doctors had awareness of the symbolism in the white attire and how it represented each person in the scheme of things. Indeed, the *white coat* served as my official cover coat during the field workdays in both hospitals. It significantly influenced how the patients and the doctors perceived me (researcher) and granted me access.

collate samples in both hospitals throughout the period. This design assured willing participants of their security, confidence, and liberty to divulge honest, private, sensitive, and necessary information needed. Apart from the wearing of a *white coat*, other attributes about me eased my efforts to relate with patients and clinicians with noteworthy examples being my identification as Ghanaian, my marital status, my personality, and my disposition. I engaged in the process as though I was a staff at both medical institutions. This approach encouraged participants and clinicians to make vital information available. I was made to feel 'belonged' despite the existence of challenges that served as hurdles to the collation of data during distinct phases of the fieldwork. The participants felt comfortable as they fully supported the semi-structured interview design as well as the audio - recordings. Indeed, both doctors and patients felt comfortable with my presence in the consulting rooms as they discussed private issues during their intimate examinations. I was taken as a medical trainee and a mentee in both hospitals apart from being known as a researcher by the patients, doctors, and the entire medical staff within both hospitals. In fact, the doctors enhanced my knowledge in OB-GYN practice.

Also, official, and unofficial presentations on fieldwork updates were made to the entire teams on duty, as was required by the units. The researcher scheduled dates and appropriate times to be around doctors and their patients to garner as much information as allowed. As the researcher and understanding the cultural confusion between *research* and *investigation* on the field, it took some time to obtain total trust especially from the patient participants. Nonetheless, once the patient participants understood the meaning and the relevance of research through the initial interactions, it became easier for them to engage entirely in the process. The experience made it necessary for

Although it is significantly reported as serving as a symbol of power which impeded the medical relationship as many patients were observed to suffer *white coat hypertension,* in my experience, the patients suggested I wear them. Coupled with institutional approval, I was given one as a gift from one of the medical sites which served as a factor that opened the door into the participants' world of experiences in gynaecological care services.

me to allow myself to thoroughly be a participant within my data sites, curbing any fear of patients not giving out free, quality, accurate and enough information.

My rationale for adopting this strategy was to create a level of familiarity that increased the trust participants felt in sharing private and personalised data. On the other hand, the doctors felt relaxed operating in their natural environment spontaneously and forgetting about the presence of the researcher. This allowed all the data to be collated in a relaxed environment. The use of open-ended questions as well as informal conversations with informants on other topics raised before the main interview sessions were among the ways pursued to mitigate cultural, linguistic, religious, and educational barriers. This strategy also enabled the researcher to know which language (s) (English or Akan (Twi) or a blend) to be used as preferred by each participant according to their cultural definitions, values, and limitations, and how to go about data elicitation with respect and as accurate as possible.

In all, I was privy to high-profile data that had been anonymously labelled for the entire study. I would attribute the said preferential treatment to my openness of mind, honesty, selflessness, and willingness to support the facility beyond my project plans. Through these behaviours, I can say my values and field work ethics positively affected data collection.

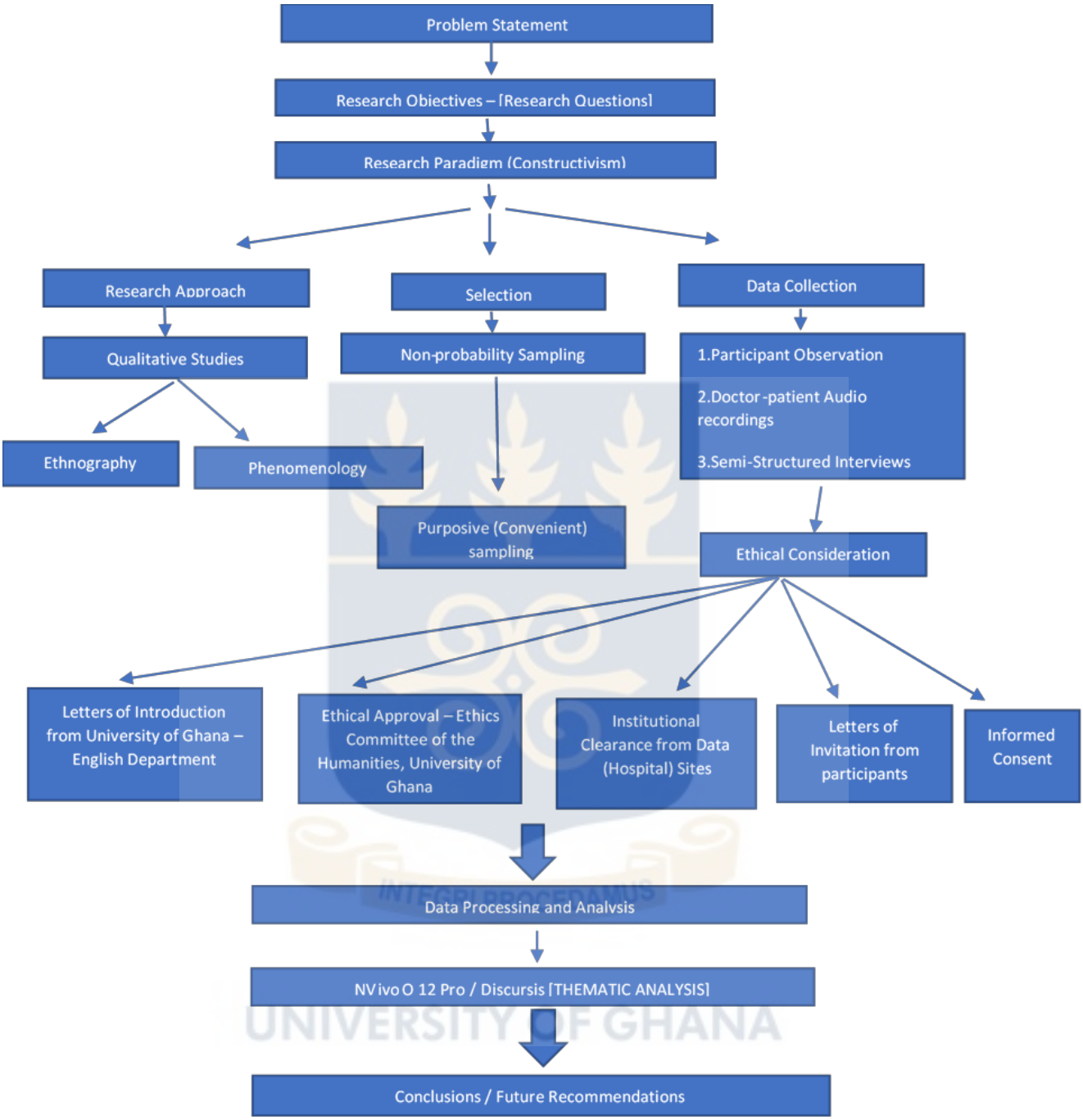

Figure 3. 4: Developed Research Design Guide for the Study

(Author's construct, 2020)

3.14 Summary

The purpose of this chapter was to discuss the methodology used in the study. The study's predominant use of qualitative data may open newer insights on the interactive needs and expectations of patients during gynaecological encounters. Based on the objectives of the work, the qualitative method served as the best method under the circumstance, although a few aspects of the data queried percentage coverages in a descriptive manner. The study, therefore, used semi-structured interviews, audio-recordings, and participant observations to certify the validity and accuracy of both primary and secondary data which were thoroughly discussed. While the primary sources included participant observation (ethnography), and adopted the emic and the etic perspectives, audio-recordings of doctor-patient interactions and semi-structured interviews, the secondary data sources depended on information from books and up-to-date online peer-reviewed journals. As reiterated by (Fetterman, 1998), doing ethnography is not devoid of etic dimensions; however, a carefully done emic analysis precedes and forms the basis for etic extensions that allow for cross-cultural comparisons and in some instances, variance. Therefore, the approaches adopted are more heterogeneous in their ontological and epistemological assumptions (Markee, 2013).

CHAPTER FOUR

DOMINANT COMMUNICATION STRATEGIES DURING DOCTOR-PATIENT GYNAECOLOGICAL ENCOUNTERS

4.0 Chapter Overview

The analysis in this chapter establishes the major and recurring communication strategies employed by both doctors and their patients in the doctor-patient gynaecological encounters that were observed. I examined the use of (socio -) linguistic features in communication by doctors and patients to negotiate culturally restrictive communication in sexual healthcare. By employing triangulation, a combination of audio-recorded data from doctor-patient consultations, doctors' and patients' semi-structured interviews, doctor-patient observations, and the dominant communicative strategies utilised during gynaecological care were examined. These strategies are analysed and discussed in this chapter.

4.1 Communication Strategies

In any context, the process of social interaction occurs at varying levels and through spoken language. The use of language is focal in the ways doctors relate and provide appropriate medical services for patients. Additionally, the use of language between the doctors and patients enhances the interpersonal nature of the relationship by serving as a medium through which patients envisage their position, rights, emotions, and level of satisfaction. Equally important is the fact that, within this process, communication can be verbal or non-verbal, intentional and unintentional (Kee et al., 2018; Ong et al., 1995). Nonetheless, doctors and patients may find their interactions impeded by several factors including culture and language. Consequently, doctors and patients

rely on communicative approaches that are mutually acceptable (Herselman, 1996), therefore, leading to the accommodation of sociocultural differences during the encounters.

In this study, although several strategies in communication were identified, 11 dominant strategies were established and recorded in this chapter. These strategies are the use of medical jargon (M-J), empathetic expressions (EMP-E), the use of the pronoun 'it' (PRN – IT), euphemisms (EUP), we-inclusivity (WE-I), repetition (REP), avoidance (AVO), code-switching (C-S), politeness (POL), Low Tones (L-T) and silence (SIL) strategies represented in (Table 4.1). While the data transcribed from the audio-recordings may not primarily highlight several non-verbal communicative strategies, although they were observed to be a part of the doctor-patient gynaecological interactions. The nonverbal cues were not a primary focus of the study. Among the communication strategies observed, medical jargon, empathetic expressions, we - inclusivity, and repetitions as communication strategies were employed by doctors, whereas the use of the pronoun 'it', euphemisms (EUP), avoidance, code-switching, Low Tones, and politeness strategies were also used by both doctors and patients. Silence (SIL) as the only non-verbal communicative strategy was employed mostly by the patients in the interactions. Apart from the use of code-switching and euphemism strategies, all the identified strategies were observed in all 35 doctor-patient interactions monitored. In the data extracts for discussion, italics has been employed on aspects of data extracts to emphasise and reference parts of the data findings under discussion.

Moreover, a complete table on a doctor-patient communication strategy employed is made up of seven listed data sets which equals 35 doctor-patient interactions. This means that each listed data set labelled as patient (PAT) is made up of 5 patients results in total. Besides, any information under PAT is a summation of five patients against a doctor - (Dr 1, Dr 2, Dr 3, Dr M, Dr B, Dr F and Dr F1) represented on Tables 4.3 – 4. 13.

Table 4. 1: Summarized File List of the Dominant Communication Strategies Obtained in the Audio-Recorded Data. *(2018/2019)*

List of strategies	Types of Communication Strategies Identified	Number of Participants	Participant's Use of Strategies
1.	Medical Jargon	7 Drs/35 PATS	{≥ 3 pat; ≤ / = 5 pat; {D}}
2.	Empathetic Expressions	7 Drs/35 PATS	{≥ 3 pat; ≤ / = 5; {D}}
3.	Pronoun "IT"	7 Drs/35 PATS	{≥ 1 pat; ≤ / = 3 pat; {D.P}}
4.	Euphemisms	6 Drs/30 PATS	{≥ 2 pats; ≤ / = 5 pat; {D.P}}
5.	"We" – Inclusivity	7 Drs/35 PATS	{≥ 4 pats; ≤ / = 4 pat; f pat; {D}}
6.	Repetition	7 Drs/35 PATS	{≥ 1 pat; ≤ / = 5 pat; {D}}
7.	Avoidance	7 Drs/35 PATS	{≥1 pat; ≤ / = 3 pat; {D.P}}
8.	Code-Switching	6 Drs/30 PATS	{≥ 1 pat; ≤ / = 4 pat; {D.P}}
9.	Politeness	7 Drs/35 PATS	{≥ 2 pat; ≤ / = 5; {D.P}}
10.	Low Tones	7 Drs/35 PATS	{≥ 1 pat; ≤ / = 5 pat; {D.P}}
11.	Silence	7 Drs/35 PATS	{≥ 1 pat; ≤ / = 2 pat; {P}}

≥ - At least & Equal to; ≤ / = At most & Equal to; {D.P}} = Both Doctors & Patients; {D} – Only Doctors; {P} – Only Patients; {ϕ pat} – Null Patients

Source: (Fieldwork – 2018/2019)

4.1.1 Medical Jargon (M-J)

Medical jargon refers to the medical vocabulary, terms, and phrases used by doctors in medical contexts. These words or expressions have Greek and Latin origin but have become part of the expected language for the training and practice of medicine. According to Thomas et al. (2014:2), "jargon refers to the technical terms used by members of a profession generally not understood by a layperson, to describe concept (s) related to their line of work". The use of jargon is pervasive within the medical field as a primary means of communication by doctors and/or medical healthcare workers. The observed jargon refers to the nature of diseases, symptoms, medical

management procedures, laboratory, and imaging investigations familiar to medical professionals. Doctors communicate through these terms effortlessly, yet might leave their patients, particularly the less educated, to imitate, or repeat after the doctors, rather than fully understanding the meaning of the term. As suggested by Hamilton et al. (2021), this practice alienates the patient from a clear understanding of the words used and their meaning in context, thereby limiting the success of the communication process. Several studies have established the extensive use of medical terminologies in doctor-patient encounters which in most cases are not understood by patients (Farrell et al., 2008; Pitt & Hendrickson, 2020). The tendency by doctors to use these terminologies when communicating with patients has been shown to influence patients' assumptions about the severity of the health challenge (Thomas et al., 2014).

Generally, doctors should aim to communicate medical diagnoses in a language that patients may understand. However, doctors often employ medical words, terms, and expressions due to doctors' familiarity with such terms. Often, doctors assume patients' ability to understand and define the medical language employed (Howard et al., 2013). Critically, the nature of communication may be hampered by minimal understanding by the patients due to the use of technical language and jargon. In the process, patients may also experience the dangers of information overload as the doctors try to assist and suggest treatment options (Thomas et al., 2014). Table 4.2 illustrates some of the recurring medical jargon used by doctors during their interactions with patients in the study.

Table 4. 2: Sample of Recurring Medical Jargon used and their Reference Coverage

Doctor/Patient	Sample Jargon Used
1. Dr F/Pat F	Transfuse
2. Dr F1/ Pat F1	Pregnancy-induced
3. Dr B/Pat B	Toxoplasmosis
4. Dr M/Pat M	De-generational
5. Dr 2/Pat 2	Dysfunctional Uterine Bleeding
6. Dr 3/ Pat 3	Lesion
7. Dr 1/Pat 1	24-hour Ambulatory

Source: (Fieldwork: 2018, 2019)

In this study, it was observed that, even where a doctor recognises that a patient may not understand the medical jargon being used, the doctor may instinctively employ the medical jargon before explaining its meaning in more straightforward language that a patient may understand (Fage-Butler & Nisbeth Jensen, 2016; Pitt & Hendrickson, 2020). This is illustrated in Extract 1, where the italicized words represent the medical jargon used by the doctors and patients during the interactions.

Extract 1:

08: Dr 1: What is the *presentation*?

09: PAT A: This is the *conclusion* that …

10: Dr. 1: Yeah, yeh, eh, how does it present? Pain, bleeding?

11: PAT A: No! *Tenderness* …

12: Dr 1: *Mass?*

13: PAT A: *Tenderness* …

14: Dr 1: *Ok, it is pain in the lower abdomen*.

15: PAT A*: Once in a while, there is intermittent pain*.

Source: (Fieldwork: 2018, 2019)

This occurrence appears to be borne out of a desire for the patient where the appropriate "medical language" is used in medical diagnosis or treatment. Where patients understand or at least appear to understand the jargon being used, doctors tend to increase the use of such terms. Doctors prefer using medical jargon as it helps to avoid miscommunication or misunderstanding, particularly where a doctor's proficiency in a common (local) language is low. This, in turn, can become a classic example of the language barrier. However, the doctor fulfils his side of the interaction with his language, while the patient may not understand nor seem to be very interested. The study shows the significant use of medical jargon during doctor-patient interactions in (Table 4. 3). This observation agrees with literature on physicians' use of jargon with diabetes patients with limited health literacy, where Castro et al. (2007) reported that 81 % of doctor-patient consultations studied involved the use of at least one term not understood by patients.

In this study, all doctor-patient consultations involved the use of several medical terms that were often not understood by patients. As expected, doctors predominantly used medical terminologies. Nonetheless, patients were observed to accommodate these medical terms by repeating them during the interactions.

Table 4. 3: Total Number and Percentage Coverages on Medical Jargon used by Doctors and Respective Patients during Interactions

Doctor's Doctor	Number of Jargons (*Reference & Coverage*) used by OB-GYN Doctors	Number of Jargons (*Reference & Coverage*) used by Patients
1. Dr. 1	186 – (4.65%)	PAT. 1- 24 - (0.54%)
2. Dr. 2	209 – (4.44%)	PAT. 2 - 33 – (0.63%)
3. Dr. 3	307 – (3.97%)	PAT. 3 - 33 – (0.39%)
4. Dr. B	233 - (2.45%)	PAT. B - 28 - (0.24%)
5. Dr. M	156 - (2.02%)	PAT. M - 54 - (0.62%)
6. Dr. F	147 - (2.02%)	PAT. F - 39 - (0.51%)
7. Dr. F1	162 - (1.84%)	PAT. F1 - 26 - (0.30%)

Source: (Fieldwork, 2018/2019)

While the data may be limited, it was observed that the lowest prevalence of the use of medical jargon was found among female doctors (1.93%) as compared to their male counterparts (3.5%). However, the level of accommodative use of medical terminology by patients did not always correspond to its use by doctors. For instance, while the use of jargon by Dr F was low, patients interacting with Dr F appeared to use jargon more often compared with patients of all other doctors. Again, the use of these medical terms and their subsequent use or otherwise by patients was related to patients' familiarity with the terms, which was primarily a factor in the recurrence of their medical visit. More importantly, patients' use of medical jargon did not always correlate with an optimal understanding of their use. Extract 1 above reflected audio-recorded data of doctor-patient communication illustrating the possible lack of understanding that may arise in the use of medical jargon. Also, in Extract 2, PAT 3 responds that she will still return for an assessment of her menstrual disorder without having the slightest clue that Dr 3 was addressing that same concern.

Extract 2:

> 648: Dr 3: We will take two different *samples*. One is just *microscopy,* and then one will tell us which actual *organism,* that we will *culture*. So, we can just do the *microscopy*, but it will also allow us to know the kind of *organism* by way of *visual inspection*.
>
> 649: PAT 3: OK, but I will still have to come back for the *menstrual disorder*?

Source: (Fieldwork, 2018/2019)

The data on the use of medical jargon reveals substantial communication disparity between doctors and patients and the possible impairment of understanding by patients. In most cases, patients' expressions revealed a lack of understanding during consultations when medical jargon was used in a non-accommodative fashion (Hagihara & Tarumi, 2006; Thomas et al., 2014). In other cases, patients may seem to feign understanding of these terms, may show less interest, encounter

difficulty in understanding the detailed medical explanation and hence, the likelihood to be betrayed by their subsequent communication interactions as highlighted in Extract 2. The pretense of understanding medical jargon used or perhaps the belief that one understands these terms was primarily associated with more educated patients. In other situations, a doctor may take for granted a patient's ability to understand medical terms owing to the patient's seemingly high educational level and high proficiency in English. Accordingly, the study also identified the improper interpretation of some English words such as "offensive" which is interpreted as 'bad odour' within the medical discourse as well as acting as a homonym when used as an M-J with exemplifications in Extract 3.

Extract 3:

837: Dr M: Is it *offensive [bad vaginal odour]*?

838: PAT D: No, Initially, it used to *itch* me and when I go to the doctor then, he will prescribe medicine for me and now it doesn't itch anymore ….

839: Dr M: … and it is not *offensive* as well?

840: PAT D: No [Confused facial expression, showing signs of discomfort through different sitting movements]

841: Nurse 1: Do you understand the doctor's word *offensive*? Do you know what he means by offensive?

842: PAT D: *Serious*, or? [Misinterpretation of the medical term]

Source: (Fieldwork, 2018/2019)

How doctors employ medical jargon in communication with patients who may be unfamiliar with the terms used has a significant impact on patient understanding and treatment decision-making (Links et al., 2019) options . The literature suggests that patient-friendly communication is crucial to patient's knowledge of their health condition and influences their satisfaction (Politi & Street, 2011; Zodan & Orelli, 2018). Where the use of medical jargon are predominant, they tend to hinder

patients' understanding of health concepts and overall satisfaction with treatment (Thomas et al., 2014; Williams & Ogden, 2004). In the study, the use of medical jargon was predominantly done by the gynaecologists (the percentage coverage of the use of medical jargon by all the five patients understudied under each doctor is still less than the total percentage coverage of that doctor's use of medical jargon). Nonetheless, due to the high level of education by the patients in the study, the patients also used medical jargon with the doctors in a converging manner. Importantly, it was observed that most of the patients did not understand the health concepts used by the gynaecologists as established in Extracts 1, 2 and 3 under the medical jargon, and they did not seek clarification but assumed to know. The responses of the patients to the doctors in the Extracts confirm the assumptions made.

4.1.2 Empathetic - Expressions (EMP - E)

The intricate and personal nature of doctor-patient communication, particularly in gynaecological care often requires that a doctor is not only able to understand a patient's perspective of the health condition, but must also understand the emotional state (Kee et al., 2018; Larson & Yao, 2005) of the patient although clinically the treatment of the disease using its symptoms overrides a further introspection of the patients' emotions within the clinical setting. As a result, a doctor must understand the "complete self" of a patient's disease to offer accurate medical diagnosis and care from the doctor's medical perspective. At the same time, it has been affirmed that obstetricians and gynecologists usually have lower psychometric empathy ratings compared to primary care physicians (Hojat et al., 2002; Rizk et al., 2005). Contrastingly, this study revealed that the gynaecological doctors employed higher levels of empathy in the exchanges. Similarly, patients confirmed this strategy (in the semi-structured interviews) as being observed by the doctors. The

patients requested for the use of empathy verbally and non-verbally (eye-contact) during their encounters. Therefore, in these medical interactions, empathy is seen as a reflection of the perspectives and understanding of a patient's feelings and thoughts about health conditions (Hoffman, 2012). During doctor-patient communication, the use of empathy involved the skills needed to effectively understand and communicate the feelings of patients. Given the private and peculiar context of gynaecological communication, the use of an empathetic expression becomes more imperative.

In the study, the use of empathetic expressions was observed to begin with the acknowledgement of patient concerns using words and expressions that convey care and understanding. More commonly, empathetic expressions are also used, as observed in Extract 4, where the italicised parts highlight the use of empathy in the interactions.

Extract 4:

> 151: Dr F: *You will be fine OK*; *you will be fine*. *You will be fine … You will be fine.* You are now 34 weeks. Remember when you started? (Dr F looking directly into the eyes of PAT 1, and working together in proximity)
>
> 152: PAT 1: {Bursts out laughing overwhelmingly with tears in her eyes as Dr F speaks}
>
> 153: Dr F: *But you have gotten to this point, do you hear*?
>
> 154: PAT 1: Yes! {Smiles and gives a response filled with hope and assurance}

Source: (Fieldwork, 2018/2019)

Empathetic expressions were demonstrated in the use of non-verbal approaches such as eye contact, nods, proximity, low-tone, and a posture of full attentiveness. These practices complemented empathetic expressions that enabled doctors and their patients to connect at a

deeper level, both biomedically and socially. from the perspectives of the doctors, Dr M emphasised the relevance of empathy in the field of gynaecology when they stated:

> *"The best consultation is when the doctor and the patient are on the same page to interact on personal issues to establish emotional closure and therefore satisfaction".*

Within the Ghanaian socio-cultural setup, eye contact with an older or revered person such as a medical doctor is frowned upon as a sign of disrespect unless that request is offered. However, the patients interviewed stressed the need for doctors' use of eye contact during interactions. In answering the question about how patients felt about the doctor's use of eye contact during interactions, the following responses were obtained:

PAT. GPA4: ... *Oh, yes! ... it [eye contact] feels good because of the relationship you have ... somebody that you have an eye contact with you can trust the person ... (P SS-I 2018/2019)*

PAT. GYN3: ... *It makes me feel he is really into what I am saying ... (P SS-I 2018/2019).*

On the other hand, patients expressed displeasure with communication without eye contact.

PAT. GYN10: ... *It will feel like you are not listening ...*

PAT. GYN3: ... *I feel maybe you even want me to leave, you are busy, and you do not want to attend to me ...*

In all, seventy per cent (70%) of the patients semi-structured interviews (P SS-I) from both hospitals affirmed the relevance of eye contact during the doctor-patient interactions. For doctors, on the other hand, while eye contact may be crucial to the success of the communication relationship, it needs to be employed with caution given the delicate role it may play in influencing a patient's emotional state.

Dr M: *It is a challenge, but we [doctors] should because some of the cues we are getting should be nonverbal. So yes, we try … we live in a culture where eye contact … is a sign of disrespect. So, if I am seeing the patient, she is older than me, I try as much as possible to have eye contact, but the patient may look down, and we do not force these things … we think respect means to look down and … it is our culture so, if we are getting the information, we do not push these things. That hey, "maami" look at my face*! *[… hey woman, look at my face] … (D SS-I 2018/2019).*

Dr 1: *Yes, I do it a lot … I think that is re-assuring …this is a human being's business … (D SS-I 2018/2019).*

In addition, empathetic expressions were noted in the ability of doctors to accommodate indirect messages expressed by patients. In most cases, these indirect messages occurred through silence or non-communication by patients. As such, doctors needed the skills to allow for the understanding of patients' facial expressions, demeanours, concerns, and viewpoints, without verbal communication. Doctors employed several convergence strategies verbally, such as repetition, speaking slowly, speaking with a very low tone, and non-verbal communication, such as nodding, making eye contact and showing emotions, including touch, as confirmed in Jain and Krieger (2011). The use of these multimodal effects, such as sitting in proximity, doctors pointing to intimate places, lowering their voices, and illustrating through graphic presentations or online searches, showed their interest, assurance, and comfort towards their patients. The practice of using empathetic expressions (verbally or non-verbally) comprised about 15% of the audio-recorded interactions. While empathy was a common feature among the doctors studied, it appeared to be used more prominently by female doctors (22.86%) in the study compared to their male counterparts (11.32%). This finding correlates with reports of similar findings in the literature that suggests that

women applied empathy more often than their male counterparts (Eisenberg & Lennon, 1983; Hojat et al., 2002; Hojat et al., 2002). This assertion is, however, muted by the limited number of female gynaecologists in the study, given the limited number of female gynaecologists in the facilities where the study was conducted. For instance, in one of the two facilities visited, 25 out of 26 practicing gynaecological consultants were male with only one female available. Table 4. 4 highlights the percentage coverage for empathetic expressions during the medical encounters by the various doctors monitored.

Table 4. 4: Table 11: Coding by Item File List summary – Empathetic Expressions

Item	Percentage Coverage
Files\\D-P CONSULTATIONS (AUDIO-RECORDINGS)\\D-P (Dr 1)	21.61%
Files\\D-P CONSULTATIONS (AUDIO-RECORDINGS)\\D-P (Dr 2)	10.88%
Files\\D-P CONSULTATIONS (AUDIO-RECORDINGS)\\D-P (Dr 3)	4.51%
Files\\D-P CONSULTATIONS (AUDIO-RECORDINGS)\\D-P (Dr B)	18.21%
Files\\D-P CONSULTATIONS (AUDIO-RECORDINGS)\\D-P (Dr F1)	10.80%
Files\\D-P CONSULTATIONS (AUDIO-RECORDINGS)\\D-P (Dr M)	1.39%
Files\\D-P CONSULTATIONS (AUDIO-RECORDINGS)\\D-P (Dr F)	34.92%

Source: (Fieldwork, 2018/2019)

Nonetheless, doctors often exercised circumspection in their use of empathetic expressions, such as maintaining eye contact, given the cultural and emotional interpretation of such gestures. For instance, in some cultures, continuous eye contact may be construed as impolite and as a sign of disrespect.

4.1.3 *We* - Inclusivity (We – I)

Using 'we' as a first-person pronoun by doctors was rampant in medical interactions compared with its singular counterparts – *I and me*. The use of 'we' was frequently used as a description of the team of doctors, their level of professionalism and their approach to managing the health

conditions of patients. This approach aimed to help patients feel the essence of being medically managed by an entire team of experts (multidisciplinary consultative process) in a medical facility instead of by an individual. The use of 'we' was also employed to express the partnership, participation, and collaboration of the doctor-patient relationship in managing the patient's health condition; hence the use of 'we' signalled a collectivist communication culture within UHS and KBTH. This helped to provide a sense of relief and belonging from the feeling of care and concern from the doctor. For instance, it was common to hear a doctor say: "we need to …" when offering suggestions on treatment. Extract 3 illustrates the use of 'we' by a doctor during interaction with a patient.

Extract 3:

109: Dr B: *We* must identify which of these four places there is a problem, and *we* will solve it …

110: PAT 3: Yeah!

Source: (Fieldwork, 2018/2019)

In the study, the actual meaning of 'we' as used by doctors at the time of use was unclear. In most cases, 'we' implied collaboration or participation with patients, and it was often interpreted as such, despite its ambiguity in meaning. Sometimes, in sharing in the pain of the patient, the doctors, as a cognitive support strategy, aided the patients in relaxing despite their challenges.

The ambiguous use of 'we' as a personal pronoun by doctors has been highlighted in the literature (Aronsson & Sätterlund-Larsson, 1987). The preferred use of the pronoun 'we' have been reported in the literature by Skelton et al. (2002). They report that doctors tend to use the word 'we' far more often (23.5%) than patients (2.9%). Given patients' preference for single-doctor management

(Corby, 2010), the use of 'we' was mostly interpreted by patients as a form of collaboration or partnership between the doctor and patient in the management of the health condition. Thus, '*we'* served more as an institutional medical vocabulary to represent partnership and collectivity involving the patient, the doctor, and the medical facility.

Also, its use as observed created hospitable and inclusive medical settings. The implication of the use of 'we' helped to encourage patient's feedback, participation and general satisfaction with the treatment process (Kaba & Sooriakumaran, 2007; Schinkel et al., 2019). In this study, the use of 'we' occurred in all the 35 doctor-patient interactions surveyed. Table 5 presents results on the use of 'we' by doctors during doctor-patient interactions. However, this strategy is highly used by male gynaecologists generally (56.05%) as against female gynaecologists (12.2%).

Table 4. 5: Coding by Item File List Summary – "We -Inclusivity"

Item	Percentage Coverage
Files\\D-P CONSULTATIONS (AUDIO-RECORDINGS)\\D-P (Dr 1)	15.30%
Files\\D-P CONSULTATIONS (AUDIO-RECORDINGS)\\D-P (Dr 2)	17.57%
Files\\D-P CONSULTATIONS (AUDIO-RECORDINGS)\\D-P (Dr 3)	8.47%
Files\\D-P CONSULTATIONS (AUDIO-RECORDINGS)\\D-P (Dr B)	11.24%
Files\\D-P CONSULTATIONS (AUDIO-RECORDINGS)\\D-P (Dr F1)	6.42%
Files\\D-P CONSULTATIONS (AUDIO-RECORDINGS)\\D-P (Dr M)	3.47%
Files\\D-P CONSULTATIONS (AUDIO-RECORDINGS)\\D-P(Dr F)	5.78%

Source: (Fieldwork, 2018/2019)

4.1.4 Repetition (REP)

The practice of repetition allows a word or phrase, or in some instances, sentences to be deliberately repeated several times in iteration. According to Tannen, repetition provides a rich resource for language production, comprehension, connection, and interaction (Tannen, 2007). Jin and Watson (2020) consider repetition as pervasive in medical discourses given the very acts of

visiting the same doctor; the constant retelling of the story by patients and feedback by doctors encourages repetition.

The use of repetition aims to make information more comprehensive to the receiver. Repetition is viewed as an approximation strategy for better interpretability of the information given (Gasiorek & Giles, 2015; Giles & Gasiorek, 2013; Street, 1991). In this context, the study established that the practice served as an oral strategy to emphasise and remind patients of critical and necessary aspects of their medical challenges that needed to be followed. In this study, all 35 doctor-patient interactions monitored employed the use of repetitions. The doctors mainly employed this technique. On average, female doctors appeared to use this strategy more often (8.23%) than their male counterparts (3.98%). Repetition has been suggested as a crucial strategy in promoting patients' involvement and compliance with treatment (Epstein & Street, 2007). This practice helped to encourage patients to understand and recall their treatment options. This process involved asking patients to repeat aspects of the information given to ensure clarity, particularly where they appear complex.

Table 4. 6: Coding by Item File List Summary – Repetitions (Doctors-Patients)

Item	Percentage Coverage
Files\\D-P CONSULTATIONS (AUDIO-RECORDINGS)\\D-P (Dr B)	2.69%
Files\\D-P CONSULTATIONS (AUDIO-RECORDINGS)\\D-P (Dr F1)	7.36%
Files\\D-P CONSULTATIONS (AUDIO-RECORDINGS)\\D-P (Dr M)	2.56%
Files\\D-P CONSULTATIONS (AUDIO-RECORDINGS)\\D-P(Dr F)	9.10%
Files\\D-P CONSULTATIONS (AUDIO-RECORDINGS)\\D-P (Dr 1)	4.38%
Files\\D-P CONSULTATIONS (AUDIO-RECORDINGS)\\D-P (Dr 2)	8.72%
Files\\D-P CONSULTATIONS (AUDIO-RECORDINGS)\\D-P (Dr 3)	1.55%

Source: (Fieldwork, 2018/2019).

In health communication, key messages must be clear, consistent, and often repeated to aid the understanding of the receiver. This is crucial as in some cases the communication may be vague

and ambiguous (Aronsson & Sätterlund-Larsson, 1987). Based on the observation in this study, the strategy of repetition ensured that doctors stressed the words/expressions that they consider crucial for patients to hear and understand, particularly to forestall inaccurate interpretation (s) of the information given. Sometimes, words or expressions are repeated several times during bimanual examinations (pelvic examination), uterine biopsy, gross examination of the vulva and when a doctor performs physical examination to confirm a urinary tract infection (UTI).

> Dr M: *If we have an encounter with a patient and you meet the patient after, the patient may even tell you she did not hear this or that. It is a lot of information just for a day. So, we try to give it bit by bit, and we move on. It is not easy … (D SS-I 2018/2019).*

The nature and consistency in the use of repetition is exemplified in Extract 5 during a a pelvic examination.

Extract 5:

> 106: Dr F1: And what did they do? Did they tell you or did they use the scan to go *under* [vagina] or what did they tell you? … Come down, I need you to relax for me. Don't close your legs, just relax for me. *Open* eh, *open up*, *open up*, just *open up*. No, I didn't say raise your dress, I said *open your* legs for me.
>
> 107: PAT E: OK

Source: (Fieldwork, 2018/2019

4.1.5 Pronoun 'it' (PRN-IT)

In each discourse, pronouns could refer to the participants (I, you), or they could refer to something or someone being mentioned (he/she/it). In the context of these medical interactions, the use of the third person neuter pronoun 'it' was prevalent. 'It' does not only function as a personal pronoun, but within these interactions, 'it' was used to tactfully represent sensitive and private concerns. 'It'

was therefore observed to be employed during sensitive areas of the conversations, such as during discussions on some female bodily fluids - menses, vaginal discharges, STIs, medication for treating STI's, lesions around patient's vulva, odour – vaginal smell, the act of sex, vaginal examinations, abortion, and its drugs as well as the process of miscarriage. About these intimate areas identified in the examined data, the pronoun 'it' served as an object. In medical encounters, both doctors and patients seemed to understand the use of 'it' within the sociocultural context of clinical management. It was therefore substituted in all sensitive areas of the patients medical concerns effortlessly. This communicative strategy aided patients and doctors to accommodate as the lived medical experiences of the patient is expressed inclusively. For instance, Extract 6 reflects such context where 'it' refers to an abnormal discharge (STI) in a consultative process**.**

Extract 6:

132: PAT 3: Or *is it* sticky?

133: Dr 3: *It* may be. If *it* is sticky then, *it* most likely what we call the mucous plug. *It* is just like slimy, phlegmy nature …

134: PAT 3: Yeah sometimes, I get *it*

Source: (Fieldwork, 2018/2019)

Thus, the approach allowed for flexibility in communicating all patient concerns during the interactions. In Table 4.7, data on pronoun – 'it' occupied 8.40% of the entire doctor-patient audio recordings. The female gynaecologists significantly exploited the use of the pronoun – 'it' with 8.40% being its highest coverage as compared to how the male doctors explored its use (6.34%). Interestingly, in the data on the pronoun – 'it' was employed in all 35 doctor-patient interactions.

Table 4. 7: Coding by Item Summary – Pronoun - IT

Item	Percentage Coverage
Files\\D-P CONSULTATIONS (AUDIO-RECORDINGS)\\D-P (Dr 1)	8.16%
Files\\D-P CONSULTATIONS (AUDIO-RECORDINGS)\\D-P (Dr 2)	3.71%
Files\\D-P CONSULTATIONS (AUDIO-RECORDINGS)\\D-P (Dr 3)	6.77%
Files\\D-P CONSULTATIONS (AUDIO-RECORDINGS)\\D-P (Dr B)	8.08%
Files\\D-P CONSULTATIONS (AUDIO-RECORDINGS)\\D-P (Dr F1)	8.40%
Files\\D-P CONSULTATIONS (AUDIO-RECORDINGS)\\D-P (Dr M)	5.04%
Files\\D-P CONSULTATIONS (AUDIO-RECORDINGS)\\D-P(Dr F)	2.26%

Source: (Fieldwork, 2018/2019)

4.1.6 Euphemisms (EUP)

Additionally, another strategy observed is the use of selected euphemisms to describe the 'vagina', which within its context of use is ascribed in all secrecy, sacredness or as an unmentionable part of the female reproductive organ. Although, the male sexual organ is also tabooed in sexual healthcare contexts, the data sampled under euphemisms focused on the vagina and not the penis due to the patient participants to the study being only females. Though both doctors and patients employed the use of these expressions, nonetheless, as indicated on Table 4. 8, only 30 doctor-patient interactions used euphemisms. In Extract 7, the vagina is described as *the place*.

Extract 7:

110: Dr 3: So, you listen to it well, Ei, you want to keep *the place* sacred paa o!

111: PAT. 3: [Begins to laugh]

Source: (Fieldwork, 2018/2019)

Table 4. 8 shows that male doctors (15.17%) mostly used Euphemisms. The use of euphemisms was not popular among female doctors (5.76%). In Table 4. 8, there was null data in the use of the

euphemisms in an entire data set on one of the female doctors. Hence, doctor-patient interactions out of the 35 doctor-patient interactions employed the use of euphemisms.

Table 4. 8: Coding by Item Summary – Euphemisms

Item	Percentage Coverage
Files\\D-P CONSULTATIONS (AUDIO-RECORDINGS)\\D-P (Dr 1)	1.86%
Files\\D-P CONSULTATIONS (AUDIO-RECORDINGS)\\D-P (Dr 2)	2.23%
Files\\D-P CONSULTATIONS (AUDIO-RECORDINGS)\\D-P (Dr 3)	6.34%
Files\\D-P CONSULTATIONS (AUDIO-RECORDINGS)\\D-P (Dr B)	2.35%
Files\\D-P CONSULTATIONS (AUDIO-RECORDINGS)\\D-P (Dr F1)	5.76%
Files\\D-P CONSULTATIONS (AUDIO-RECORDINGS)\\D-P (Dr M)	2.39%

Source: (Fieldwork, 2018/2019)

Information from Extract 8 further projects the nature of an interaction based on the use of the pronoun 'it' during the doctor-patient interactions.

Extract 8:

196: Dr B: Alright, but you say sex is painful …

197: PAT 3: Yes

198: Dr B: Is *it* when he is entering or when he goes very deep?

199: PAT 3: When he goes very deep. Yes, when he goes very deep, I feel *it here* [pointing to vagina]

200: Dr B: You feel *it down there*?

201: PAT 3: Yes!

202: Dr B: … "Sorry, OK. *It* is not supposed to be like that."

Source: (Fieldwork, 2018/2019)

One can identify the communicative restrictions in the use of the female reproductive organs, and therefore, its substitution as *down there* which could also be labelled as taboo expression, and the act of sexual penetration as *going very deep*. Both doctor and patient seemed to have had an idea or prior knowledge of their use of the pronoun – 'it' as well as taboo expression as they

communicatively engaged in an accommodating sequence. Crucially, through the interviews, doctors enhanced and encouraged patients' responses to the discussion with their use of the pronoun – 'it' and sometimes with euphemisms. Therefore, this pattern emphasises that patients' relationship to their health challenges through language and based on context follows indirection. Overall, results on the use of the pronoun – 'it' identifies critical and sensitive medical concerns being communicated and represented as 'it' especially when the concern is identified as personal or intimate. This form of interaction is affirmed through the doctor semi-structured interviews (D SSI), where doctors admit to the challenges encountered, especially during private and intimate discussions with their patients.

> Dr 3: *Well, I think you know how we were all brought up, it is difficult to mention some of these vital organs with what they classify as "private organs" in the local language, so English can also be used interchangeably when it comes to mentioning certain words in gynaecology (D SS – I 2018/2019).*

> Dr B: *Our culture, as opposed to the western world where they have demystified the genital area, we still have that challenge, and it is like, we do not mention those things. You know, those things are secrecy and all that (D SS-I 2018/2019).*

An instance was given by Dr 3 to situate the challenge being expressed in Twi as *"Me p3 s3 me hw3 woase ho [your 'down there'] translated as [I would like to examine your 'down there']?"*. Hopefully, the patient understands that situation which according to Dr 3 serves as some form of indirection. Conversely, when he was asked whether he had used these sensitive terms explicitly, he responded that *it is always difficult!* and so he acknowledges that he always avoids its use.

> *Yes, because sometimes if you use the raw language, the client or the patient might even look at you with some "Ei! [Exclamation of bewilderment] Doctor Wei y3 raw papa" translated as* (Ei! this doctor is too vulgar) *(D SS-I 2018/2019).*

However, in the patients semi-structured interviews (P SS-I), some patients confidently stated they do not feel shy saying vagina as it is. For example, PAT. GYN3 says *Oh, for today, I do not feel shy to mention my private part (P SS-I 2018/2019).*

Moreover, PAT. GYN4 affirms in her response that doctors use other forms of language adjustments in *yes, they (doctors) do not just go raw, they polish them as putting them in "quotes".* These explanations allowed for such natural co-operative communication practices on the use of the pronoun 'it' and euphemisms to occur in the face of medical treatment where both doctors and patients converge in their discussions to aid in the delivery of care. Here, the use of indirection also emphasises the euphemistic nature of medical communication to discuss inhibitions within gynaecological encounters (Herbert, 2016; Mcglone & Batchelor, 2003), especially in the Ghanaian settings where cultural constraints on the discussion of sex, and sexuality shape individuals' views on these topics (Abramson & Pinkerton, 1997; Finley, 2018).

4.1.7 Avoidance (AVO)

Avoidance tends to occur when a non-verbal form of communication within a verbal communicative structure is unpleasant, or the use of intimate words or phrases is omitted in sentences (Kamwendo, 2004). It is usually initiated based on some level of relationship, which may be propelled by avoidance tactics to balance private and disclosed concerns (Petronio, 2000, 2013). In disclosing confidential information, the context, as well as the complex relational factors and their rules may guide what needs to be shared or concealed.

Avoidance, therefore, serves as the medium through which relations are protected, maintained, and enhanced (Knobloch & Carpenter-Theune, 2004) through a process of emotional or psychosocial escapism. In Table 4. 9, the use of avoidance strategy occurred in all 35 doctor-patient interactions. This practice was by both doctors and their patients. The results projected the number of references taken from each doctor-patient data and its total coverage. Nonetheless, avoidance was extensively used in the interactions of male doctors (18.23%) as against its use by female gynaecologists (5.46%). Interestingly, the exploration of this feature was about the same percentage coverage in both interactions of the female gynaecologists understudied.

Table 4. 9: Coding by Item File List Summary – Avoidance

Item	Percentage coverage
Files\\D-P CONSULTATIONS (AUDIO-RECORDINGS)\\D-P (Dr 1)	1.93%
Files\\D-P CONSULTATIONS (AUDIO-RECORDINGS)\\D-P (Dr 2)	8.44%
Files\\D-P CONSULTATIONS (AUDIO-RECORDINGS)\\D-P (Dr 3)	3.31%
Files\\D-P CONSULTATIONS (AUDIO-RECORDINGS)\\D-P (Dr B)	1.47%
Files\\D-P CONSULTATIONS (AUDIO-RECORDINGS)\\D-P (Dr F1)	2.75%
Files\\D-P CONSULTATIONS (AUDIO-RECORDINGS)\\D-P (Dr M)	3.08%
Files\\D-P CONSULTATIONS (AUDIO-RECORDINGS)\\D-P(Dr F)	2.71%

Source: (Fieldwork, 2018/2019)

Again, the use of avoidance may aid in curbing an altercation that may negatively impact the communicative encounter between the participants in the conversation. Thus, this interaction between the doctors and the patients emphasises commonalities (Roloff & Ifert, 2000). In instances where these conflicts still occur, the use of avoidance as a strategy enhanced communication accommodation in surmounting the hurdle. Thus, the strategy of communication subterfuge can simply be explained as an act of dodging or avoiding a direct or indirect verbal response that can threaten one's face and serve as a distancing measure in the communication between doctors and patients (divergence). This strategy was noted as a smart and intentional way of hedging.

In adopting this procedure, one avoided aspects of the conversation considered inappropriate within one's personal or sociocultural context. Dailey and Palomares (2004) support this claim by maintaining that individuals engaged in a relational communicative encounter avoid certain topics to protect their relationships. This strategy was also identified within the doctor-patient encounters as doctors and patients were observed deliberately evading some of the topics surrounding sex, sexual, and reproductive health interactions. For instance, the samples below serve as an illustration of that effect**.** Extract 9 highlights doctor-patient interactions with the application of avoidance strategies in discussing candidiasis. Other challenging topics discussed where doctors and patients employed avoidance strategies included: pelvic pain, vaginal discharge, missed menses, irregular menses, abnormal growth within the vaginal area, pelvic mild discomfort, uterine fibroids, sexually transmitted diseases (STDs) and instances of sexual violence.

Extract 9:

776: Dr F: I have to know what is wrong with you first. Are you having any *discharge*?
777: PAT. 4: {a lateral click} *I do not like* …
778: Dr F: Any *discharge*, any water *from your* ...?
779: PAT. 4: No, no, no, *it* is like a week ago that I saw something like white.
780: DR F: Then, it stopped or *it just …?*
781: PAT. 4: No, I feel, even this morning when *I washed* ... I saw something.

Source: (Fieldwork, 2018/2019)

In this interaction (Extract 5), both doctor and patient avoided the use of a sensitive term such as vagina in lines 777, 778, 780 and 781. In line 779, PAT 5 used euphemised terminology for discharge *"white"* to replace the term when she could not avoid mentioning discharge through Dr F's history taking design. The participant observation enabled the researcher to identify PAT 5 as a *(25-year-old Muslim woman, married and a businessperson).*

In observing the nature of the interaction, an interview with PAT 5, confirmed that the sexual organs to them (Muslims) is regarded as impure (P SS-I 2018/2019).

This may have highlighted her hesitancy in explicitly mentioning the organs in her interactions, but due to Dr F's foreknowledge of this practice, and previous encounters with PAT 5, Dr F followed the same communicative pattern. The results discussed on the use of avoidance strategies reveal that when patients feel the words to communicate are intimate and confidential, they immediately adopt an avoidance strategy due to their possible perceptions about treatment. Such acts as the data have shown were used to avoid such personal/sensitive information, and, in such processes, the patients maintained their communicative assonance with their doctors.

There are instances where avoidance may prevent the smooth flow of communication by eluding the sharing of information, often out of uncertainty or anxiety (Duronto et al., 2005). Under challenging health conditions, avoidance is associated with anxiety, depression and stress (Yu & Sherman, 2015). Avoidance has been observed to occur not only among patients, but also among doctors. This is often because doctors may not consider the issues to be their responsibility, have low or no knowledge of ready solutions, find them embarrassing or lack the necessary resources to help address such challenges (Gott et al., 2004; Stead et al., 2003; Wendt et al., 2007).

For patients, avoidance means minimal feedback, silence, or indirection, often because of shyness, anxiety, or discomfort. Under these circumstances, patients avoid asking for clarification or making direct requests and tend to employ non-verbal strategies such as nodding or shaking of the head. In addition, patients intentionally leave out words or sentences for doctors to fill in, an attempt for them to avoid the use of such words/terms (Aronsson & Sätterlund-Larsson, 1987). Nonetheless, there are other instances where both doctors and patients felt free to communicate in English as the baseline language, and in this process, they interlaced it with any of the local

languages to enhance and strengthen the doctor-patient interactive encounters resulting in the use of code-switching as another integral communicative strategy.

4.1.8 Code-Switching (C-S)

Codeswitching has been defined by several researchers as "the alternate use of elements from two (2) or more different languages within the same conversation or even the same utterance" (Lawson & Sachdev, 2000). In multilingual societies such as exists in Ghana, codeswitching is widespread and commonly involves the use of English and a local language (Amuzu et al., 2014) in an interaction. Although the practice is generally regarded as an informal conversation strategy, the behaviour has gradually moved from casual conversation to various formal settings in Ghana, including radio (Flamenbaum, 2014). The phenomenon is seen as one of the remarkable behaviours resulting from multilingualism in Ghana and is generally seen not only as a lack of proficiency in one language or the other, but as a show of proficiency in both languages (Flamenbaum, 2014 ; Kamwangamalu, 2010).

Based on the audio-recorded data on doctor-patient discussions in the study, several participants were observed to frequently use code-switching. In all cases, two different languages were employed, with English serving as the base language. While the focus of this study was on participants who could speak English, the level of proficiency varied. It was observed that when doctors noticed low proficiency in English, they employed mostly inter-sentential code-switching as a remedy.

It was further noted that even in instances where the doctor and the patient appear to be highly proficient in a common local language, code-switching with English was substantial as the participants adapted to the dominant socio-cultural contexts. The use of a local language helped to

increase patient understanding and contribution to the conversation whereas simultaneously both doctors and patients engaged in lexical borrowing of English or medical terms to complement the conversation.

146: Dr 3: *Ad3n, wo di sh3 ho s3n [why, how do you put it in there?] … Push it up, way up! (Process of inserting a vaginal drug)*

Also, intriguing was the fact that, while some patients preferred engagement in the local language, they were uncomfortable using or hearing words describing sexual parts in the local language, largely due to cultural taboos. Twi is the predominant local language that was alternated with English. Table 4. 10 communicates the results derived on the percentage coverage of code-switching texts employed between doctors and their patients. From the audio-recorded data, the results on code-switching revealed that the male gynaecologists employed this technique significantly more (32.71%) than their female colleagues (4.33%) under study. In all, code-switching was observed among all the male gynaecologist's native to the context in the study. Nevertheless, this practice was minimally used in the data of the female gynaecologists, especially given the foreign background of one and their inability to speak competently in any of the local languages, but an ability to understand Twi due to the number of medical schooling/working years in Ghana (refer to Chapter 3 for detailed demographic information).

It was observed that the frequency of code-switching was associated with a doctor's level of proficiency in the local language (s) of the patient (s) involved. Accordingly, the more gynaecologists had command over the patient's language according to the data, the higher the percentages derived under the code-switching techniques. The predominant use of code-switching, code-mixing and lexical borrowing during doctor-patient encounters have been reported in the literature (Deumert, 2010; Kajombo, 2021b; Street, 1991). Code-switching has been described as

an important interactional strategy aimed at improving linguistic convergence in medical consultations (Gasiorek et al., 2015).

Table 4. 10: Coding by Item File List Summary – Code-Switching

Item	Percentage Coverage
Files\\D-P CONSULTATIONS (AUDIO-RECORDINGS)\\D-P (Dr 1)	1.13%
Files\\D-P CONSULTATIONS (AUDIO-RECORDINGS)\\D-P (Dr 2)	18.88%
Files\\D-P CONSULTATIONS (AUDIO-RECORDINGS)\\D-P (Dr 3)	8.45%
Files\\D-P CONSULTATIONS (AUDIO-RECORDINGS)\\D-P (Dr B)	2.09%
Files\\D-P CONSULTATIONS (AUDIO-RECORDINGS)\\D-P (Dr F1)	4.33%
Files\\D-P CONSULTATIONS (AUDIO-RECORDINGS)\\D-P (Dr M)	2.16%

Source: (Fieldwork, 2018/2019)

Extract 10:

109: PAT 1: Yes, Dr 3,
110: Dr 3: Mm huh
111: PAT 1: the drug, I am supposed to insert…
112: Dr 3: Mm huh
113: PAT 1: it all comes out {Begins to laugh} every 5 minutes.
114: Dr 3: *Adɛn wo di hyɛ hɔ sɛn?* [why, how do you insert it?] … {laughter} Push it up, way up.
115: PAT 1: I have been pushing! {laughs}

Source: (Fieldwork, 2018/2019)

In the above extract of communication between Dr 3 and PAT 5, the conversation begins and largely takes place in English. However, Dr 3 introduces a rhetorical question in Akan (Twi) to elicit a more accurate and direct response from PAT 5 and to better understand PAT 5's narration on the act of her unsuccessful vaginal insertion of a prescribed drug. This system of language alternation was pervasive in doctor-patient communication among bilinguals. In the above context, despite the use of English/Akan (Twi) C-S in the data of Dr 3 in line 148, PAT 5 still responded in English. During the interaction, Dr 3's use of the local language helped to ease the tense

environment and mood of the patient. Also, importantly is the fact that the patient chose to respond to the doctor's comments/questions in English, which was a relatively easier way to avoid using sensitive words**.** The practice of using English to avoid "taboo" words in the local language is recognised and practised not only by patients, but also, by doctors.

> "*Let us say you tell an Akan woman, "ɛtwe" [vagina], I mean, like a vagina, it is a limit. I do not know. I see it [English] as better… it neutralizes the sensitivity of it … [D SS-I data 2018/2019].*

4.1.9 Politeness (POL)

Politeness in communication is appropriate in every culture. Thus, all cultures have their rules, norms and acceptable expressive acts required in conventionalised interactions which must follow socially constructed patterns. This work establishes first order politeness as the perceptions are derived from socially accepted rules of behaviour during the encounters. According to Anchimbe and Janney (2011), the level of pragmatic heterogeneity in multilingual and multiethnic interactions behaves according to the norms of the varied collectivist cultures where clear expectations from each participant regulate the expectations of the interactants. Consequently, each interactive context is uniquely specified. The identification of this approach further describes the cultural environment and the need for this strategy to be incorporated into healthcare delivery as a socially acceptable way of engagement. In the results on the audio-recorded data on politeness below, the highest codes on the application of politeness principles were 18.53% as compared to the least explored where the use of politeness covered 4.26% of the entire data coverage. In all, both doctors and patients explored this technique during the 35 doctor-patient interactions observed. Table 4. 11 affirms its percentage coverage.

Table 4. 11: Coding by Item File List Summary-Politeness

Item	Percentage coverage
Files\\D-P CONSULTATIONS (AUDIO-RECORDINGS)\\D-P (Dr 1)	18.53%
Files\\D-P CONSULTATIONS (AUDIO-RECORDINGS)\\D-P (Dr 2)	14.42%
Files\\D-P CONSULTATIONS (AUDIO-RECORDINGS)\\D-P (Dr 3)	4.26%
Files\\D-P CONSULTATIONS (AUDIO-RECORDINGS)\\D-P (Dr B)	9.59%
Files\\D-P CONSULTATIONS (AUDIO-RECORDINGS)\\D-P (Dr F1)	15.57%
Files\\D-P CONSULTATIONS (AUDIO-RECORDINGS)\\D-P (Dr M)	8.71%
Files\\D-P CONSULTATIONS (AUDIO-RECORDINGS)\\D-P(Dr F)	8.11%

Source: (Fieldwork, 2018/2019)

Politeness is classified as an accommodation behaviour that deals with how people are treated in terms of courtesy and good manners (Ogundoyin & Soola, 2014). While it is largely employed in verbal interaction such as requests, or questioning, it also caters for emotional expressions such as embarrassment, anger, or fear (Spiers, 1998).

Besides, politeness has been proposed as an essential feature in improving doctor-patient communication interactions (Aken, 2008; Liu et al., 2015). Herselman (1996) has reported politeness and submissive disposition of some communities in Africa based on sociocultural and psychosocial factors as well as societal roles which the homogenous nations cannot efficiently enact. This interactional feature is commonly at play in medical settings during doctor-patient encounters and may be manifested in patients' total agreement with a doctor's instructions and a lack of questioning of doctors' views (Herselman, 1996).

In other cultures, as occurs in Asia, the doctor-patient relationship is expected to rely on a high value of politeness and positive etiquette rather than on the development of a strong long-term relationship based on openness and mutual trust (Claramita et al., 2011). Moreover, a high value is placed on the non-verbal expression of politeness. In the current study, politeness was interposed in the show of respect by patients and the display of respect, attentiveness, and empathy by doctors.

Evidence of politeness was found in the exchange of greetings, requests, line of questioning, level of support, collaboration, and feedback (Aronsson & Sätterlund-Larsson, 1987) as well as patients' show of politeness in the medical exchanges (Schouten & Meeuwesen, 2006). Extract 11 confirms the level of reverence that existed during the interactions, especially from the positioning of patients. In the Ghanaian context, the use of *please* depicts reverence or high regard for people in high authority, powerful in 'parental position', elders, and in this setting, it suggests humility. It is communicated (verbally) as a cultural enforcement. Thus, it becomes natural and a critical requirement for patients to respond in *yes,* followed by *please* in a local language as in *[Mepa wo Ky3w - Pleading with you] [Aani -Yes [Twi]*].

The omission of please may signal some level of distancing, disrespect, pride, and some level of informality. However, due to the interactions being done in English, this societal requirement is still transferred to English, where the use of *yes* only would satisfy the acceptability conditions under politeness in English. Contrastingly, in this context, the use of '*yes please'* becomes the norm and the preferred *as* reflective in Extract 11.

Extract 11:

16: Dr 1: You say you have been bleeding heavily when you have your period?

17: PAT 6: *Yes, please*

18: Dr 1: It doesn't stop?

19: PAT 6: It stops but for the first three days … it clots?

20: Dr 1: It clots and pain?

21: PAT 6: No!

22: Dr 1: It clots and painless?

23: PAT 6: *Yes, please*

Source: (Fieldwork, 2018/2019)

4.1.10 Low Tones (L-T)

This communicative strategy occurred in interactions when depending on the discussion, either the doctor or patient expressed themselves using a deep and soft pitch and in other situations in unintelligible ways. The results on low tones (L-T) in Table 4.12 established that this strategy featured in all the seven doctor/patient interactions. It was exploited more in the encounters of Dr B/Patients (11.82%) as against its lowest use in the encounters of Dr F/Patients at (1.28%). Significantly, this strategy occurred in all the 35 doctor-patient interactions observed; although it was practised more in the interactions of the male gynaecologists, the patients were observed to practice it more and especially during uncomfortable and intimate concerns.

> PAT 3 *during her encounter with her Gynaecologist found it challenging to mention the name of her prescribed drug to treat her vaginal infection, hence, her responses resulted in low tones where the doctors immediately adjusted to also responding similarly (Participant Observation 2018/2019)* as observed in Extract 8.

Extract 8:

> 193: Dr B: Oh, [LOW TONE] STI, your partner will be treated, or your sexual partner has gone to the hospital to be treated … or he will be treated and asked to come and find and bring you to be treated …
>
> 194: PAT 3: O, o … OK [Low-Tone]
>
> 195: Dr B: Alright, but you say sex is painful …? [Low-Tone]
>
> 196: PAT 3: Yes [Low-Tone] …
>
> 197: Dr B: Is it when he is entering or when he goes very deep? [Low-Tone]
>
> *Source: (Fieldwork, 2018/2019)*

Dr B in Extract 8 adapted low tones to inform PAT 3 of the diagnoses (STI) of the issue in line based on lab medications. The tone of his voice was low to engage and have the patient trust him

with her most sensitive information. The patient also accommodated this strategy and therefore gave out all the needed history. For instance, when Dr B asked PAT 3 about her sexual intercourse challenges, *you say sex is painful?* PAT 3 responded in a low tone, again exhibiting shyness/embarrassment/vulnerability and respect for the doctor. However, the interactions affirm the appreciation and, therefore, the reciprocal response as the doctor employs a similar tone and speed (Ishikawa et al., 2006), also establishing non-verbal convergence (D'Agostino & Bylund, 2014).

Table 4. 12: Coding by Item File List Summary – Low Tones (L-T)

Item	Percentage Coverage
Files\\D-P CONSULTATIONS (AUDIO-RECORDINGS)\\D-P (Dr 1)	5.63%
Files\\D-P CONSULTATIONS (AUDIO-RECORDINGS)\\D-P (Dr 2)	4.77%
Files\\D-P CONSULTATIONS (AUDIO-RECORDINGS)\\D-P (Dr 3)	5.42%
Files\\D-P CONSULTATIONS (AUDIO-RECORDINGS)\\D-P (Dr B)	11.82%
Files\\D-P CONSULTATIONS (AUDIO-RECORDINGS)\\D-P (Dr F1)	4.01%
Files\\D-P CONSULTATIONS (AUDIO-RECORDINGS)\\D-P (Dr M)	5.81%
Files\\D-P CONSULTATIONS (AUDIO-RECORDINGS)\\D-P(Dr F)	1.28%

Source: (Fieldwork, 2018/2019)

4.2 Non-Verbal Strategies

These strategies may serve as a useful way of communicating with emotions using body language, facial expressions, eye contact, personal space, gestures, and facial expressions instead of verbal communication. Importantly, the appropriate use of these strategies must align with verbal behaviours to enhance easy understanding, active listening, relational quality, and mutual satisfaction. In effect, how they are expressed and perceived are interpreted in the social context as well as the respective roles established between the doctors and the patients (Hess, 2016).

4.2.1 Silence (SIL)

Silence can also serve as an integral form of communication. It is usually a brief pause or quietness maintained in interactions. This feature can give rise to emotional interpretations of the interpersonal messages being sent and received in varied sociocultural contexts (Back et al., 2009; Bagwasi, 2012). In this approach, silence is a situation where there is no verbal utterance from the patient or the doctor within a few seconds (4 -10 seconds) of the interaction. An interesting perspective on the use of silence is its 'chameleonic' function, especially in the health encounters observed. It, therefore, becomes imperative to identify its impact as being negative or positive within the specific culture (s) of communication. For over three decades now, this feature has been researched within healthcare literature to properly situate its nature, applicability, and salience within medical interactions. In the data coding, although silence was not a variable being considered due to the face-to-face nature of the interactions being sampled, we could not overlook its representation as another significant theme derived for the study.

The results ascertained noted that silence was mostly observed during the male gynaecological-patient interactions as compared to its lower percentages coverages of use during the female gynaecological-patient interactions. Patients were mostly noted to be the predominant users of silence. The use of silence (SIL) was inextricably interconnected to the strategies identified. Therefore, silence was noted to be largely shaped by culture, and it was significant in impacting the communicative engagement observed. Furthermore, silence as a non-verbal approach was used as an expression of restraint or hesitancy to reflect the personal, private, sensitive, painful, discomforting nature of the topics discussed. Again, the use of silence emphasised the cultural context of the interactions.

Table 4. 13: Coding by Item File List Summary – Silence (SIL)

Item	Percentage Coverage
Files\\D-P CONSULTATIONS (AUDIO-RECORDINGS)\\D-P (Dr 1)	2.85%
Files\\D-P CONSULTATIONS (AUDIO-RECORDINGS)\\D-P (Dr 2)	0.88%
Files\\D-P CONSULTATIONS (AUDIO-RECORDINGS)\\D-P (Dr 3)	1.14%
Files\\D-P CONSULTATIONS (AUDIO-RECORDINGS)\\D-P (Dr B)	5.66%
Files\\D-P CONSULTATIONS (AUDIO-RECORDINGS)\\D-P (Dr F1)	1.83%
Files\\D-P CONSULTATIONS (AUDIO-RECORDINGS)\\D-P (Dr M)	3.68%
Files\\D-P CONSULTATIONS (AUDIO-RECORDINGS)\\D-P(Dr F)	0.11%

Source: (Fieldwork, 2018/2019)

Extract 9 further complements the summary results above as an extract of the audio-recorded interaction sampled to give context and meaning to the interactions on silence. In Extract 9, the consulting room had Dr M, House Officer 1 (managing the case, but had to seek further clarification from Dr M (OB-GYN Specialist), the consulting room nurse, and researcher. Hence, the nature of the sensitive topic within a non- secluded setting will impact on PAT B's response.

Extract 9:

314: Dr M: But it may contribute and with that, you may not need any medication. If you can erm do something about the weight alone … and that one is extreme if you have extreme of weight … that's the first question I asked him is whether you were obese or *down there is/are not good* … it's not good because you need a certain amount, certain percentage, or certain body percentage of fat to be able to have regular menses. So, all that I am saying is that all these may be contributory, and they are simple things to do … it is not about you eating well or not, you eating well, is it showing? (About 90 seconds)

315: PAT B: *{NO RESPONSE / SILENCE [6 seconds]} – [Facial expression reflecting confusion, sadness…]*
316: Dr M: It has to show, are you getting it?
317: PAT B: Yes {Responds in low tone}
318: Dr M: No, so do something about it
319: PAT B: So, what do I do?
320: Dr M: Ei, that one …
321: Dr M: Let her go and see the dietician.

Source: (Fieldwork, 2018/2019)

In this data extract, we could not help but note the *no-response* from PAT B as Dr M touched on a sensitive subject - *irregular menses*. The patient's inability to be in control of this aspect of her reproductive development may have impacted on her *no-response*, indicating an overpour of emotions, and therefore, reluctance. In these samples, the *no-response* from the patient could be attributed to the uncomfortable nature of the patient in the medical environment, which lacked privacy, or the nature of Dr M's questioning demanded *no-response,* but reflections on the necessary steps to be taken next.

> *In all instances, the patients met with mostly male doctors in their consulting rooms filled with a house officer, a nurse, and sometimes medical students (Participant Observation 2018/2019).*

Silence from the results occurred in face-to-face interpersonal interactions and may pose medical challenges for the doctors who need every information for their diagnoses. Importantly, data on silence reinforces an integrated approach to caregiving. Therefore, its use as a non-verbal component adds to the verbal exchange mostly on intimate issues and sets the relevance and urgency of how this strategy may negatively impact the medical process and the management plans. Relegating these prominent features which describe the biopsychosocial states of the patients at a given time totally to the periphery renders the interaction ineffective and may be prone to numerous medical errors since communication has the most meaningful contribution to the patient receiving direct care. Therefore, failure in the verbal exchange between the doctor and the patient may lead to multiple degrees of adverse outcomes that may indefinitely affect the medical relationship.

4.3 Summary Discussion on the Eleven (11) Communication Strategies Derived

In Table 4.14, it is ascertained that each doctor/patient encounter studied had either more/less percentage coverage in more than one strategy except for Dr F1/Patients who were noted to have dominated in only one strategy – pronoun – 'it' (PRN – IT). Whereas Dr F/Patients dominated in empathetic expressions (EMP-E) and repetitions (REP), they had the lowest in medical jargon (M-J), pronoun – 'it' (PRN – IT), low - tones (L-T) and silence (SIL) with a null set for Euphemisms (T-E) and code-switching (C-S).

Dr 1/Patients had the highest in their use of politeness (POL) and lowest in their use of code-switching (C-S); Dr 2/Patients exploited 'we' - inclusivity (WE-I), code-switching (C-S) and avoidance (AVO) more than any of the doctor-patient interactions; Dr 3/Patients dominated in medical jargon (M-J), Euphemisms (T-E) and they had the lowest coverage in repetitions (REP) and politeness (POL); Dr B/Patients employed a significant coverage of low tones (L-T), and silence (SIL) than all the other interactions and the lowest use of avoidance (AVO) in the overall data. Finally, Dr M/Patients had the lowest use of expressing empathy (EMP-E) and 'we' - inclusivity. It is detected that the strategies utilised the use of more accommodating strategies than non-accommodating (diverging ones). All the strategies operated on accommodation to enhance the intimate nature of the interactions.

In all, it can be argued that in each interaction, the doctor-patient interactional idiosyncrasies worked in tandem to derive the specific, classified and uniquely observed communication strategy under each interaction as noticed in Table 4. 14. Notwithstanding, some of the strategies in other instances were mutually exclusive.

4.4 Doctor-Patient Audio-Recording Visualisation using Cluster Analysis in NVivo

The aim of using cluster analysis was to extend the qualitative data derived on the audio-recordings through data visualisation. As an explorative technique, it assisted in visualising patterns in this study by grouping the sources or nodes. It usually contains all objects in the data set. Also, it may specify the relationship of the clusters to each other, This correlation is visible through word, coding, and attribute similarity. As well, it aided in understanding the elements of qualitative data. Nonetheless, this exploration focused on word similarity.

The use of NVivo under the feature of cluster analysis confirmed an interesting outcome where the generated cluster analysis diagram graphically represented similarity or dissimilarity of items being compared by using colour (to identify clusters) and the positioning of the items relative to each other. Thus, related items are close together whereas dissimilar items are apart. These differences are created by default and the results of the cluster analysis are displayed as a dendrogram as represented in figure 4.1. Figure 4.1 communicates word similarity in both the KBTH and UHS doctor-patient interactions established links to communication patterns existing and accommodating in two separate ways. Insightfully, from the KBTH data, the female doctor-patient interactions (Dr F/Dr F1) were grouped together as having correlated features, whereas the two other male doctor-patient interactions (Dr B/Dr M) were also grouped together in similar pattern. Notwithstanding, all the doctors from KBTH had four distinct colour codes that still established some level of variability in their doctor-patient gynaecological interactions.

On the other hand, data from UHS established word similarity between the doctor-patient interactions of (Dr 1/ Dr 2). However, this related node from UHS also used two distinct colour codes in communicating some level of variability. The final doctor-patient interactions at UHS (Dr 3) had an independent pattern, yet the interactional pattern of the doctor-patient interactions reflected and accommodated to the same colour code as the doctor-patient interactions in (Dr 1).

These visualisations noted similarities within the interactional patterns. Yet, I observed some level of variance due to the varied colour codes representing each doctor-patient interaction. These explorations support accommodation as one of the communication behaviours and simultaneously the uniquely specified interactions. Therefore, the varied strategies noted may be due to doctor-patient idiosyncratic tendencies also impacting the nature of interactions studied.

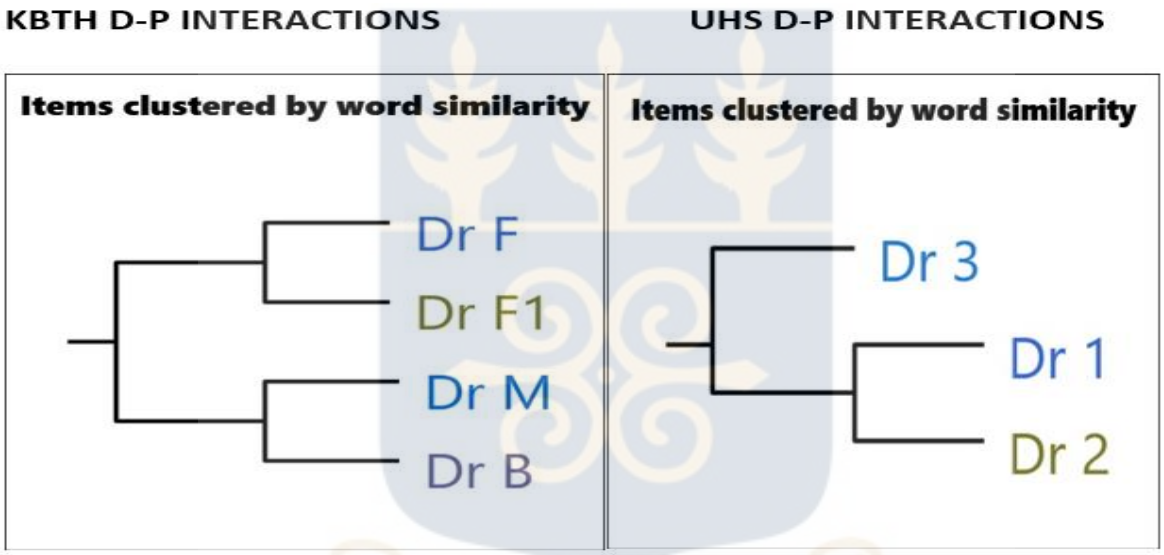

Figure 4. 1: Items Clustered by Word Similarity

Table 4. 14: Final Summary List of Communication Strategies Used between the Doctors and Patients in Gynaecological Encounters.

D-P	M-J	EMP-E	PRN-IT	T-E	WE-I	REP	C-S	POL	L-T	SIL	AVO
Dr 1	186/24	21.61%	8.16%	1.86%	15.30%	4.38%	1.13%	18.53%	5.63%	2.85%	1.93%
Dr 2	209/33	10.88%	3.71%	2.23%	17.57%	8.72%	18.88%	14.42%	4.77%	0.88%	8.44%
Dr 3	307/33	4.51%	6.77%	6.34%	8.47%	1.55%	8.45%	4.26%	5.42%	1.14%	3.31%
Dr B	233/28	18.21%	8.08%	2.35%	11.24%	2.69%	2.09%	9.59%	11.82%	5.66%	1.47%
Dr FI	162/26	10.80%	8.40%	5.76%	6.42%	7.36%	4.33%	15.57%	4.01%	1.83%	2.75%
Dr M	154/54	1.39%	5.04%	2.39%	3.47%	2.56%	2.16%	8.71%	5.81%	3.68%	3.08%
Dr F	147/39	34.92%	2.26%	ϕ	5.78%	9.10%	ϕ	8.11%	1.28%	0.11%	2.71%
	CON	CON	CON	CON	CON	CON	CON	CON	CON	CON	CON

↑ - Highest/Maximum doctor-patient coded percentage coverage; ↓ - Lowest/Minimum doctor-patient coded percentage coverage; ϕ - Null/Empty set; CON - Convergence

Source: (Fieldwork, 2018/2019)

4.5 Conclusion

In this chapter, I have shown that communicative strategies are pervasive in the gynaecological care communicative encounters in Ghana. In this setup, varied strategies were employed in each interactive set in almost every discourse between the doctors and the patients. These acts were mutually exclusive as the doctors interacted with each patient with varied socio-demographic features which impacted the nature of strategies developed in each dynamic encounter.

Although strategies such as the use of medical jargon (M-J), repetitions (REP), 'we'-inclusivity (WE-I) and the use of empathetic expressions (EMP-E) were mostly used by the doctors, the use of pronoun 'it', the use of euphemisms (EUP), avoidance (AVO), code-switching (C-S), low tones (L-T), and politeness (POL), occurred between the doctors and patients simultaneously. Finally, the patients explored the use of silence (SIL) exclusively. The act of indirection in the use of avoidance, pronoun 'it' and euphemisms impacted the data significantly and the nature of how such interactive encounters ensued. Often, sexual parts or actions in the extracts discussed were either implied, omitted, or characterised by the pronoun 'it' and/or euphemisms.

These strategies adopted followed the cultural norms of restrictive communication and therefore aligned its communicative pattern within its socially censored settings on sexual healthcare. Therefore, the entire gynaecological interactive process followed an accommodative process, especially from the perspective of the doctors. Doctors in their use of empathetic expressions, 'we' - inclusivity, repetition, code-switching, the pronoun 'it', euphemisms, low tones, and politeness naturally converged with the patients, and this allowed the patients to bond with the doctors emotionally, psychologically, and confidentially as the patients divulged exclusive personal history for medical management as established in the data extracts. In this regard, doctors were

observed to be incorporating varied adjustment techniques to enhance patient openness and confidence as they guided them to communicate their primary concerns.

In addition, the exploration of cluster analysis using NVivo generated an insightful accommodative pattern at KBTH where female doctor-patient interactions aligned in word similarity on the one hand notwithstanding, the different professional status whereas the male-doctor-patient interactions also aligned on the other hand. However, at UHS, word similarity alignment occurred according to professional status, where the doctor-patient interactions that involved the OB-GYN specialists also aligned in word similar due to the effective use of NVivo.

CHAPTER FIVE

DOMINANCE IN DOCTOR-PATIENT INTERACTIONS

5.0 Chapter Overview

The chapter examines how power dynamics shape the nature of interactions that occur between gynaecologists and their patients. Data were analysed using NVivo to explore how the doctor-patient communication relationship is articulated in these encounters. The chapter also investigates doctor-patient consultations using Discursis as a visual text analytic technique to visualise the conversations and to identify key interactional patterns. This allows one to augment the already conducted NVivo qualitative analysis (Angus et al., 2012). The interactions created by Discursis are interpreted in the context of CAT (Ogay et al., 2005). The use of this approach serves as a novel application within the context of Ghanaian medical interactional analysis.

As a tool to aid conversation transcript analysis, Discursis makes interactions visible through the generation of interactive visual plots. These plots reveal patterns of interactions between doctors and patients. Hence, visual plots from seven gynaecological doctor-patient transcribed audio recorded exchanges were generated. These plots were selected to show moderate to high-level and low-level speaker interactional engagements, respectively. Details of these engagements were investigated for doctor-patient application of CAT strategies to examine the level of doctor-patient engagement and therefore, the nature of the doctor-patient communicative relationship.

5.1 Interactional Verbosity in Doctor-Patient Consultative Process with the Aid of NVivo

Doctor-patient communication is the foundation of the relationship needed to allow both doctor and patient to take an active role in treatment decisions. Several models have been proposed to

account for the nature of the conversation and therefore, communication strategies employed by both parties (Guo et al., 2018; Petracci et al., 2017; Pierloot, 1983). Research shows doctors' communication behaviour with their patients is crucial to patient satisfaction, adherence to treatment and overall healthcare outcomes (Makoul & van Dulmen, 2016; Matusitz & Spear, 2014). As part of the doctor's communication behaviour, dominance serves as one of the examples. Dominance is thus, one aspect of a doctor's communication behaviour that has received considerable attention in the literature (Schmid Mast et al., 2008). This behaviour encompasses control over information and services, and treatment decisions in the doctor-patient relationship. Medical professional dominance is primarily expressed by ineffective communication by doctors, often due to the reluctance to provide information to patients about their condition, the use of medical jargon and by evasion of direct questions from patients about the illness (Phillips, 1996). On the other hand, patients' hesitation, discomfort in discussing intimate areas and trepidation in meaningful communication with their doctors may also influence the nature of interpersonal control and communication behaviour explored in the doctor-patient relationship. For instance, patients' perception of the doctor as a highly revered, knowledgeable, and busy person may hinder their desire to ask questions or seek more information about their illness. Extracts 1 – 7 discussed under section 5.1.1 of the study represent seven data texts analysed using NVivo.

These texts underpin the nature of interactions between gynaecologists and their patients. The sampled interactions establish doctor-patient communication exchanges, where the doctor stays on each topic longer (about 5 -13 utterances) in each turn – compared to the use of short (1- 3) responses from patients in observing interactional verbosity, revolving around the patients' medical challenge, medical plan, and modifications or new directives on patients' medication. In all instances, doctors demonstrated more of this practice placing them in a dominant position. The

samples garnered identified doctors naturally using large amounts of information. Generally, in patient's history taking, the giving of medication plan to patients, patients physical and laboratory results discussions, doctors initiated and stayed on the interactions longer. As a result, it was common for the doctors to dominate the interaction sessions rather than the patients.

5.1.1 Sampled Texts Analysed in NVivo

Extract 1: Dr 1/ Patients

Reference 11 [Male Gynaecologist / 62-year Female Patient]

> 62: Dr 1: … You see there is something erm now. We are looking at *blood pressure (BP) management* racially – Black, white, black, and white. There are certain *medications*, *BP medications* that are known to do better in black people. They don't do better in white people – '*The Calcium Channeling Blocker'*, this one we call it … *backbone drugs, 'thiazide'* for black people – backbone drug ok. I am not surprised that you started this, and you are having a problem – eh yeh, that is a drug reaction. That problem mmhu, eh yes [2 seconds break as Dr 1 reorganizes his thoughts], that problem … that problem may be that the BP is not getting controlled even though you are taking it. The problem may be that you are having these *reactions* you are having ok. So, if you had come today without this, I would stop this ….
>
> 63: PAT 5: Oh, OK …

Source: (Fieldwork, 2018/2019)

In Extract 1, the doctor provides more information about the history of the patient's disease and gives technical information using medical language to help the patient to understand the nature of what she is experiencing. Also, there is focus on the patient's physical pain or symptoms. The doctor uses about ten utterances to communicate this concern to the patient. In this form of communication, the doctor provides details. However, the patient responds with just two words

which does not give adequate information or clarity about the patient's clear understanding of what was explained to her.

Extract 2: Dr 2/Patients

Reference 4 Male Gynaecologist / 28 years female patient]

56: Dr 2: So, I will say *s3* [local word meaning 'like or for instance'] within a year, you may use this about three or four times. Because … what we have found out is that it is the major, the main thing that *upsets the cycle* and it makes it *irregular* and all that. So, that is *emergency contraception*, OK. I hope you know it. How do you use it?

57: PAT 1: Mmmm, after sex {low tone}

58: Dr 2: Exactly, exactly, after sex and you find it reliable, isn't it?

59: PAT 1: Yeah [Low -Tone]

Source: (Fieldwork, 2018/2019)

Extract 2 gives further information on a doctor's use of medical jargon in his interactions. The doctor is perceived to identify the problem and its cause and effects and through the interaction, the doctor tries to find out if the patient is aware of the function of the emergency contraceptive and its use. Since this discussion is sensitive (about sex and contraceptives), the patient is observed to suddenly adopt the use of low tones (L-T) when the doctor starts discussions on her sex life. In all, the patient gives four responses - *Mmmm, after sex, yeah,* whereas Dr 2 uses about 6 (six) utterances.

Extract 3: Dr 3/Patients

Reference 3 - [Male Gynaecologist / 26 years old female patient]

490: Dr 3: So, you listen to it well. Hi, you want to *keep the place* sacred *paa o*! [*extremely well* emphasis in local language].

491: PAT 3: {Begins to laugh}

492: Dr 3: {Laughs as well}. Normally, the *organism* exists in a form that you won't see, and they don't cause any problem. They are sitting somewhere … minding their own business, Good! The reason is that *the vaginal environment is very acidic*, so it *restricts* the *abnormal growth* of these *organisms*. Because the only time you will experience them is when they grow into *a large colony,* and you start seeing the discharge, sometimes it is itchy. Do you understand? It means that they are growing abnormally. So, anything that will change the *hostile environment* of the vagina will allow them to grow. Do you understand? So, anything that will *neutralize the acidic, vaginal environment* will allow them to grow. And that *acidic vaginal environment* is produced by very useful bacteria in the vagina. So, prolong use of *antibiotics* for whichever reason can kill the useful bacteria that produce the acid and therefore, alter the environment and then, allow them to grow. Thus, women who like washing their vagina unnecessarily …

493: PAT 3: {Laughs}

Source: (Fieldwork, 2018/2019)

In Extract 3, Dr 3 expresses himself with numerous medical jargon (M-J). Notably, when Dr 3 ends his narrative, PAT 3 laughs without uttering a word. The lengthy and verbose information from Dr 3, involving about 13 utterances, also brings about laughter from PAT 3. It is uncertain if PAT 3 understood the detailed medical message being communicated to her. The patient appeared to be surprised by the level of detail being shared by her doctor, the doctor's use of language, and his level of openness. This information seems to create a more comfortable but unexpected atmosphere; thus, PAT 3's inability to find appropriate words to respond to Dr 3. Under this circumstance, PAT 3 "laughs" as her only emotional, spontaneous response observed. The difficulty in quantifying this emotional response gives varied interpretations during this

counselling session, such as allowing the patient to handle the uncomfortable topic more easily, using it to reduce patients anxiety or tension, enabling patients to encourage more intimate discussions or a sign to support accurate information being given by the doctor (Granek-Catarivas et al., 2005; Hardy, 2020).

Extract 4: Dr B/Patients

Reference 12 [Male Gynaecologist / 29 years old female patient]

> 296: [Consulting room has 3 people apart from PAT 3 – Consulting Room nurse, Dr B, and field researcher] - Dr B: So, let me conclude with you. I was saying that he [husband] should make sure that you get *orgasm*. It is in his interest. I was telling you these three phases {low tone}. Right now, what you have mentioned here, it looks like you have a problem with phase 1. You don't have the desire to have sex. That is what you mentioned. When you are having foreplay and you people are trying to have sex, and he *stimulates* you, do you get *aroused*?
>
> 297: PAT 3: No {low tone}
>
> 298: Dr B: Do you get into the mood?
>
> 299: PAT 3: No {low tone}
>
> *Source: (Fieldwork, 2018/2019)*

Extract 4 also presents another interesting interaction on *sex and orgasm*. The doctor dominates the intimate discussion as usual and employs familiar, candid, and related intimate terms to allow the patient to appreciate the nature of her situation. Despite the level of relatedness established through the doctors' use of words to give further clarity, captured in about 8 utterances, the only responses from the patient are when she says "No" in low tones (L-T), showing her discomfort at discussing the subject, perhaps due to its sensitivity to her and significantly, her discomfort about

the number of people in the same room. Significantly, the doctor employs yes/no questions instead of open-ended questions. This practice may have inhibited patients' open discussions or reluctance to provide full details in the interactions. Patients rather adopt low tones (L-T) as the communicative strategy to navigate intimate discussions.

Extract 5: Dr M / Patients

Reference 3 [Male Gynaecologist / 27 years old female patient (a nurse)] [Consulting Room – Dr M, House Officer 1, Nurse, Researcher]

32: Dr M: I'm not saying you don't eat well … I'm not saying you don't eat well … Eating well must show. Weight below 50 is a problem … for menses and it is not just the weight. Usually, normal menstrual flow, you need about three things … three things means that the *genital tract* must be … and you've had it before so {LOW TONES} it's likely there are no … obstructions anywhere OK. Then, err the *hormone*, the *axis*, *hypothalamus*, and everything should be intact and … they are affected by weight changes … I am not saying that is the solution.

33: PAT B: OK

Source: (Fieldwork, 2018/2019)

In Extract 5, the doctor is observed to give explanations, ask rhetorical questions, and adopt ways of letting his patient understand her underweight issues and their significant impact on her inability to experience regular menses. The doctor uses about nine utterances in the extract. The topic under discussion seemed to make the patient uncomfortable, hence her terse response. Given the patient's background as a nurse and thus possible knowledge of her health challenge, a more engaging conversation may have been expected. However, the interplay of the nurse-doctor relationship, on the one hand, and the patient-doctor relationship, on the other hand is suggestive of power roles

that may have impacted the interactional roles and expectations, thus, the nature of PAT B's response.

Extract 6: Dr F/Patient

Reference 18 [Female Gynaecologist / 25-year-old Muslim female patient-[vaginal examination]]

39: Dr F: Because you see eh, I am thinking that you have some *urinary tract infection*. Usually, it is here, then, your kidneys are here {pointing to a graphical diagram}, do you understand?

40: PAT 5: Mmmm

Dr F: So, it can be here, then it starts, it starts going … spreading … it starts going up here. Then, you now start having *infections*. So, I think you have had it for a while now. And it is now spreading to this place and that can lead to *pre-term labour* and all that.

41: Pat 5: Oh, OK

42: Dr F: So, I am admitting you so we can give you *IVs (intravenous),* then we will discharge you.

43: PAT 5: OK

44: Dr F: So, we will start with *IVs*, then, we will change to *oral medications*, then you will go.

45: PAT 5: OK

Source: (Fieldwork, 2018/2019)

In Extract 6, despite the fewer sentences used as compared to Extracts 1-5, PAT 5 was observed to respond using sentence fillers. In this interaction, the doctor (also female) uses fewer medical jargon (M-J), about nine utterances, in comparison to the male doctors, whereas PAT 5's uses terse responses of "*Mmmm", "Oh OK", "OK"*, which may either reflect a sudden grasp of knowledge or the desire for her doctor to move on with the diagnosis and treatment without her interference

or contribution possibly also due to the severe level of pain being experienced due to her medical challenge - *urinary tract infection*.

Extract 7: Dr F1/Patients

Reference 11 - [Female Gynaecologist / 25-year-old female patient]

> 92: Dr F1: No, no, no, for now … [unintelligible/ low tone as Dr F1 examines patient] How are you feeling? Do you feel something there? When you wee-wee, do you feel pain? Or it is just, but you said before that in your menses you used to have pain there? … The bleeding, did it come popo popo? … Ehhh? … or how many pads did you change? ...
>
> 93: PAT C: … I think two …
>
> 94: Dr F1: Two? Is it more than your normal menses or is that how your normal menses has been?
>
> 95: PAT C: No

Source: (Fieldwork, 2018/2019)

The above interaction between Dr F1 and PAT C has less medical jargon (M-J) as compared to earlier extracts. The common gender shared by both doctor and patient did not seem to improve patient's participation in terms of the quantum of language responses being used by the gynaecologist (about seven interrogative sentences) used in history-taking.

In this sample, the female doctor dominates the conversation even though she tries to use accessible and colloquial language. Interestingly, the way the doctor uses 'weewee' instead of 'urinate' is suggestive of superiority or the doctor condescending toward the patient. Nonetheless, the nature of PAT C's responses may have been because of the pain being experienced. Notedly, the pattern of dominance is identified as occurring in all the interactions irrespective of the quantum and frequency of medical jargon (M-J) used by the doctors nor their gender in any way impacting the

patients' responses. Interestingly, male doctors tend to incorporate more technical information, especially in Extracts 1 – 5 (Bertakis, 2009).

5.2 Results and Discussion on the Exhibited Model of Doctor-Patient Interactions with the Use of NVivo

The above data texts (Extracts 1-7) illustrate the nature of communicative roles and dominance during doctor-patient communication among participants. The analysis of the 35 doctor-patient interactions clearly points to a dominant and controlling role by doctors in the direction and verbosity of language used in the interactions. The verbal dominance of doctors, in parts, is due to their expertise and better knowledge of the health condition being discussed.

In addition, the reverence society accords those in the medical profession means that it is acceptable, perhaps even expected, for doctors to initiate and engage actively in the interactions. This establishes their competence, influencing patients to build their trust in the medical management process. Nonetheless, the reluctance of patients to be fully involved in the interactions significantly enhances the communicative dominance of doctors.

While there is strong support for the claim that patients respond favourably to non-dominating doctors (Street, 1991), the evidence from this study suggests otherwise. Rather, patients tend to prefer the pseudo-paternalistic model of treatment where treatment decisions are entirely arrived at by doctors with little or no help or involvement from patients. For instance, in the patient's semi-structured interviews (P SS-I), the responses derived from questions inquiring about patients' expectations of the doctor confirmed the following responses where the onus is placed on the doctor by the patient to solve the challenge:

PAT.GYN3: … *Because I feel I have a problem, and for me to get a solution to the problem, the doctor has to go deep and delve into whatever issues I have before he can give me a very definite solution (PSS-I 2018/2019).*

PAT.GYN4: … *looking at him, he is kind of a father, maybe an uncle or father, so I want that father-daughter relationship … what I am expecting today is, "you are ok, start your maternity ... this ..." I want him to give me all the necessary information that I need (PSS-2018/2019).*

PAT.GYN 5: … *Because if I am not confident in what you are saying, you [doctor] is not that confident in yourself and other things, I would not buy your idea ... (PSS-I 2018/2019).*

Whereas the doctors served as drivers of the encounters, patients served as (passive) communicators or oriented towards doctor control no matter the level of language being used or the level of engagement by doctors. Patients expected doctors to own the interactions as expressed in the semi-structured interview data. This finding also corroborates beliefs about doctor control (Kamwendo, 2004; Street et al., 2003). The form and nature of the interactions observed suggest paternalism that seems to align with the guidance co-operation model of communication (Szasz & Hollender, 1956).

In this relationship model, the doctor is given an autonomous position due to medical knowledge they exhibit that the patient lacks. The expectation from the patient is for the doctor to decide what is in the patient's best interest and to make recommendations accordingly. The patient then complies with these recommendations based on the confidence exhibited by the doctor. The model is constantly being negotiated based on the patient's high regard for the doctor and willingness to conform or agree to the doctor's diagnoses or observations without any challenge (Mira et al., 2012).

Gynaecologists in the above samples speak at length in a continuous impersonal fashion, strictly scientific with special terminology for each disease, symptom and treatment (Kasimtseva et al., 2019), yet the patients seeking care rather respond with sentence fillers - *OK, Mmmm, Mmhu, and Yes/No* responses which can denote acceptance of the medical discussion, expression of pleasure, thoughtfulness or hesitation and expressions of agreement or disagreement (Kasimtseva et al., 2019). The use of *Mmmm and OK* (Reference A and B) suggested some expression of pleasure in the conversations as noted in the audio-recorded exchanges A and B. Whereas in reference A, *Mmmm* initiated a sensitive topic in a humorous manner, *OK* on the other hand was used to tease out the financial decision from the patient.

Reference A

> 315: Dr B: How many times do you people have sex in a week?
>
> 316: PAT 3: Mmmm, a week dier [dier is an Akan (Twi) response meaning 'probably'], maybe once, twice, or none.
>
> 317: Dr B: Mmmm, you haven't tried enough, maybe that is why we are asking you, maybe how many times in a month … [LAUGHTER IN THE ROOM]

Reference B

> 120: Dr 3: Ah, and we thought it was eh, yeh, yeh, yeh, so, what? I remember, I remember. What we said was we were going to do a hormonal profile if you were ready … PAT 1: yeh, yeh, yeh … Dr 3: And probably have the scan done.
>
> 121: PAT 1: Okay – {satisfaction in response}
>
> 122: Dr 3: Ok, alright. Maybe I should warn you. Hormonal labs are usually a bit expensive if you are OK with it.
>
> 123: PAT 1: {Begins to laugh}

The relationship between a predominantly dominating doctor and a silent and compliant patient established in the above extracts represents the most traditional model of healthcare - doctor-

dominance (Ballard-Reisch, 1990). Table 5. 1 also shows the results of interactions on doctor dominance (based on NVivo analysis). This data indicates high male doctor dominance of 141.4% as compared to the female doctor dominance of 32% where the percentage coverage of this practice was derived through the addition of the total percentage coverages employed by the male doctors and female doctors and then divided against their total number within the interactions. In this analysis, NVivo aids in the realisation of a CAT strategy – that is the nature of interpersonal control revealed interactionally. Table 5. 1 is complemented by the histogram in Figure 5.1 giving a graphical overview of male doctor dominance within their interactions.

Table 5. 1: Dominant – Coding by Item Summary

Item	Percentage Coverage
Files\\D-P CONSULTATIONS (AUDIO-RECORDINGS)\\D-P (Dr 1/PAT)	54.25%
Files\\D-P CONSULTATIONS (AUDIO-RECORDINGS)\\D-P (Dr 2/PAT)	40.73%
Files\\D-P CONSULTATIONS (AUDIO-RECORDINGS)\\D-P (Dr 3/PAT)	11.11%
Files\\D-P CONSULTATIONS (AUDIO-RECORDINGS)\\D-P (Dr B/PAT)	32.73%
Files\\D-P CONSULTATIONS (AUDIO-RECORDINGS)\\D-P (Dr F1/PAT)	24.67%
Files\\D-P CONSULTATIONS (AUDIO-RECORDINGS)\\D-P (Dr M/PAT)	12.49%
Files\\D-P CONSULTATIONS (AUDIO-RECORDINGS)\\D-P(Dr F/PAT)	14.11%

Source: (Fieldwork, 2018/2019)

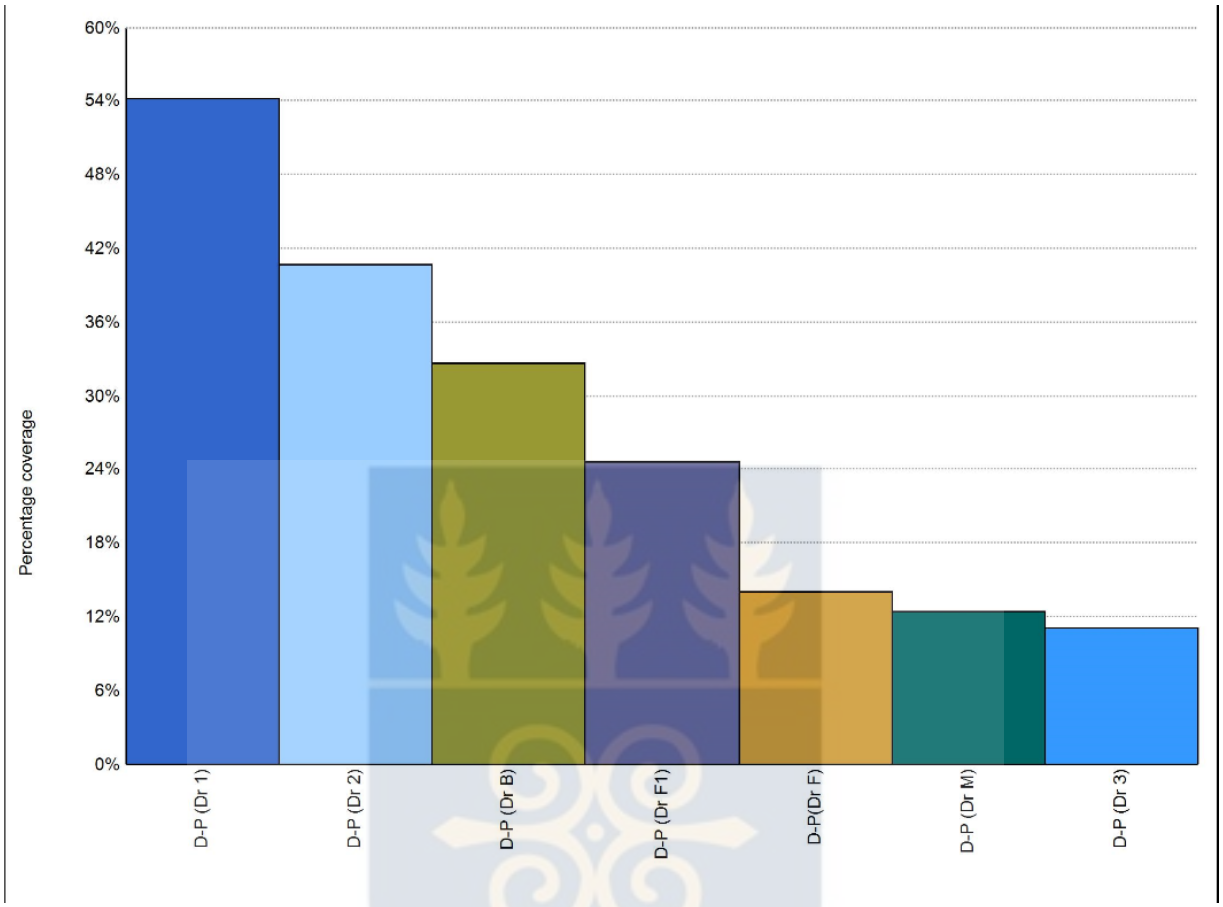

Figure 5. 1: Doctor-Dominance: Coding by Item Summary on a Histogram

5.3 Discursis as a Complementary Qualitative Software

The chapter further explored the use of Discursis to enhance the qualitative angle of the gynaecologist-outpatient interactions as well as to ascertain the level and nature of visualised interactional engagement with a focus on the theory of CAT (Chevalier et al., 2018). Discursis created plotted interactions to ascertain the relative contributions of each speaker.

The analysis on Discursis corroborated the already analysed NVivo interpretations from audio recordings, semi-structured interview transcripts and participant observations (Chevalier et al., 2017). Importantly, Discursis has been employed in the analysis of several medical interactions such as physician-patient consultations (Angus et al., 2012), interactions between dementia

patients and their residential caregivers (Baker et al., 2015), and the disclosure of adverse events in doctor-patient interactions (Watson et al., 2015) to reveal turn-taking and engagement patterns within the interactions. The use of discursis is to identify specific CAT strategies in the gynaecologist doctor-patient episodes of engagement and how this information relates to the model of doctor-patient interactional relationship established by NVivo.

5.3.1 Episodes of Doctor-Patient Engagement on Discursis

In contrast to the spatial (or semantic) focus of many text analytic tools, the approach to the technique of Discursis (Angus et al., 2012) is to analyse temporal (or episodic) aspects of communication. In this study, Discursis analysed sampled texts from doctor-patient audio recordings. This process of analysis extended an existing visualisation technique called recurrence plotting. This specific plotting displays and identifies trends within time series data (Eckmann et al., 1987), especially doctor and patient, communicative behaviour.

Discursis has the potential to establish varying levels of doctor-patient engagement on the plot; thus, the realisations of a low, medium, and high-levels of interactional engagement. Nevertheless, Discursis allowed the levels of engagement to be established, observed more efficiently, and easily distinguished, but the tool was unable to label the specific content or display the relevance of such content. The analysis of the plots was to establish the level of speaker engagement in each interaction despite the interactional relativity that existed. Table 5. 2 explores indicators or a glossary of definitions that guided the interpretation of the study using Discursis. The exploration of Discursis is to visually note the levels of engagement (low, medium, or high) that existed in the interactions (Chevalier et al. 2018, p. 5). In Table 5. 2, the study defined its parameters for interactional engagement.

Table 5. 2 Glossary of Interpretation on Recurrence Plots

Terms	Definitions
1. Concept	The group of related words that is identified by Leximancer in each communication exchange
2. Engagement/ Episodes of	Points in time indicating speaker (s) contribution in interactions. It is represented on the plot as two coloured or off-diagonal blocks
3. Leximancer	Software using a natural language processing conceptual algorithm that identifies major concepts in an interaction It uses recurrence plotting to create unique plots by identifying the main themes and how they relate in a conversation. Thus, it provides word frequency counts (quantifying) and visually displaying the connectedness of concepts (Leximancer, 2021)
4. Low-Level Engagement	This study assigned this concept to episodes of engagement dominated by patterns of alternating single-coloured squares/boxes establishing self-repeated concepts discontinued from previous speaker responses
5. Medium Level Engagement	Concepts of engagement dominated by patterns of few patterns of alternating single-coloured square boxes and off-diagonal off patterns [*Emphasis Mine]*
6. High level Engagement	This study assigned this concept to episodes of engagement containing multiple clusters or episodes of off-diagonal blocks throughout the interactions
7. Off - Diagonal block	Two coloured blocks, a period in conversational time when a speaker uses the concepts of the other speaker
8. One - way Conversation	Dominance of conversation by one speaker/ participant
9. Two - way conversation	The existence of turn-taking establishing the involvement of the speakers

10. Same-Saying	Repeating the words of another speaker by another
11. Recurrence Plotting	Visualisation technique used to display and identify trends within a time series data

(Chevalier et al. 2018:5)

Besides, Figure 5. 2 showcases the use of Discursis to aid the recurrence plot in doctor-patient interactions. This plot graphically represents the communication that ensued and the level of interactional engagement. Discursis plot arranges conversational turns as coloured squares along a diagonal line, with the length of each turn (word count, or real timing data if known) reflected through the size of the square (Angus & Wiles, 2018). Each diagonal square is coloured based on the channel (s) of participants engaged in the conversations.

On the plot, recurrences that appear below the diagonal are coloured according to whether they correspond to a recurrence by the same channel or between the different channels engaged. A single colour code is assigned to a channel; however, conceptual recurrence appears in two coloured shaded rectangles confirming concepts shared between two participants.

In these interactions, if two turns contain similar concepts, then the corresponding vertical and horizontal intersection blocks (below the diagonal) are shaded in both channel colours to indicate conceptual similarity. Find examples of this feature in Figure 5. 2. The generated plot has an instance of many blocks of red and blue to indicate that the doctor and the patient are self-repeating each other's concepts during the entire consultation. The conceptual content contained in the patient and the doctor's initial turns frames the consultation as indicated by the blocks of blue, red, and red and blue blocks underneath these initial statements.

These recurrence plots present conversations in a diagonal turn-by-turn format to display the use of same-concepts by the interactants, repetition of own/self-concepts or dissimilar discussions. In instances where the turns from the participants contain related concepts, the vertical and

corresponding intersection blocks beneath the diagonal is automatically shaded in two colours and in this study, the colour options selected are red and blue to signal conceptual similarity. Nonetheless, the repetition of the same concept or unrelated concepts by the same speaker or both participants is represented as single-coloured squares (either shaded in only red or only blue) (Angus et al., 2012).

Also, in accessing any text, left click and drag the mouse over the areas of interest. This process allows the software to magnify and reveal the dialogue adjacent to the plot squares allowing immediate verification of the varied episodes of interactional engagement. Visual illustrations of this feature are observed on all seven recurrence plots discussed under section 5.3.1.1.

Finally, horizontal stripes from individual turn-taking actions is reviewed from the right of the diagonal to the left indicating a summary of concepts within that specific time of each speakers input (Angus, Smith, et al., 2012) as illustrated on sample Figure 5. 2. The legend attached to the plots (1-7) displays the channel values according to the speaker dominating the interaction and the colour codes selected to distinguish each participant. All the transcripts used to plot the seven representative recurrence plots are a maximum of 100 utterances in all data illustrations in section 5.3.1.1 for all visualisations. Sample text represented aspects of the episodes of engagement randomly selected to illustrate the communicative patterns that occur.

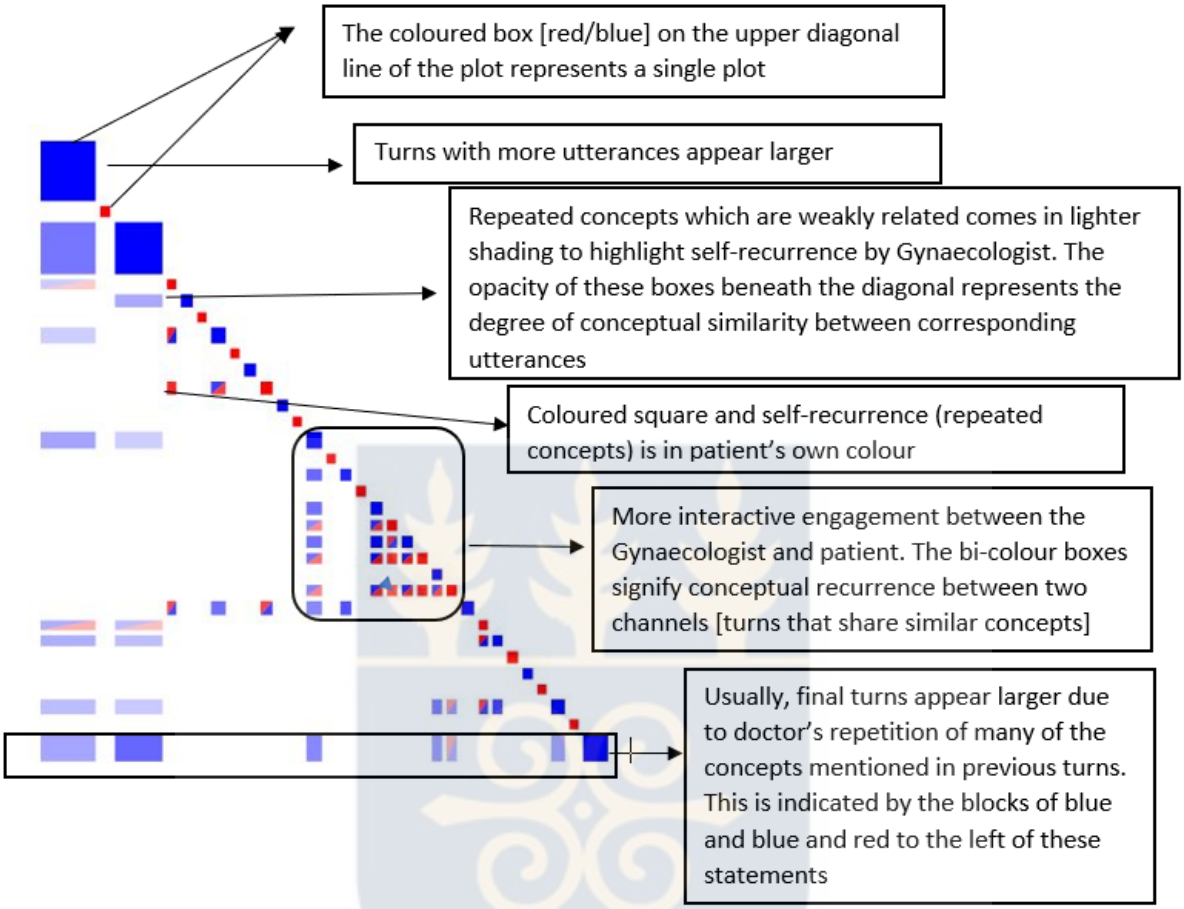

Figure 5. 2**:** Recurrence Plot Outline [Red-Patient / Blue- Gynaecologist]

5.3.1.1 Sampled Data Exploration (Extracts 1-7) on the Recurrence Plots

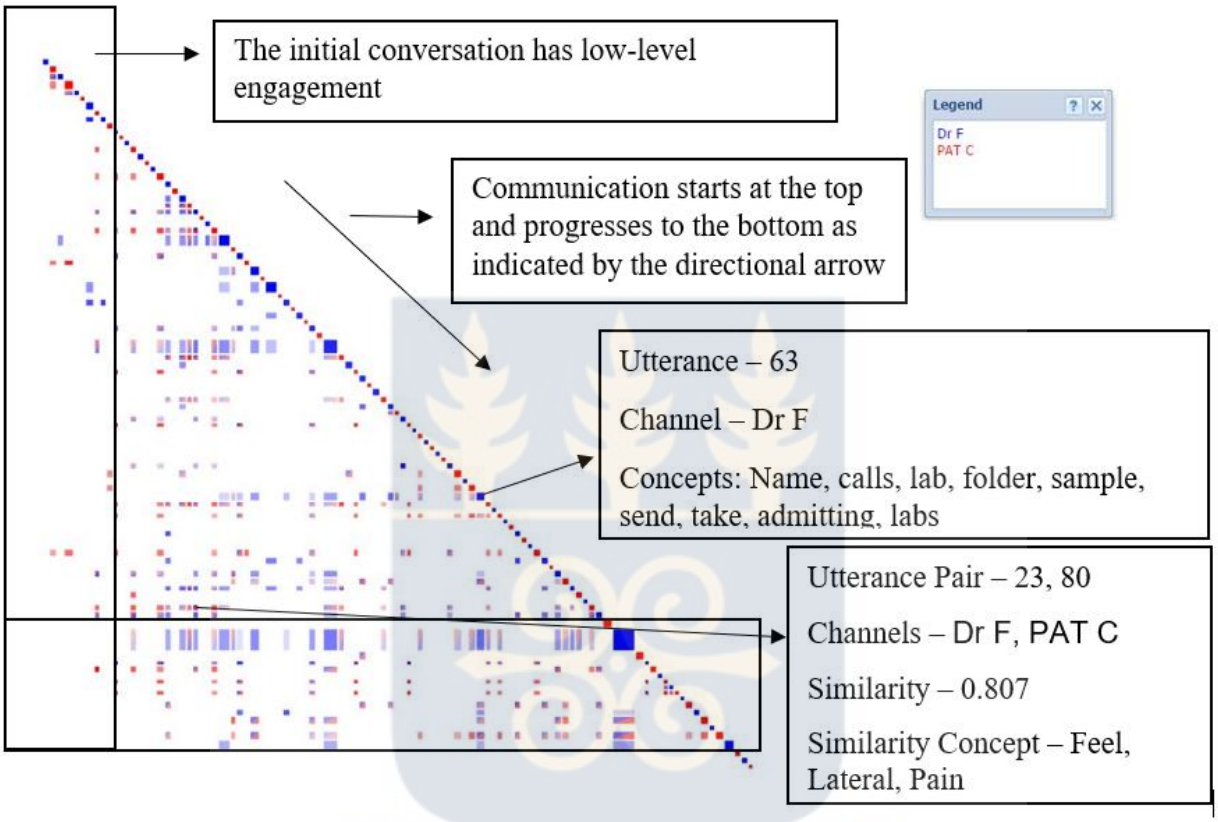

Figure 5. 3: Recurrence Plot of Dr F / PAT C

Sample Texts Selected from Figure 5. 3

Utterances – 23, 80 (Dr F, PAT C)
Similarity – 0.807
Similar Concepts – Feel, lateral, pain
Utterance 23 Text
When I do this, do you feel any pain?
Utterance 80 Text
No, but I didn't feel the pain again, but yesterday {lateral clicks}

Figure 5. 3: Recurrence Plot of Dr F (Gynaecologist/ PAT C)

In Figure 1, Dr F verbally dominates the interaction despite its medium-high level of engagement noted in the medial part of the plot represented in blue/red multiple clusters of off-diagonal boxes. On the legend plot, the level of dominance is demonstrated clearly, as shown above, where the participant dominating is listed first. Initial plots have less interactive activity as the first 12 turn-taking utterances lack interactional engagement. This occurrence is represented with a band of white space within the plots. This white pace signals that a single utterance has inadequate conceptual similarity to all other utterances in time (Angus, Smith, et al., 2012). This is indicated with a few diagonal-off boxes in the space of the interaction.

At the end of the diagonal plot, there is an indication of large utterance squares at the end, indicating repetitions of earlier conversations by either the doctor and/or the patient's self-repeated concepts. However, the doctor repeats more concepts than the patient in this plot which reveals 1-100 of 166 interactive turns.

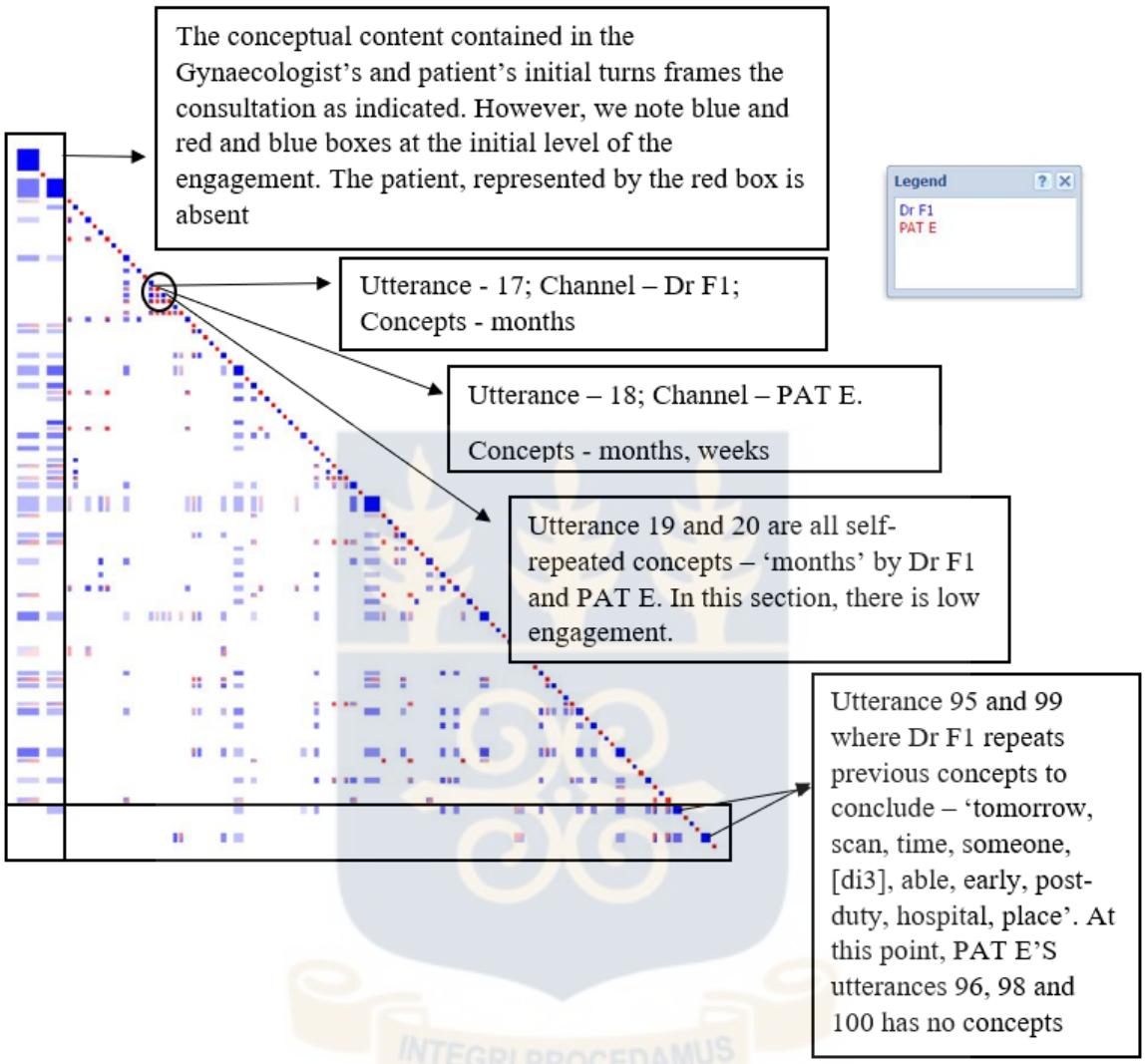

Figure 5. 4: Recurrence Plot of Dr F1 / PAT E

Sample Text Selected from Figure 5. 4

Utterance 17 (Dr F1)
And therefore, I said three. How many months was the first one?

Metadata/ Channel - Dr F1
Concepts - months
Utterance 18 (PAT E)
5 months, three weeks

Metadata - *Name*: PAT E

Concepts - months, weeks
Utterance 19 (Dr F1)
5 months? What about the second one?
Metadata - Name Dr F1
Concepts - months
Utterance 20 (PAT E)
3 months
Metadata – Name (PAT E)
Concepts – months

Figure 5. 4: Recurrence Plot of Dr F1(Gynaecologist/ PAT E)

In this plot between Dr F1 and PAT E, Dr F1 verbally dominates the interaction since the patient represented by red boxes has minimal interactional engagement. The plot highlights self-recurrent or repeated concepts from the doctor in blue lightboxes. In the legend plot, the level of dominance is demonstrated clearly in Discursis, where the doctor appears first. The initial discussion between the doctor and patient is interactive, with similar concepts shared demonstrated through the multiple clusters of off-diagonal boxes, especially from utterances (1 – 4). There are numerous self-repeated concepts from Dr F1 from utterances 31 and below. These repeated concepts by Dr F1 are represented with light shades of blue. The level of engagement from PAT E at this point is low where the labelled plot has several white spaces with more blue boxes from Dr F1. At the end of the diagonal plot, there is an indication of two large utterance blue squares confirming earlier repeated concepts discussed especially from the perspective of Dr F1 on a plot revealing 1-100 utterances of 109 total utterances. The utterances highlighted are the lowest used in all the seven interactive plots observed.

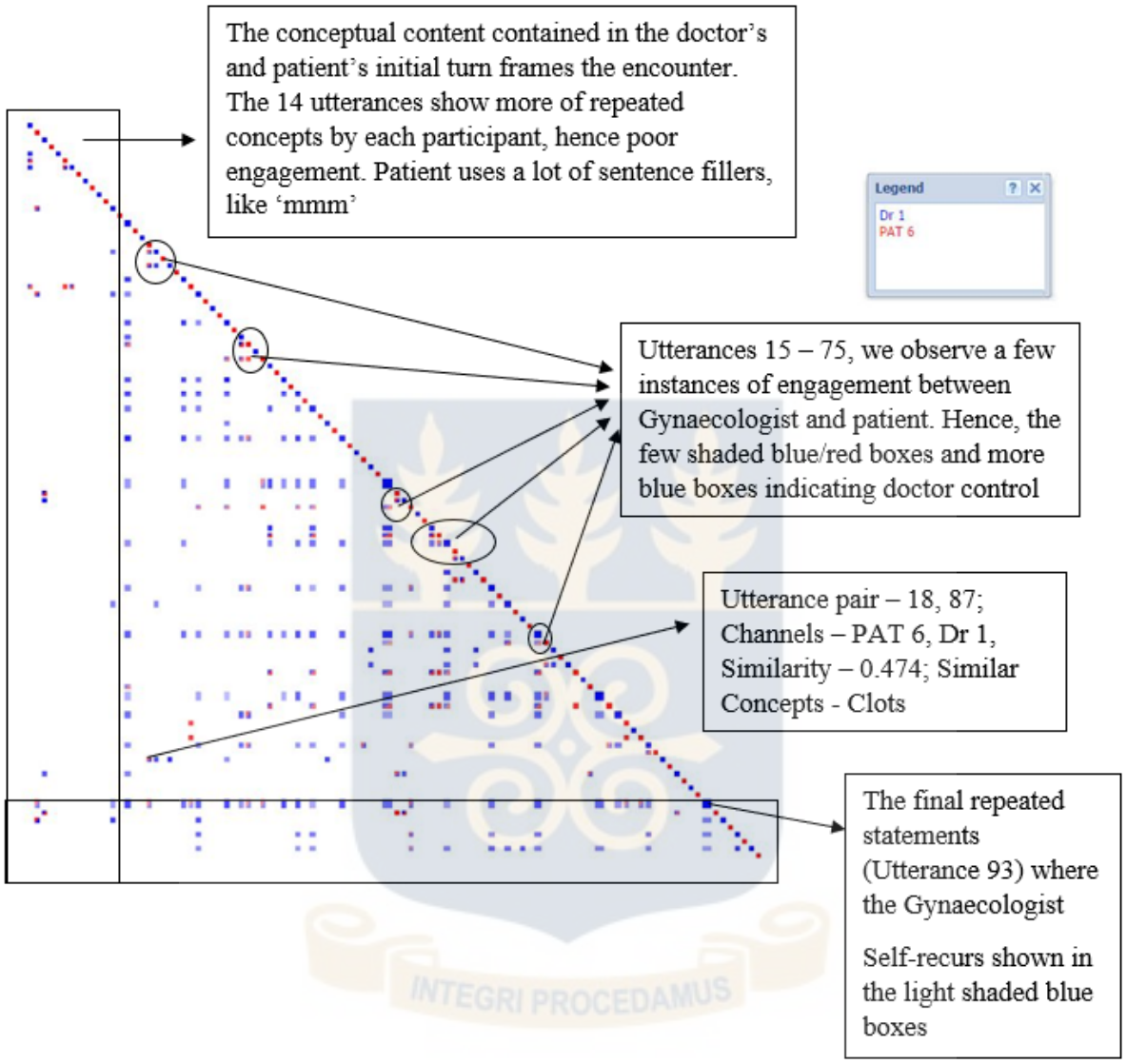

Figure 5. 5: Recurrence Plot of Dr 1 / PAT 6

Sample Text Selected from Figure 5. 5

Utterance 93 (Dr 1)
Whether now or before? It was [LOW TONES]. Because now the bleeding had started yesterday so, before then this bleeding stops … It is like a cyclical thing. Your period comes, you bleed heavily, you get more sick, weak, bla, bla, bla, before the next period you build up your HB, sort of, then, you start again. Is that not what has happened? For the past or more than a year or two? Or, since you started having your period?

Metadata/ Channel *Name*: Dr 1

Concepts: period, started, start, comes, bla, bla, bleed, take, heavily, bleeding, having, stops, yesterday, low

Figure 5. 5: Recurrence Plot of Dr 1 (Gynaecologist / PAT6)

Again, in this plot between Dr 1 and PAT 6, Dr 1 verbally dominates throughout the interaction with minimal or low-level engagement from the patient. This level of engagement is established with high levels of blue squares representing the doctor's interaction on the plot and fewer red squares showing patients' utterances. The level of dominance is demonstrated clearly as shown with Dr 1 positioned first on the legend plot. The initial interactions between the doctor and patient are less engaging as Dr 1 repeats his concepts throughout and dominates with a repetition of his concepts. However, it is observed that most of the concepts from patients are *yeh, yes please, no* (single responses), emphasising a low level of engagement. At the end of the diagonal plot, there is an indication of a blue utterance square representing repetitions of earlier conversations by the doctor. In this plot, Discursis examined utterances 1-100 of 139.

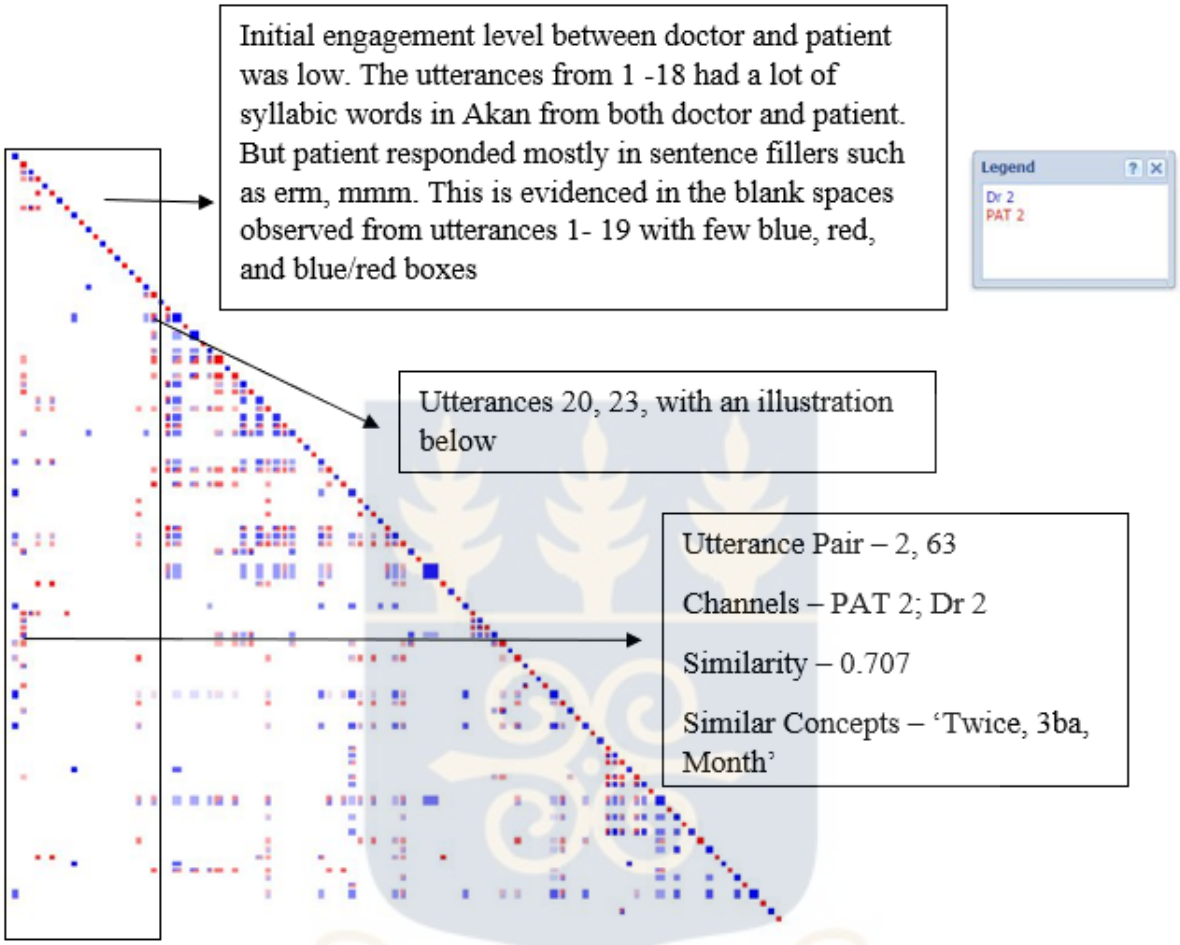

Figure 5. 6: Recurrence Plot of Dr 2 / PAT 2

Sample Text Selected from Figure 5. 6

Utterances 20, 23 (PAT 2, Dr 2)
Similarity - 0.607

Similar Concepts mmm, seconds, boyfriend
Utterance 20 Text
{about 6 seconds break} I do not have a boyfriend

Utterance 23 Text
A year! OK, so you have discontinued with your boyfriend for one year now. The old one?
{two seconds silence from PAT 1} the old one?

Figure 5. 6: Recurrence Plot of Dr 2 (Gynaecologist/ PAT 2)

In this plot between Dr 2 and PAT 2, Dr 2 verbally dominates throughout the interaction. However, there is a medium level of engagement episodes from the patient. This level of engagement is established with high levels of blue squares representing the doctor's interaction on the plot and fewer red squares showing patients' utterances. On the legend plot, the level of dominance is demonstrated clearly, as shown above, with Dr 2 being on top of PAT 2. There are instances where the plots lack engagement between the doctor and patient (utterances 6 – 17). Here, there is an interactional run-on from Dr 2 shown in all the deep blue squares and the repeated light blue concepts, all stressing the level of doctor dominance. Yet, it is observed that most of the concepts used are captured in *ni, use, year.*

Again, at the end of the diagonal plot, there is an indication of a blue utterance square emphasising a summary of earlier conversations by the doctor. However, at this point in the time of the interaction, there is only one off-diagonal plot, with the entire space being blank. This is suggestive of no more concepts from both participants. In this plot, Discursis reveals utterances 1-100 of a total of 128 utterances explored.

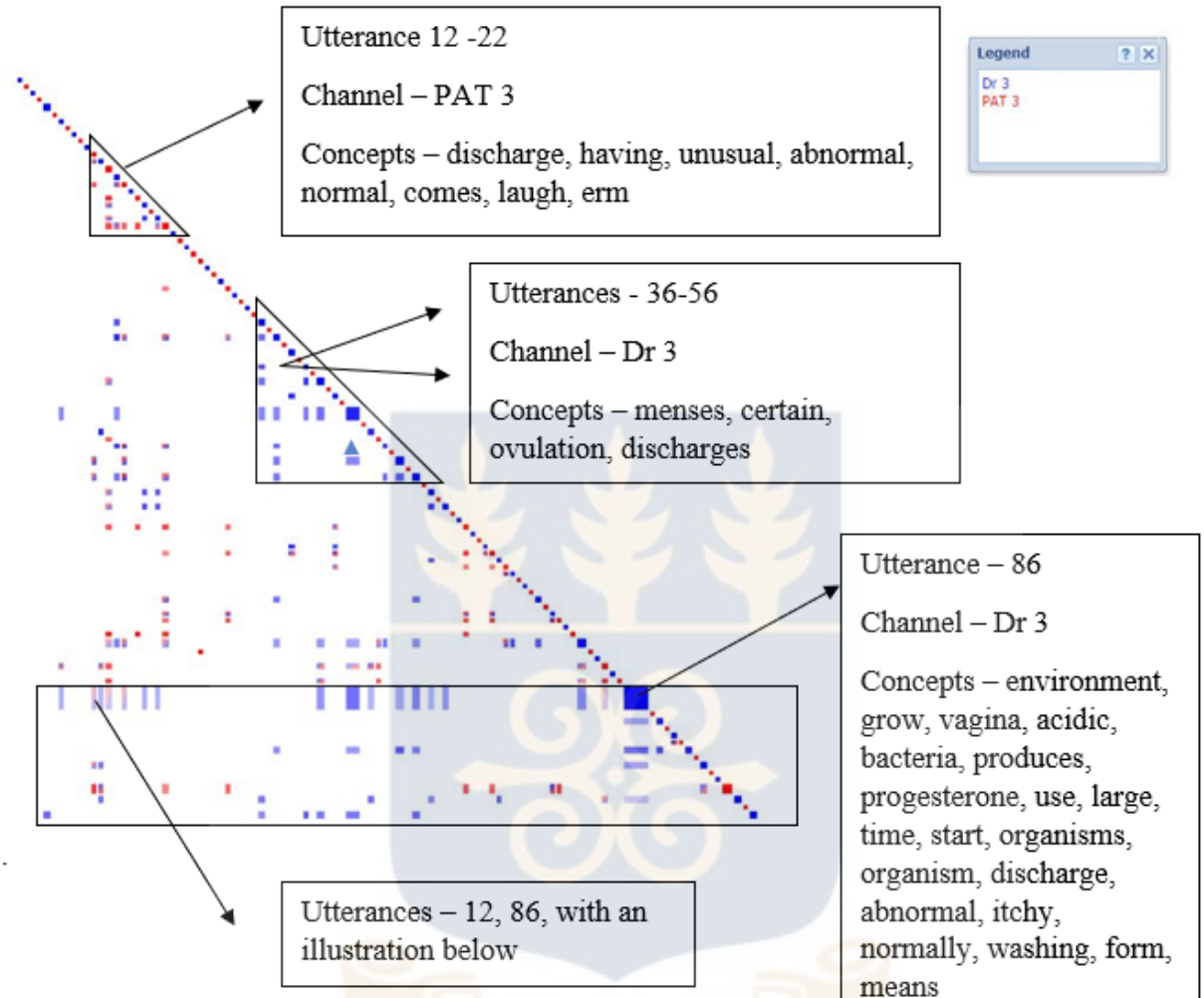

Figure 5. 7: Recurrence Plot of Dr 3 / PAT 3

Sample Text Selected from Figure 5.7

Utterances 12, 86 (PAT 3, Dr 3)
Similarity - 0.056

Similar Concepts discharge
Utterance 12 Text
[[I have been having unusual discharge]]

Utterance 86 Text

{Laughs as well}. Normally, the organism exists in a form that you would not see, and they do not cause any problem. They are sitting there somewhere, minding their own business. Good! The reason is that the vaginal environment is very acidic, so it restricts the abnormal growth of these organisms. Because the only time you will experience them is when they grow into a large colony, and you start seeing the discharge sometimes itchy. Do you understand? It means that they are growing abnormally. So, anything that will change the hostile environment of the vagina will allow them to grow. Do you understand? So, anything that will neutralize the acidic, vaginal environment will allow them to grow. And that acidic vaginal environment is produced by very useful bacteria in the vagina. So, prolong use of antibiotics for whichever reason can kill the useful bacteria that produce the acid and therefore, alter the environment and then, allow them to grow and 2. Women who like washing their vagina unnecessarily.

Figure 5.7: Recurrence Plot (Dr 3/PAT 3)

In this plot, Dr 3 also dominates the interactive verbal activity with a minimal or low level of engagement from the patient. The patient is observed to respond in *Hmm, yes, no* (utterances 1-11). However, utterances 12-22 are noted with more patient engagement. There are instances of self-repeated concepts from the doctor (utterances 36-48), which are also represented with blue shaded boxes. This level of engagement is established with high levels of deep blue squares representing the doctor's interaction on the plot and fewer red squares showing patients fewer utterances, especially with the use of sentence fillers. On the legend plot, the level of dominance is demonstrated clearly, as shown above, with Dr 3 positioned at an initial position. At the end of the diagonal plot, there is an indication of a large utterance deep blue square at the end of the plot indicating repetitions of earlier conversations by Dr 3 on a plot revealing utterances 1-100 from a total of 240 utterances.

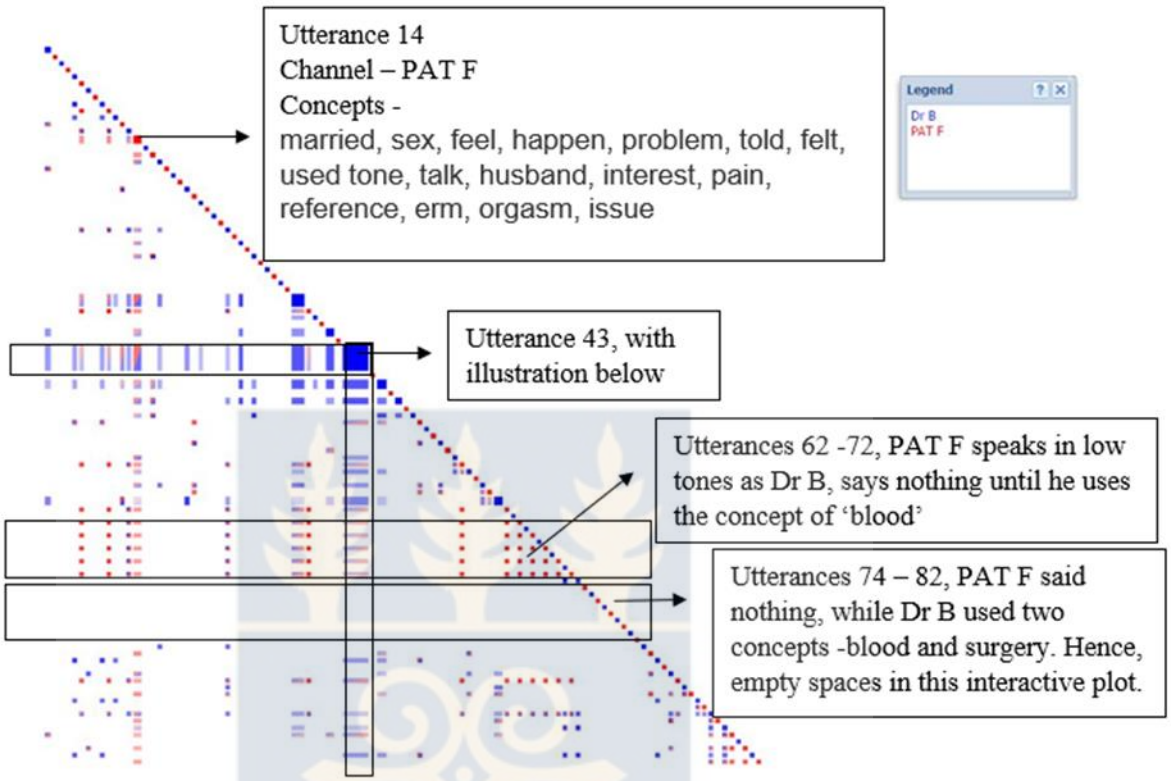

Figure 5. 8: Recurrence Plot of Dr B / PAT F

Sample Text Selected from Figure 5.8

Utterance 43 (Dr B)
But our society does not allow people to talk about it freely, so they do not get help. So, they suffer quietly. But you are not supposed to be just enduring it because when you do that the relationship is not sweet, is not sweet, so, you just do it to make him happy, everyone is just there. It is a fulfilment to make sure [Dr B BREAKS BRIEFLY TO ADDRESS ANOTHER THING] Aha, wo y3 wei no wo tua y3? fr3 wo kunu no bisa no, wo te tis3 koliko. So, I will suspend my discussion because there are interested parties who are not ... they, they are benefiting from the discussion. They are trying to benefit her came ooo hmmm and you koraa it doesn't look like you are ready to talk about it. That is why I wanted to suspend it. Give brief information, suspend. She goes to analyze what I have told her and then when we meet again, I give more. Hopefully, with her partner. So, all that I am trying to say is that you must understand that it is a problem. Of course, there is no way that problem could have been solved whiles you were not married. Because you were not in any sexual relationship. Even if you have thought of something, you cannot practice it, and the commitment of the male partner was not there. If you ask this man and you ask a hundred men, they will tell you when they are dating or getting a girlfriend and they are trying to sleep with the girl, they do not know when the girl will agree. The day the girl agrees, there is no time o because if you waste the time the girl will change his mind, her

mind [LAUGHTER IN THE ROOM]. When you agree noo kpam! Because if you waste time, [LAUGHTER] meanwhile if it is your wife, you can take your time but if it is your girlfriend, what if you waste the time and she says she is no longer interested. If you try and they will say you have raped her. Do you understand me? And no man will be patient with you to take you through it unless you are married. In a marital setting, first, the man needs to know that it is in his interest for you to be sought fully [LOW TONE/UNCLEAR] and the solution is not for you but the both of you. So, if a man knows that this is something that if I participate in, it will work well for all of us to have, to enjoy, then, the understanding is different. There is not so much you alone can do. It is something that even if one person has a problem, we need to treat the two. Do you understand? Because for instance, if the problem is just the desire, then you do not ever get the desire because if you do not have the desire, it is difficult to switch you on. If you are not switched on, everything else that follows is just there, you are not interested. If you are switched on, it moves from your mind to become a physiological something, changes the heartbeat [UNCLEAR] and the whole body which you can no longer control. So, at that point, you are in for it, and you will enjoy it. Are you getting it? So, if you are switched on, it is a very different thing. And the critical sex is how to get the desire, how to be switched on. As for orgasm issues the management are there. But there are people, it is possible you do not have any problem with orgasm because the first two steps are not working. Do you understand?

Concepts:
interested, orgasm, problem, unclear, man, switched, trying, longer, agree, laughter, time, mind, understand, talk, girl, take, people, married, sex,
desire, partner, different, sure, dr, tone, tell, interest, look, needs, does, solution, bleed, da y, work, told, happy, change, freely, go, tubes, sexual
Metadata *Name*: Dr B

Figure 5. 8: Recurrence Plot (Dr B / PAT F)

In this recurrence plot, Dr B also verbally dominates throughout the interaction from utterances 38 to 43. Surprisingly, PAT F dominates from the beginning of the episode to utterance 14, and this is observed from the horizontal stripes extending from right to left on the plot to indicate a summary of the concepts by PAT F. In the legend plot, the level of dominance is demonstrated clearly as shown above with Dr B leading the engagement. However, it is observed that most of the concepts from PAT F revolved around low - tones, no concepts, and in a few instances, some expressed concepts as in utterance 14. At the end of the diagonal plot, there is no indication of a large utterance square at the end. Furthermore, the off-diagonal plots are suggestive of moderate

level doctor-patient engagement. However, there is a continuously high-level of engagement as if conversations were just beginning – This pattern is non-existent at the initial phase of the interactions (Utterances 1-5). Figure 5. 8 reveals utterances 1-100 from a total of 158 explored.

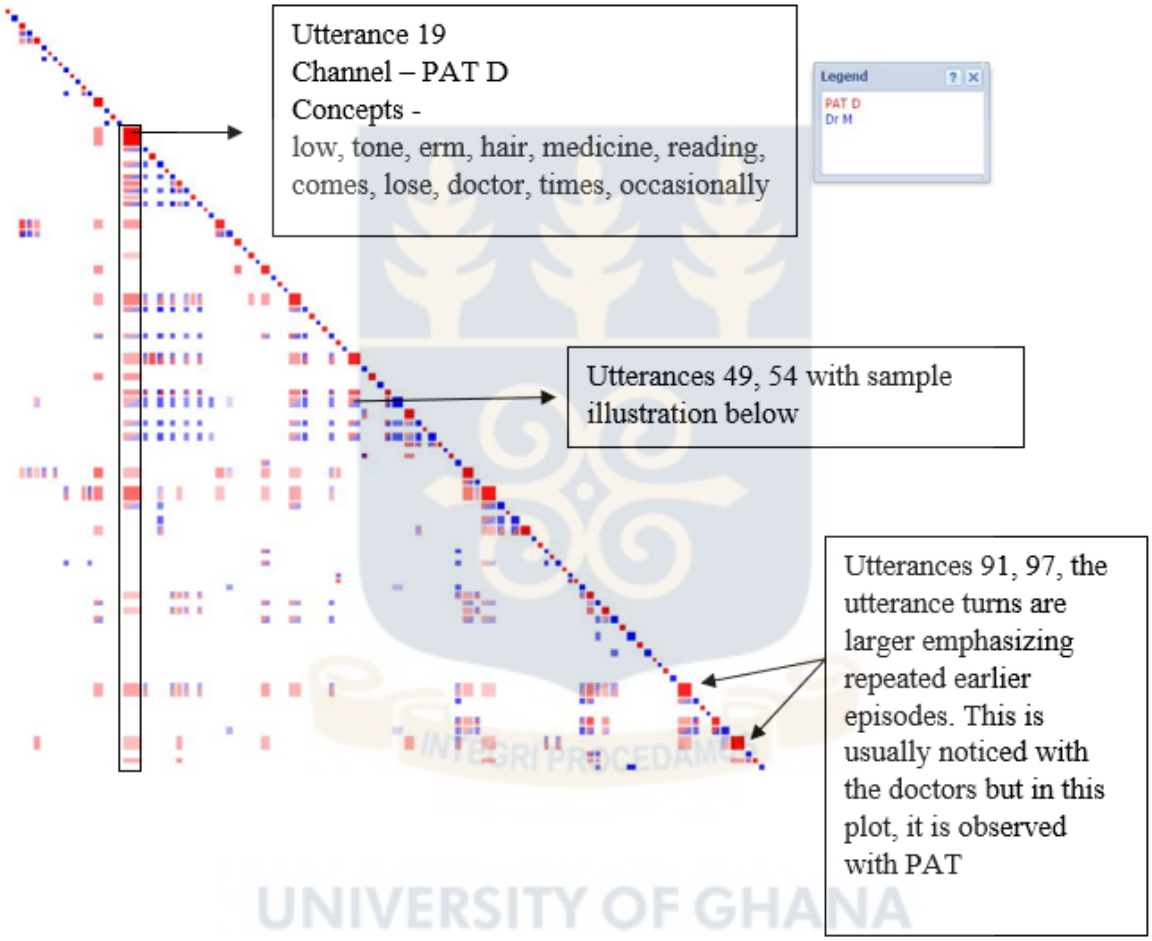

Figure 5. 9: Recurrence Plot of PAT D / Dr M

Sample Text Selected from Figure 5. 9

Utterances 49, 54 (PAT D, Dr M)
Similarity - 0.425

Similar Concepts hair
Utterance 49 Text
I cannot tell now because it is all grown now. It can be, yeah, it can be any part, yes! Yes, it just falls out like it is, the place becomes … Yeah, bald, no hair at all.

Utterance 54 Text
Mm mm, then what else? That one I have never heard of is that polycystic ovarian syndrome (PCOS) gives you hair loss. It rather causes excessive hair growth.

Figure 5. 9: Recurrence Plot (PAT D/Dr M)

The recurrence plot on Dr M and PAT D reverses the order of dominancy seen so far. In this plot, PAT D is observed to verbally dominate throughout the interaction with medium-high level engagement with Dr M. This level of engagement is established with high levels of red squares from PAT D and less level of blue squares from Dr M. On the legend plot, the level of dominance is demonstrated clearly, as shown above with PAT D being listed first on the legend.

The initial interactions between the doctor and patient are less engaging with self-repeated concepts from PAT D. Nevertheless, it is observed that some of the concepts from PAT D were self-repeated, but in all, PAT D had about 14 big red squares serving as a summary to all her earlier discussions. At the end of the diagonal plot, there is an indication of two large red utterance squares despite the continuous engagement.

This plot is an interesting one based on how the patient leads. However, the final interactive box, which normally appears in blue as an instance of doctors' final submissions and repetitions, interestingly, in this plot, there is a reversal where it appears red suggestive of patient (PAT D) dominance. Discursis reveals utterances 1-100 from a total of 209 explored utterances.

In Table 5. 2, Discursis identifies the pseudonym of doctors and patients and the number of total utterances that they employed in their encounters. Table 5. 2 further establishes the male doctors and their patients as using lots of utterances during their interactions as compared to the female doctors and their patients.

Again, the lowest scores on utterances used were found between the female doctors and their patients in Table 5. 2. Significantly, in all the seven recurrence plots, Discursis aided in establishing six low-medium level interactional engagements but one low-level engagement. These conversations are defined as multiple episodes of two – colour off-diagonal blocks illustrating interactional variety and contrasts. In addition, whereas six of the interactions exhibited doctor dominance, one recurrence plot demonstrated patient dominance; hence, dominance as a feature of CAT is indicative of doctor interactions rather than the patients. Table 5. 2 summarizes the levels of doctor-patient interactions on the recurrence plots.

Table 5. 2: Number of Utterances used between the Gynaecologists and the Patients in their Interactive Engagements using Discursis.

Name of Folder	Number of Utterances	Level of Engagement
1. Excel sheet Dr F/PAT C	166	Medium-High [Gynae Dominance]
2. Excel sheet Dr F1/PAT E	109	Low [Gynae Dominance]
3. Excel sheet Dr 1/PAT 6	139	Medium-High [Gynae Dominance]
4. Excel sheet Dr 2/PAT 2	128	Medium-High [Gynae Dominance]
5. Excel sheet Dr 3/PAT 3	240	Medium-High [Gynae Dominance]
6. Excel sheet Dr B/PAT F	158	Medium-High [Gynae Dominance]
7. Excel sheet Dr M/PAT D	209	Medium-High [Patient Dominance]

5. 4. 2 CAT Strategies Observed in the Interactions using Discursis

In this chapter, Watson and Galloise's argument becomes focal. This argument places much emphasis on the needed understanding of the significance of the bi-directional relationship between the patient and the doctor during their interactions (Watson & Gallois, 1998). These levels of interactions have their shortfalls, hence the need to pursue an in-depth analysis with a focus on CAT strategies practised between the doctors and patients and how it impacts the interactive

dynamics observed. The doctor-patient interactions show a predominantly medium-level engagement confirming levels of approximation, interpretability, and interpersonal control as against the realisation of discourse management where the doctors had several sentences against the few terse responses from patients. However, a few emotional expressions such as *mmm*, hmmm, or none [no-response] were captured on the plots.

The use of conceptual similarity among the participants is identified with the representation of multiple clusters of off-diagonal boxes in the episodes of engagement. Five of the plots identified the use of medical jargon in doctor explanation, interrogation, explanations, and statements during the history-taking phases of interactions. Nevertheless, one plot confirmed low-level engagement suggestive of a high-level doctor dominance such that the patient had limited time to deeply reflect on the medical information (Angus et al., 2012).

5.4 Results and Discussion on CAT Strategies Using Discursis

In a society such as Ghana which is predominantly patriarchal, the expectations of the predominant female patient participation are carefully managed by the predominant male doctors. Underlyingly, the perceived societal differences in the hierarchy between patients and doctors are normalised, where female patients irrespective of their knowledge or level of education are naturally perceived to engage interactively in a subordinating position. The participants in most of the situations used more sentence fillers and offered fewer responses encouraging doctor dominance. Despite doctor dominance, patients communicated high satisfaction levels during treatment (refer to *section 6. 6* of the study). In this study, the heteronormative genders or same-sex genders between the doctors and the patients during the interactions as established, did not influence the nature of patient

responses. As a result, the female patients described their level of satisfaction no matter the gender or ethnic background of the doctor.

Distinctly, patients communicated emotionally through laughter or by adopting a no–response approach. In instances where patients have conditions that they perceive to be sensitive or embarrassing, they tend to communicate better with doctors of the same gender (Siu, 2015), and this information correlates with studies on females from non-Western societies having a stronger preference for consulting with female doctors on sensitive topics (McLean et al., 2012; Rizk et al., 2005). Contrastingly, the communication patterns of the patients observed during gynaecological care had little or no information, allowing the doctors, whether female or male, to dominate. The data presented disagreed with studies suggesting that patients are less likely to provide the required information or ask questions during healthcare encounters due to their poor socioeconomic status (Hellin, 2002; Pilnick & Dingwall, 2011). Nonetheless, in this study, patients were all literate, yet at all levels, their feedback in the interactions was minimal. This practice confirmed gaps in the visualisation plots represented in plain white spaces within the episodes of doctor-patient engagements.

5.5 Conclusion

The Discursis software was an efficient qualitative tool that augmented qualitative analysis of gynaecological-patient interactions. The use of the software visualised the conversational patterns unique to each interactive plot, the level of doctor-patient engagement levels and, therefore, the CAT strategies employed. These plots enhanced the identification of distinct patterns occurring within the doctor-patient exchanges. Six medium-level doctor-patient engagements featured the representation of a few off-diagonal squares, whereas the alternating single-coloured squares were

suggestive of low doctor-patient engagement. The engagement levels reflected CAT strategies especially in approximation and interpretability, which is suggestive of the intimate nature of discussions that ensued and, therefore, the practice of interpersonal control from the perspective of doctors. The data obtained revealed that in six out of the seven interactive plots, the gynaecologists dominated the interactions, whereas, in only one plot, the patient (PAT D) dominated.

In general, doctors tend to dominate conversations as represented in the larger blue square boxes on the diagonal plots whereas *none* established as no-response on the plot was featured more within patients' turn-taking. This attitude is critical and, thus, requires attention as the diverse patients and gynaecologists in terms of culture and language established variability and hence, the need for effective communication that balances the doctor-patient relationship. Paternalism appeared to be the de facto model of communication embraced by patients.

CHAPTER SIX

PERCEPTIONS OF DOCTORS AND PATIENTS ON THE GYNAECOLOGICAL ENCOUNTER

6.0 Chapter Overview

This chapter examines the responses collated from the semi-structured interviews granted by seven doctors and ten patients selected from the Obstetrics and Gynaecological (OB-GYN) units at the two medical sites. By employing a non-probability purposive sampling technique, a diverse sample of doctors and patients were recruited based on factors such as age, professional practice, ethnic background, and level of education. Responses from the individual semi-structured interviews include the language preference, nature of the doctor-patient relationship, the influence of socio-demographic factors such as age, gender, and ethnicity on the interactions within culturally restricted areas, and how they correlate with doctor-patient satisfaction/dissatisfaction. All the responses collected with an iterative qualitative data design were coded and examined thematically using NVivo. The discussions focused on the doctors' semi-structured interviews, the patients' semi-structured interviews, and the data derived via participant observations. These data sources were triangulated in this chapter.

6.1 Results and Discussions

6.1.1 Choice of Language During Gynaecological Care

Given that this dissertation is based on English, it was ensured that participants who were engaged in the study could communicate in English without prejudice to their ability to communicate in other languages. This was done to ensure the ease of conducting interviews and transcribing audio-recorded data. However, this requirement was only necessitated during interviews after doctor-

patient interactions to help avoid any influence on the choice of language during the doctor-patient interactions. During all doctor-patient interactions, English was the dominant language used in both health facilities. Nonetheless, there was significant use of a local language, particularly Akan (Twi), often in addition to English during consultations. Interactions in the local languages seemed to frequently occur between doctors and returning patients, particularly those who appeared to be familiar with their doctors. Under this scenario, the use of a local language during interactions was sometimes prolonged and dominant, often involving code-switching with English. The co-existence between English and a local language is further reiterated in a study where English and Chichewa (a national language in Malawi) were observed to function together during gynaecological consultations in a Chichewa-speaking hospital in Malawi (Kajombo, 2021).

Ghana's multi-cultural nature is reflected in the multiplicity of languages, with about 80 local languages and dialects being spoken in the country (Obeng, 1997; "The Languages of Ghana," 1988). However, English is the official language and a second language for most inhabitants. Given the multiplicity of languages, English is the lingua franca in cosmopolitan settings, as occurs in Accra, the capital city of Ghana. In addition, English serves as the main medium of expression throughout primary, secondary, and tertiary education in Ghana, including medical education (Anyidoho & Dakubu, 2008).

In interviews conducted within the two health facilities (Korle-Bu Teaching Hospital and the University Health Services), it was established that most of the participants spoke at least one indigenous language, in addition to English. These indigenous languages include Akan and other dialects such as Buem, Ewe, Ga, Krobo, and Nzema (Table 1). However, the preference for English during the doctor-patient gynaecological encounters was undeniable. This occurred even in cases when a doctor and a patient shared a common ethnic background and local language. It was

observed that patients' preference and comfort with English was associated with their level of education. This view, widely held by Ghanaian society, may sometimes influence the choice of English even when a patient appears to have low proficiency. The choice of English is usually borne out of a patient's desire to "belong" or be seen as "educated". In contrast to traditional medical settings, patients primarily consider the hospital a formal professional setting with English as the primary medium of exchange. As such, patients with low proficiency in English attempt to use English in their interactions with doctors. Another considerable influence on patients' choice of English appears to be the general inconvenience associated with a lack of English proficiency during gynaecological visits. This often restricts the number of doctors available to a particular patient and may contribute to extensive waiting periods for patients.

Interestingly, patients' choice and preference for English are also influenced by the relatively easier expression of gynaecological terms than in the native languages. Given the stringent control of sexual utterances in traditional communities, tangible expressions of sex and sexual organs primarily occur during formal education in English for most individuals. Consequently, patients often show greater comfort and ease in communicating sexual health-related matters in English compared to a native language, even when proficient in both.

The initial verbal exchanges between a doctor and a patient are crucial in determining how the interaction will unfold (Manning & Ray, 2002). The interactions begin with a doctor welcoming a patient and asking about the reason for the visit. In all cases, greetings occur in English. The welcoming of patients using English is seen as polite and professional. Moreover, doctors do this because English is perhaps the only language in which the doctor is confident of a patient's response, as the patient may not understand the doctor's choice of a local language. Following

greetings, a doctor may then discern a patient's knowledge and level of comfort with English and consequently proceed or change the language of interaction to one of mutual understanding.

Given that the diagnosis and the management of the patient's health condition primarily rely on the patient's narration of her health challenges, the language used is crucial. In most cases, the doctor attempts a summary of the patient's account with the help of follow-up questions to better understand the patient's health challenge (Ashton et al., 2003). Through this interaction, trust is built between doctor and patient as they work together in a common language to address the health challenge (s) discussed (vom Lehn, 2006).

It was observed that doctors also employed a local language to make patients feel comfortable. This is because, culturally, using a native language between two or more persons promotes a level of personal relationship or familiarity, particularly in professional settings (Aelbrecht et al., 2019). A doctor's decision to continue code-switching between English and a native language is based mainly on a patient's response to the languages being used. For instance, a patient responding to a doctor's query in English by using a native language or English with some native words implies her comfort with the local language and with the conversation.

Given that not all patients have a proficient level of comfort with English, the choice of native language to use is a crucial decision for doctors. Often, rather than ask which language patients may prefer to use (as this is often seen as impolite), doctors rely on patients to make this request. Without this, doctors tend to use Akan (Twi), the most common native language in Ghana, spoken by most inhabitants across many ethnic groups (Obeng, 1997; Press, 2017; Sadat & Kuwornu, 2017). Nonetheless, the name of the patient is a good indication for doctors to deduce the likely native language based on ethnic origin. Based on responses from interviewees, the native languages of participants included Twi, Ga, Ewe, Buem, Krobo, Nzema, Dagaare, Sehwi, Siwu,

and Igbo. In general, the participants (doctors) appeared to show higher competency and proficiency in a greater number of native languages as compared to patients.

Based on responses obtained, 30% of patients interviewed preferred using only English as the medium for engagement with their gynaecologist. Another 30% of patients preferred using a combination of English and a local language, commonly Twi, while 40% were open to either option of English only or English in combination with a local language. Table 6. 1 summarizes the self-assessment of participants regarding their communicative competencies in their mother tongues, other local languages, and English. In the 35 doctor-patient audio-recorded communication encounters, English was the most predominant language used compared to the local languages available within the context and emerged as the preferred language for consultation from the perspectives of both doctors and patients.

Table 6. 1: Common Languages Used and Proficiency

Doctors	L1	Other Language (s)	Read & Write (R/W) Local	Read & Write (R/W) L2/L3
1. Dr 1	Ewe	Twi [* Broken]	Ewe	English
2. Dr 2	[10]Twi [As.]	Twi [Ak.]	Twi [As./Ak.]	English/German
3. Dr 3	Twi [As.]	ϕ	Twi [As.]	English
4. Dr B	Dagaare	Ga/Twi /Krobo	Ga / Twi	English
5. Dr F	Igbo	ϕ	Igbo	English
6. Dr F1	Siwu	Hausa/Twi[*Broken]	Siwu	English
7. Dr M	Sehwi	Twi [As./Mf.]	Sehwi/Twi [As./Mf.]	English
Patients				
1. UGHS 5	Ga	Twi [As.]	Ga	English
2. UGHS 10	Buem	Ewe/Twi [As.]	Twi [As.]	English
3. UGHS 3	Twi [As.]	Twi [Mf.]	ϕ	English
4. UGHS 4	Twi [As.]	Twi [Ak.]	ϕ	English

[10] The use of Twi comprises all the Akan languages used. However, the specific Twi language is abbreviated or written in full to represent the type of Twi being discussed. Hence, Asante Twi becomes [As.], Akuapem Twi is represented as [Ak.] and Mfante becomes [Mf.]

5. UGHS 8	Ewe	Twi [Mf.]	ϕ	English
6. GPA 7	Krobo	Ewe/Ga/French	Twi [As.]	English
7. GPA10	Twi [As.]	Ga	Twi [As.]	English
8. GPA 9	Ga	Twi [As.]	ϕ	English
9. GPA 4	Twi [Mf.]	Nzema	Twi [Mf.]	English
10. GPA 6	Ewe	Twi [As.]/Ga	ϕ	English

∗ - Below Average; ϕ - Null Language Representation/Not Applicable

Based on responses from participants, it was evident that patients and doctors preferred using English as the primary medium of communication except when a local language may elicit a greater understanding of the ideas being expressed. For well-educated patients, English was the preferred language, irrespective of proficiency in a local language. In ascertaining the choice of the most appropriate language (s) which will enable patients to feel relaxed, expressive, and satisfied with their medical consultation, some patient responses were as follows:

> PAT. GP7a: *The language, it should be two, Twi or English because, at times, you come and if you are not highly educated you can express yourself in the Twi and the doctor must know how to speak Twi too, so that with the English and then the Twi, it will be good (P SS-I 2018/2019).*

> PAT. GPA6 *"he started speaking Twi to me, and I told him that I will be more comfortable speaking English with him" (P SS-I 2018/2019).*

In general, patients' preference for English or English in combination with a local language was associated with a higher level of literacy and proficiency. In contrast, the greater use of local language was associated with lower education and, thus, the expression of discomfort regarding patients who are competent in only a local language. During doctor-patient encounters, it was realised that, while patients may have varied ethnic backgrounds and local languages, Akan (Twi)

was predominant across diverse ethnic identities. This may be due to the dominancy of the Akan (Twi) language and its common use as lingua franca in many communities in Ghana. Consequently, where English was a barrier, patients tended to speak Akan (Twi) as the most likely language option that the doctor may understand. This somewhat "default" local language choice occurred even in patients with low proficiency in Akan (Twi) and difficulty in articulating some of the Twi terminologies.

Ironically, it was observed that, while patients aim to speak in English, a language they tend to associate with the medical practice, doctors, in turn, seek to speak in a local language where possible to aid in patients' understanding. Notably, doctors were the first to introduce a native language in medical conversation in almost all cases. In consequence, the choice of language by doctors, who in most cases begin the medical encounter is primarily based on their perception of the level of education and comfort of the patient with English or a local language. Thus, according to doctors, a patient's response and demeanour serve as the main determinants in the choice of the language (s) used during these interactions. As such, given adequate proficiency in a particular language (s), a doctor may alternate between English and a local language (s) to assess a patient's level of comfort and language preference and therefore maintain the language preference during the interactions.

> Dr 3: *Well, it depends on which one the patient is comfortable with…. When they come in and you test the waters and they are comfortable with the local language Akan (Twi), you go on, but while at it, you can always chip in the English. Sometimes when you bring in the*

English, and you realize that they are not comfortable with the English, you can then change ([11]D SS-I 2018/2019).

Dr B: *English, Twi, and Ga, but English is rated high because I was trained in that. So, when the patient speaks that one, it is very easy for me to get the information that I want without having to interpret [it]. However, if they speak a Ghanaian language, then the challenge comes, interpretation comes with a lot of challenges.*

Since doctors are trained in English (Lodhi et al., 2018) and may easier express medical terms, including sickness, body organs, and health conditions, in English, doctors tend to prefer English. At the same time, the overall aim of the medical practice is to diagnose, treat and manage ailments of patients (Roter & Hall, 1989). Communication between the doctor and the patient is key in this regard, and the choice of language is crucial in ensuring understanding between the two (Farzadnia & Giles, 2015). As such, doctors tend to communicate in local languages with patients. Where possible, they use easy-to-understand English words to facilitate the communication process and ensure successful diagnosis and treatment. Hence, while doctors tend to communicate in English a lot more than in the local languages, English is employed only when the patient shows adequate proficiency in the language.

During doctor-patient interactions, doctors type into a computer or handwrite patients' history, conditions, diagnosis, and treatment in English. Similarly, almost all inscriptions within the hospitals visited were in English. It was rare to read medical inscriptions in any of the existing local languages. This may have been since most persons who are unable to read English are also

[11] D SS-I 2018/2019 – Doctors Semi-Structured Interview – (2018/2019 data)

unable to read the local languages. Instead, public education in this format is focused on pictures and diagrams to convey the message(s) intended for the public.

Apart from the use of the English language, doctors acknowledged the use of other languages, including Akan (Twi), Ga, and Ewe particularly for patients who were more comfortable in their use. This information correlates well with the results on language use and its proficiency by doctors and patients (Table 6. 1). The choice and use of language are largely controlled by doctors based on their perception of the patients' language preference and comfort. Often, this preference is not uttered by, but discerned by the doctors based on their experience through their interactions with patients.

Moreover, during the participant observation, it was noticed that, before a patient enters the consulting room, the doctor quickly reviews the socio-demographic data, including age, ethnicity, and educational level on the medical record either online or archived in hard copy. This background information helps to point doctors in the direction of a more appropriate choice of language. More often, English is the starting language and is commonly used during greetings and welcoming of patients. Based on a combination of the patient's response to the initial greetings and sometimes information on the educational background of patients, English or an appropriate local language may emerge. In most cases, the language used may involve a combination of English and a local language, often through code-switching. Where a patient's proficiency in English is low, a patient may respond to a doctor's request in her preferred local language. Under these circumstances, a doctor may switch to the patient's preferred local language where possible, ask for an interpreter, usually a health worker conversant in the functional local language or request the patient to consult with a doctor who is proficient in the patient's language.

For most patients, English, in combination with a local language, is a preferred means of medical communication, a situation also established in (Kajombo, 2021). Nonetheless, some doctors viewed Akan (Twi) and other local languages as inadequate in meeting the detailed language requirements for explaining some conditions. Often, this inadequacy was partly because of the doctor's lack of proficiency in the local language. Notably, the cultural restrictions of communication on sexual parts and conditions influenced the difficulty of communication using local languages by both doctors and patients as they often struggled to find appropriate words to clearly express their intentions, particularly related to Gynaecology.

> Dr 2: *The interesting thing is that [Akan]Twi is not detailed, but it is adequate. For instance, Twi does not have parts of the vagina, or the female reproductive organ is not detailed. So, a woman will say "mase" [Twi term which literary means 'my under']. "Mase" is inadequate for the vagina. But in English, I have had some University students come and point to me details about the vulva, the vagina inside, the clitoris and all that ... (D SS-I 2018/2019).*

> Dr B: *English will aid it [interactions] because we have euphemisms. You can even use for what appears to be called culturally very sensitive to say, but if you take it to any of the local languages, it is difficult to find euphemisms for some of the things. And to do that you may pick up information that is not exactly what it is. So, English is easy because it is direct. You can get the medical information directly. So, when you are dealing with overly sensitive issues, you can use words that you know that the person also understands (D SS-I 2018/2019).*

The extracts above reinforce the importance of English, at least when used together with a local language in communication with patients. While English appears to facilitate the ease of

communication for most doctors, it does not necessarily improve the ease of understanding by patients. To overcome this, doctors were observed to first communicate in English using fairly as many non-technical terms as possible and subsequently restate their communication in a local language or using common English expressions that patients may better understand. In some cases, this resulted in oversimplification of the issues being discussed.

> Dr F1: **S***ince most female issues are a bit sensitive, yes, obviously if we are not able to communicate in the language that the person speaks, it may inhibit some of the information (D SS-I 2018/2019).*

For almost all patients, a clear understanding of their condition appeared to be more important irrespective of how simplified it may be presented. This understanding also helped in better communication as patients tend to ask more questions related to the condition once they appreciate the medical challenge being clearly expressed (Birhanu et al., 2010; S. D. Moore et al., 2009).

It was also observed that some patients were quick to suggest their understanding of the medical situation, largely out of reverence and trust for the doctor and in a bid to facilitate treatment decision-making by the doctor. This sometimes occurred in situations where it became apparent that a patient's clear understanding of the situation may be lacking.

6.2 Ethnicity and Doctor-Patient Communication

The role of ethnicity is closely related to the indigenous language (s) of the patient and the doctor. As such, ethnicity appeared to have a low influence on a doctor's preference or the communication relationship. Instead, language appeared to be the main factor of concern. The apparent lack of influence is also explained by the fact that patients and doctors may speak several languages

outside of their ethnic language. For all patients interviewed, the ethnic background of a doctor was not important in the choice of a doctor or the nature and level of communication relationship.

PAT. GPA4: ... *no! ... I do not even ask ...*

PAT. GPA6: ... *no! For me it is expertise ...*

PAT. GYN8: *It does not matter. It depends on you and the doctor, how you can understand each other.*

Although similar ethnic backgrounds could strengthen the nature of the therapeutic relationship (Deumert, 2010; Granek et al., 2020) due to common beliefs, norms, and practices, or at least the understanding of such patients viewed ethnicity as less important in this study as also confirmed by (Aelbrecht et al., 2019). This view may also reflect the largely biomedical focus of care and less focus on social factors. As a result, patients relied on doctors' expertise and a common language of understanding. The responses may also point to the role of a largely "elite" group of participants due to the focus on English language-mediated communication. Under such circumstances, patients seeking care are less reliant on a doctor's ethnicity/local language. In contrast, doctors viewed a common ethnic background/language as vital in influencing the level of communication and the doctor-patient relationship.

Dr 2: *They [patients] are better, and they open more about their problem in the local language. For instance, in talking about their menses, when you ask questions in the local language, they can express how they feel in terms of pain, the extent of pain ... (D-SS-I 2018/2019).*

In many doctor-patient interactions, it was observed that patients contributed better when doctors employed a local language in addition to English. This appeared to help patients to relax as they

actively engaged with doctors during the interactions. This code-switching behaviour was emphasized in the audio-recorded data of patient-doctor interactions (Kajombo, 2021). In thirty (30) out of the 35 doctor-patient interactions, code-switching of English and a local language (commonly Twi) occurred (Refer to Table 4. 1). In rare instances where there was no common language between a doctor and a patient, they resorted to available non-professional language interpreters, who were usually hospital staff, family members, or other patients. Considering the nature of the communication taking place during gynaecological interactions, the presence of a "third person" playing the role of an interpreter may be quite unnerving. As such, this occurrence, although rare, commonly occurs in cases where a patient is experiencing severe disease conditions. In addition, the use of an interpreter prolongs the consultation sections and may also result in miscommunication (Hamilton et al., 2021; Wolz, 2015).

Dr F: *It makes the work longer (D SS-I 2018/2019)*

Dr M: *Some of them may hear what the patient has said, and then interpret it their way (D SS-I 2018/2019)*.

6.3 Doctor-Patient Communication Relationship

Studies show that the patient healing process does not only rely on biomedicine, but also depends on the level of relatability with their doctor (Hesse & Rauscher, 2019). In general, patient satisfaction with their medical encounter largely depends on their level of interaction and communication relationship with their doctor (Dibbelt et al., 2009; Matusitz & Spear, 2014). In this study, all patients expressed having a cordial, secure, open, or satisfying relationship with their doctors. These responses may, however, have been influenced by the fact that most respondents were returning patients having visited the facility or their doctors at least on one previous occasion.

Nonetheless, for most respondents, the gynaecological encounter provided a secure platform and opportunity to talk about their sexuality, sex, and related health challenges without shyness or discomfort. Respondents expressed a feeling of empowerment due to the interactive freedom given to them. Notably, to some, the gynaecological encounter represents an avenue for expressions of sex and sexuality rather than a barrier to sexual expression. Nonetheless, this view was greatly helped by empathetic communication (Ha & Longnecker, 2010) by doctors, which represents a significant and definitive factor in the views of patients on the therapeutic relationship with doctors.

> PAT. GPA4: *Oh, it is perfect! As for Dr X, I have a cordial relationship with him… I can ask him any question if I do not understand anything about my issue. I can even chat with him, and he will explain it to me. So, I have a [good] relationship with him (P SS-I 2018/2019).*

> PAT. GYN5: *Oh, I am extremely comfortable here. I am happy… because I am given my full rights as a client. Sometimes I feel I even get too much… I am not shy in the consulting room because I feel this is the only place I can be that open, saying anything, passing judgement. [when] you come, the doctor even remembers what you talked about the last time, recommendations he gave, and all. It makes you feel special (P SS-I 2018/2019).*

Also, evident from the responses of patients was the level of trust in the competency of doctors. Research on patients with systemic lupus erythematosus established that trust exhibited by both doctors and patients enhanced higher satisfaction (Bennett et al., 2011). Perhaps by the two medical facilities chosen, one a referral facility and the other representing a hospital owned, and manned by the country's premier University, almost all patients considered the doctors in both facilities as among the most competent, trustworthy, and experienced in the country. This helped

in promoting trust and cordial doctor-patient relations. On the other hand, the trust and confidence in doctors' abilities and competence inhibited doctor-patient interactions through patients' unwillingness to contribute to promote paternalistic healthcare behaviour. From the perspective of doctors, the role and feedback from patients are crucial in promoting the doctor-patient communication relationship. While patients are the direct recipients of the medical service, the success of the communication relationship is at least partly based on their role.

> Dr 2: *Essentially, they [patients] are the recipient of my service. But then I noticed that with the feedback they give, they let you have more insights. They also educate us indirectly (D SS-I 2018/2019).*

> Dr B: *The consultation is about them [patients]. It is we [doctors] who are there to solve their problems. We are there to listen and find out what their issue is. So, their role is as critical as anything else because without them, then, there is no consultation. So, how to be able to get them to express what exactly they feel, and for you to be able to also, understand it, for you to also document it for other purposes is always the issue … (D SS-I 2018/2019).*

> Dr M: *To make the diagnosis to be able to help patients, you need them to tell you, their stories. It is based on their story, we put things together, and we can help (D SS-I 2018/2019).*

Generally, doctors viewed their role as facilitating the communication relationship aimed at arriving at good diagnosis and treatment outcomes. Importantly, doctors accentuated an interdependent relationship where they endeavour to promote open expression, dialogue, confident engagements, and knowledge sharing about concerns of patients for redress.

6.3.1 Influence of Age on Doctor-Patient Interactions

According to the literature, the age or age difference between a doctor and a patient engaged in gynaecological consultations may have an impact on the nature and outcome of communication relationships (Gott & Hinchliff, 2003; Julliard et al., 2008). This is because the age difference may influence the willingness of patients to share information, the amount of information shared, how information is shared and general satisfaction with the interaction. For most patient participants (60%), the age of the doctor being consulted matters as it is linked to his/her level of experience, and hence, level of medical expertise. For most patients, the older a doctor, the more experienced he/she is and the higher the level of confidence in his/her treatment decisions.

In addition, older doctors were seen to be more mature and trustworthy, thereby promoting confidence in openly expressing patient challenges. Contrastingly, a study on physician age and outcomes in elderly patients in a US hospital rather established that within the same hospital, patients treated by older physicians had higher mortality than patients cared for by younger physicians, except for those physicians treating high volumes of patients (Tsugawa et al., 2017).

On the other hand, some patients expressed a bit of hesitancy in communication when interacting with young doctors, whom they often identify as less experienced, particularly during their first encounters. These responses from the participants correlate with findings from a retrospective review of patient complaint records from a large 1500 bed hospital in Singapore, where many doctors undergoing communication training during their medical school were identified to perform poorly in their doctor-patient communication skills and even in situations where they needed to break bad news (Dosanjh et al., 2001; Kee et al., 2018).

PAT. GYN10: *I feel if the person is older, then the person has more experience …*

PAT. GYN3: *For the age, most at times when I come to the Obstetrics and Gynaecological unit (OB&GYN), and I see a younger person, sometimes I begin to wonder "how long has the person been doing this job, and how experienced is the person***?** *But when I see the older doctors, I have a little confidence in them that at least, they have done the job for a while and have experienced it, and they will be able to assist you (P SS-I 2018/2019).*

Similarly, other patients showed indifference regarding the age of doctors they encountered during gynaecological care. These participants generally showed faith in the medical system and were of the view that once the medical facility has approved a doctor, she/he is competent enough. Here, younger doctors were considered equally good as older ones and deemed to have been well-mentored by older colleagues in skills and competencies needed in handling gynaecological cases. Thus, age did not seem to be a deterrent in the choice of doctor, or ease of communication.

PAT. GYN5: *Not really because I have encountered some younger associates of my gynaecologists, and I do not know if it is because of the directions, he gives them, but some of them are good (P SS-I 2018/2019).*

Based on participant observation, there were two major perspectives on age: either as an influence or not. Based on the nature of their training, younger doctors, who are generally residents, or house officers consult with older and more experienced colleagues, who are usually consultants and specialists. This practical training procedure was particularly common at KBTH due to its set-up as a medical training facility. The practice helped to introduce younger medical officers in the presence of older consultants as they engaged in medical interactions with patients. It was evident that the preference for older medical officers where they exist was associated with expertise and experience and not the nature of communication interaction.

Also, patients who had visited the medical facility for a longer duration tend to exercise a greater degree of choice and often a preference for older and more experienced doctors. This choice was often exercised even though they were associated with considerably longer periods of waiting time. Thus, from the doctor's perspective, age may have a significant impact on discussing sensitive personal information. In particular, the age difference may be a significant barrier to the approach and nature of doctor-patient communication, as also affirmed in (Peck, 2011). Whereas 43 % of doctor participants observed no impact of age in the divulging of sensitive medical information by patients, 57 % found age and age differences as a critical factor in how patients share information. Generally, young and unmarried patients were suggested as being less forthcoming in sharing intimate concerns, whereas adult patients tend to freely divulge intimate information, perhaps due to their greater experiences with gynaecological care.

> Dr B: *Age does not contribute … Some of them, it is not about age at all (D SS-I 2018/2019).*
>
> Dr M: *In my practice, what I have realized is that, yes, age has a role to play … The young ones are a bit more gathered [shy]. And we also appreciate it. We know that the young ones, the unmarried ones, we must do more work to let them feel more relaxed and open… But the older ones … do not mind … (D SS-I 2018/2019).*
>
> Dr 1: *Examinations can be very intimidating. You are prying into the private parts of a female patient. Most patients, or for that matter my clients, are not happy about that. So, what I do is as much as possible is just explain it that we need to inspect [sensitive parts] to see your problem. And what I am talking about now is worse among the younger people, that is the younger generation, commonly, anybody 15 years and above (D SS-I 2018/2019).*

The established findings above on older patients contradict results from earlier research which suggests that older patients show less desire to be a part of the medical decision-making process. In contrast to this study, it has been observed that younger patients show greater difficulty in sharing intimate information with doctors (Greene et al., 1994). Responses to questions such as "are you sexually active", "when last did you have your menses", "do you use any contraceptives", "are there any signs of pregnancy", "do you have previous abortion experience" were all faced with hesitancy and difficulty of communication. However, doctors seemed to receive prompt and easier feedback on medical history after the physical examination of patients. Whereas the older patients were found to provide the necessary sexual history needed more readily, the younger patients had challenges divulging similar information.

6.3.2 The Role of Gender in Doctor-Patient Interactions

There is considerable evidence in the literature on the role, and impact of gender in gynaecological encounters (Bertakis, 2009; Jefferson et al., 2013; Roter et al., 2002). This is particularly evident where the physical examination of patients is concerned. Here, gender discordance between a patient and a doctor may be emotionally challenging for patients, particularly when the age difference is not significant. Ghana's gynaecological setting is characterised by a predominantly male doctor population (Anderson et al., 2014). This situation tends to considerably reduce the choice of gender preference in gynaecological care-seeking. For first-time gynaecological care-seekers, and particularly where physical examinations are needed, this may be traumatizing given the prevailing cultural context (Berman et al., 2003; Shifren et al., 2008; Street et al., 2009).

In the current study, many patient participants (80%) believed gender had no major impact on their choice of doctor and treatment. While these responses may have been due to their satisfaction with

the care given (irrespective of the gender of the doctor), they may also have been influenced by the fact that most patients interviewed had never had access to a female gynaecologist. This apparent lack of choice removes any desire for gender preference.

> PAT. GP7a: *At times you feel shy when the male doctors see you. At times, they must do a procedure at your private part, under your vagina, and at times you feel bad. But when the woman is taking care of you, you are okay because she is also a woman, so when she sees anything, it is okay. So, I prefer a female, and elderly (P SS-I 2018/2019).*

> PAT. GPA9: *The way they [female OB-GYN doctors] talk to us, they encourage us. Even if you have a problem, and you sit with them, they nicely tell you, as they give you the heart, they give you the patience too. But for the males, sometimes it is like they do not listen to what you say… you tell them whatever you are going through, they just tell you that since they are doing their work, that is what they do ….*

> PAT. GPA4: *I am comfortable with any, but I have not been with a female doctor before. So, I do not know the difference.*

In the above responses, many patients believed that the gender of a doctor is not a crucial factor in the care being given. These patients seemed to focus on a doctor's professionalism or skill set instead of gender. On the other hand, the preference for female OB-GYN doctors was apparent given the option. While unavailable or severely restricted at best, the preference for female doctors remains merely an aspiration. Moreover, given that majority of patients have never experienced the care given by female doctors, it may be difficult to assess their preference based on gender. Nonetheless, some patients believe that female doctors offer better emotive and relational care (Roter et al., 2002) in addition to professional competence and, hence are preferred where available. This belief was buttressed by data from audio recordings which revealed that the highest

percentage of empathetic expressions was practised during doctor-patient interactions involving female doctors (Refer to Chapter 4).

> Dr F1: *From where I stand, I think gender does not play a role. Generally, I think over the years "Gynaecology" has been dominated by males, and if you talk to most women, even [educated ones] some of them are more comfortable seeing male gynaecologists than females. The only places of restrictions are cultural. Sometimes when the culture does not allow them to see males, they are forced to see females. But occasionally when they see female gynaecologists who can understand them, not make them feel less of a woman, then they are more open (D SS-I data 2018/2019).*

In the view of several patients, male doctors are described as biomedically care-focused and generally lacking effective care. From the perspective of male doctors, a professional focus on biomedical care is often important due to the personal and private nature of sexual care and communication, particularly when a doctor and a patient share similar age. This also helps to avoid emotional attachment that may impair the quality of the doctor-patient professional relationship. Likewise, religion and strong cultural beliefs were also found to be significant in the choice of gender during gynaecological care. For some female patients, religion, or culture bars them from seeking sexual healthcare with a male doctor. Under such circumstances, patients and the medical system may go to great lengths to ensure the availability of a female doctor.

> Dr B: *In some religions, the belief is that it is religiously inappropriate for another male, other than their [patient's] partner to see sensitive parts of them. In some situations, you have patients who do not want to be seen by a male [the doctor]. These are patients from very formal, traditional, and Islamic backgrounds. They do not want to be examined by a male Gynaecologist. (2018/2019 D SS-I data).*

6.4 Continuity of Care with the Same Doctor (s)

Continuity of care refers to the quality of care over time. In the hospitals visited, one of the recurring challenges for most patients was the lack of continuity of care from a doctor, or team of doctors following their first visit. Commonly, patients may be addressed by as many doctors as per the number of visits. This is because the hospital system tends to assign returning patients to any available doctor instead of the doctor on their first visit. Naturally, this process tends to introduce considerable unease to the doctor-patient communication relationship, as a new relationship may have to be established with a new doctor on each visit. Moreover, there is a feeling of a lack of privacy among affected patients as a patient's health challenge becomes known to several doctors. This often brings considerable emotional distress on the part of patients.

> PAT. GPA10: *In the beginning, I was not comfortable [with the change of doctor] because I would have preferred one person [the doctor]. I thought the person [who] started with you, knows your case and everything so, it sorts of follow up (P SS-I 2018/2019).*

> PAT. GPA4: *I prefer to maintain one [the doctor] because of the way I relate to him [the doctor]. Because with one person he knows you, right from the beginning. He knows what is wrong, and how to go about it, in case of any emergency. But then you keep on changing, changing, changing, everybody will have to [physically examine you] ... I am saying this based on experience (P SS-1 2018/2019).*

> PAT. GYN5: *I prefer maintaining one because I happen to have special issues. Anytime a different person sees you, you will have to recount the whole story. It can be painful, yes. I have had a lot of traumatic experiences and going over, and over through them, it is not that pleasant, if you have one person who knows the history you just continue from wherever you left off (P SS-I 2018/2019).*

For most patients, a change in doctor could be traumatizing as sensitive and private experiences may have to be recounted several times, negatively impacting their psychological health and care. From the perspective of patients, there is the need to have one resolute doctor for follow-up visits. This helps to promote a healthy relationship with trust – a view shared by all patients. Nonetheless, few patients made this demand at the medical facilities due in part to the powerful role of the medical system and the urgent needs of patients.

Again, the request for a preferred doctor is often associated with long waiting periods and sometimes rescheduling of appointments. Consequently, patients "conform" and reluctantly consult with available doctors while hoping the new experience will be less traumatic. According to patients, this procedure was more prevalent in the bigger (referral) hospitals such as KBTH.

From an observational point of view, doctors appeared to be overwhelmed with the number of patients they needed to care for daily. On average, doctors consulted with 15 – 25 gynaecological outpatient cases daily. This severely restricts proper communication engagements and tends to hinder the ability of a doctor to remember every patient s/he has seen previously and their peculiar challenges. As a result, while a patient may easily build familiarity with a doctor, the doctor's major focus on biomedical care means that little relational experience may occur with a patient (Paternotte et al., 2015, 2016) until after several visits. Adding to this complexity is the hospital's rotational system which ensures that some doctors may be unable for periods during the care of a particular patient (2018/2019).

6.5 Strategies in Doctor-Patient Communication in Sexual Healthcare

Sexual healthcare often demands open dialogue involving a broad range of intimate and personal discussions on one's biology, psychology, and physiology backed by strong socio-cultural

underpinnings. However, several challenges to candid interactions on sexual health exist, including shyness in divulging concerns, inadequate confidence in discussing such topics, cultural perceptions of sex and diseases, nature of medical settings, and duration of consultations (Basu & Duckett, 2009; Do et al., 2014; Schinkel et al., 2019; Schmidt et al., 2018).

In Ghana's socio-cultural context, several restrictions exist on sexual communication (Donkor, 2017; Mack, 2011). This has ensured that little or no discussion on sex and sexuality occurs in various segments of society, including homes. This situation is compounded by the private and sensitive nature of sexual communication, which inherently restricts its expression. For most patient respondents, sexual education, if any, begins in the home and is primarily instigated by mothers and complimented in schools by teachers and peers, or through self-education (Bochow, 2012). However, the current school curriculum is largely focused on the biology and physiology of human biology, particularly related to reproduction, and less so on sexual health. While anecdotal, the rarity of sexual education in most homes, borne out of cultural and parental restrictions, coupled with the inadequacy of the topic in the school curriculum, means that, for most adults in Ghana, sexual education is largely influenced by peers and self-teaching.

> PAT GP7a: *Oh, of course, our mothers and from school and friends*
>
> PAT GPA10: *It is self-teaching ... no, no, no, not mother, not father, and at school, you are taught at your basic level. You are taught some things. So apart from that nobody educated me on it.*
>
> PAT GNY3: *Oh, growing up it was a friend, a male friend who used to teach me because he was into public health. So, if I had any little issues, I spoke to him about it and he used to educate me and sometimes, I read about it sometimes.*

In sexual healthcare, communicating sex and sexuality is a requirement and not a social or cultural privilege. Thus, seeking gynaecological care-seeking represents a balancing act of privacy, restrictions, openness, well-being, and safety for most patients. Within the existing impediments, patients tend to come up with various strategies for communicating their sexual health needs. These strategies may include the use of jargon and euphemisms. For instance, several euphemized names for vagina exist in various local languages. For instance, "Akosua Kumaa" in Akan (Twi) and "Pupu" in the Buem language.

Similarly, the patient participants commonly referred to the vagina as a "private part". It must be noted that several names are coined about the vagina within ethnic groups and even in individual family cultures. To these patients, using such names or descriptions made it profoundly easier to communicate. Ironically, most patients found it more challenging to mention actual names of their sexual parts in their local languages where they exist, and it is largely due to the culturally abhorrent view of openly expressing such names.

> PAT. GPA10: *I feel okay because it is a name. It is a part of the human body that needs to be mentioned. But because of societal conception, when you mention it, (laughs) they think that maybe you are a bad person. But I am with a doctor, and I must feel free, and mention it so that the doctor can know my problem and take diligent care of me. When you go outside [western world], they are free to talk about anything. But here [in Ghana], it is like as a child - you are forbidden to say certain words, which is bad!*

> PAT. GPA4: *That is my private part (giggles). Ok, that is my vagina (laughs). I have been trained like that by mummy to say "Akosua Kumaa" [euphemized name] especially when in a group of people.*

> PAT. GP7a: *For Ghanaians, we think mentioning those names is not respectful.*

PAT. GYN5: *In Ga language, the mention of the vagina is heard in insults. In Ga, the vagina is termed 'under there'. It is euphemized, but the internal structure like the womb is 'fomo nii' [something used in giving birth], but the cervix is a phrase that would describe the cervix. I have not heard a specific word being used for the cervix.*

Likewise, medical doctors show restraint in explicitly expressing sexual parts (Hordern & Street, 2007) particularly based on a patient's behaviour and reception of these expressions. In sexual communication, however, most participants revealed the use of the English language as the preferred medium for expressing sexual parts. This is because the English language is viewed as less benign compared to local languages in expressing sexual parts. The "foreignness" of the English language, in addition to the ready availability of euphemisms, helps in this regard.

Dr 3: *You know how we were all brought up. It is difficult to mention some of these vital organs which they classify as "private organs" in the local languages. So, English can also be used interchangeably when it comes to mentioning certain words in Gynaecology. As it is in our local languages, you try to "dress it up" in a way. Sometimes you tend to use the English pronunciation of these bodily parts since they are much simpler and more widely accepted than the local languages. Right now, with the local languages, we may have to use certain phrases to mean the same thing (D SS-I data 2018/2019).*

Dr B: *English will aid it [sexual communication] because we have euphemisms you can even use for what appears to be culturally very sensitive to say. In any of the local languages, it is difficult to find euphemisms for some of the things. And to do that you may pick up information that is not exactly what it is. So, English is easy because it is direct (D SS-I 2018/2019 data).*

Most patients (70 %) expressed discomfort with explicit communication with their doctors and preferred to be less direct while employing euphemistic language. Nonetheless, some patients (30 %) expressed confidence in mentioning sexual terms explicitly without any discomfort or fear of repercussion. While all patient participants agreed to the need for an open discussion on their sexual health concerns for doctors to proffer appropriate treatment, they nonetheless believed that it was the doctor's responsibility to elicit such communication. In this regard, all patients expressed the desire for their doctors to be explicit and detailed in their sexual health communication with them. This approach is believed to help "normalize" and facilitate the use of explicit words, particularly where patients may not be used to them.

> PAT. GPA6: *I prefer for you [the doctor] to tell me as it is and not to lighten it or anything because if I know exactly what it is then my fears will be alleviated, or I will ask for further treatment. I will prefer for him to be explicit… (P SS-I 2018/2019).*

> PAT. GYN3: *because I feel I have a problem, and for me to get a solution to the problem, the doctor must go deep and delve into whatever issues I have before he can give me a very definite solution (P SS-I 2018/2019).*

In all doctor-patient encounters, it was observed that patients found it difficult to initiate sexual health interactions. Instead, they relied on doctors to initiate the conversion and to utilize sexual-related words or terms, which they tended to repeat. It was also noted that the more explicit wordings a doctor uses, the more likely the patient is to use such words, irrespective of how uncomfortable they may initially appear to the patient. In doing so, doctors were noted to adopt various forms of communicative indirections and other strategies to enhance the interaction *(Participant Observation 2018/2019).*

For patients, the willingness to be open and expressive is instigated by their doctor. Often patients take a cue from the doctor's line of communication. Consequently, the use of explicit and detailed language by a doctor may help patients to be more open. Notwithstanding a desire for their doctors to be explicit and direct in sexual health communication, often, the initial reactions of most patients to a doctor's use of sexual language include being shocked, startled, or dumbfounded. The nature of the ensuing interaction is largely based on how a patient recovers from the initial reactions as doctors help to accommodate patients' preferred nature of interactions.

> Dr 3: *It is always difficult because sometimes if you use the raw language, the client [patient] might even look at you with some [disgust]… (D SS-I 2018/2019).*

> Dr B: *I am a Gynaecologist. You want to ask somebody how many times you have sex in a week. If you mention that the person immediately stares to see who else is around, why would you mention something like that? Or [you ask a patient] what is your lifetime number of sexual partners? I mean the people [patients] become hesitant to tell you such information. Generally, talking about vagina, penis, and all that is not culturally very appropriate to our patients. So, sometimes, they are not very comfortable mentioning that. Even when they are narrating their own story (D SS-I 2018/2019).*

> Dr M: *The patients coming with those problems, especially involving those private areas, are a bit shy, because of our culture. Nobody wishes they have a problem like that, [and] to have to go to a hospital for people you [patient] do not know to look "down there" [euphemism for vagina and associated parts] (D SS-I 2018/2019).*

In most cases, doctors employ a combination of English and a local language to help with patients' understanding. Largely, the use of the local language is restricted to illustrations to help with understanding by the patients. For both doctors and patients, the mention of sexual parts in a local

language is greatly abhorred. Commonly, sexual parts are referred to through euphemized descriptions and not in direct names. Where a name is mentioned, mostly in English, subsequent referrals tend to avoid re-mentioning and instead use locatives ('nominal groups and the pronoun 'it') such as "down there" and "it" in place of sensitive parts or unpleasant conditions. The use of the pronoun "it" or [“down there, my under”] is used interchangeably to replace the vagina and other bodily fluids such as discharge, candidiasis, and blood. This communicative occurrence is further examined in the audio-recorded data of patient-doctor interactions (in chapter 4). In 30 out of the 35 doctor-patient interactions, euphemisms were used, whereas, in all the 35 doctor-patient interactions, the use of the pronoun IT was adopted in the interactions (Refer to chapter 4). Notwithstanding the inherent social, cultural, and personal challenges to communication, it was observed that, where patients' conditions were severe, such as heavy bleeding, severe pain, or worsening chronic conditions, patients were more open, explicit, and detailed about their issues. As well, patients were more willing to undergo physical examination without shyness, nervousness, or reservations *(Participant Observation 2018/2019)*.

In addition to using more than one common language and the linguistic features employed, doctors identified other strategies that helped made patients feel relaxed to communicate more readily. These include discussing related but more pleasant issues, telling jokes, making fun of oneself, and using quips during interactions.

> Dr 2: *The moment you can make them comfortable, they will tell you everything. [For instance] by cracking a joke. You [a doctor] can talk about their work before the issue. You distract their attention from the problem they came up with. So before long, they [patients] are not scared because you have asked about their children, their work,*

something to distract them, and then they open about their real problem ... (D SS-I 2018/2019).

Dr 1: *I mean [use] specific words that will represent or put across what I want to say (in Twi). I try to do that one, but people laugh at it [Respondent not a proficient speaker of Twi]. And I am happy about that one because it makes the patients very relaxed, especially when we are talking about issues concerning the female genitalia. People get tensed up [so] it is a way of getting them to speak ... (D SS-I 2018/2019).*

6.6 Doctor-Patient Expectation/Satisfaction

Worldwide, patient satisfaction with the care given is viewed as one of the most critical measures of the healthcare system. Although the medical system itself may have an impact on patient satisfaction, the measure of satisfaction heavily relies on the doctor-patient communication relationship. At the same time, patient satisfaction is primarily based on the level of expectation. In the study, all patients expressed satisfaction with their visit to and interactions with their gynaecologists. The satisfaction was primarily based on confidence in the competence of the medical system, medical doctors, ease of access to doctors, and ease of communication with doctors.

PAT. GPA4: *Yes! Because he [the doctor] will let you go to the lab, and he will continue from there. If I do not understand anything, I will find out. I will ask him, yes, because some of the things I want to know why it is like this, and he will explain it (P SS-I 2018/2019).*

PAT. GPA6: *Yes, I have his number. So anytime I must see him, he is easily accessible. All you must do is [to] call and book an appointment with him and if he will not be able to*

talk, he will give you the right time to call him. So, for now, I can communicate with him all the time (P SS-I 2018/2019).

PAT. GYN3: *I told him [the doctor] how I was feeling, and then he let me know that I am not the only person in that situation so, I should not worry. And then he confirmed whatever I was thinking. So, he made me know that he knows what he is about so that made me satisfied (P SS-I 2018/2019).*

PAT. GYN8: *Oh, I see him [the doctor] like, no matter the pain, he makes it feel like something small, and you will be fine (P SS-I 2018/2019).*

PAT. GYN5: *Yeah, the way he [the doctor] explains things, he calls you by name, he knows you even outside of the consulting room. Should he meet you outside in the corridor he knows you. Yes, so, you feel like you are important. Here, [Referring to the medical facility] you [the doctor] try to relax us and make us comfortable, ask us how we are doing, even how we are doing alone solves a lot of things (P SS-I 2018/2019).*

Based on the patient responses, satisfaction with care is highly correlated with a good relationship with their medical doctor and is achieved through developing relations, appropriate use of language, empathy, assurance, and professionalism in all engagements. However, the level of satisfaction may have been influenced by the influential role that patients offer doctors and the medical system in general. In this regard, doctors are accorded high reverence particularly as patients believe that their life and well-being are in their hands, and that of the medical system. Thus, patients are hesitant to express any form of dissatisfaction with doctors or healthcare systems, particularly where they continue to patronise that institution. On the contrary, patients are quick to express praise and satisfaction with care.

PAT. GP7a: Y*es, I am incredibly grateful because if I did not come here [hospital], by now, I would not know what has [would have] happened to me (P SS-I 2018/2019).*

PAT. GYN10: *I feel like if I come ... it is the last stop. I will be attended to well (P SS-I 2018/2019).*

Given that healthcare is a service rendered to patients, the focus of satisfaction is primarily on patients' assessment of the service received. Nonetheless, considering the peculiar challenges of sexual healthcare in the context of the study, and its effect on both patients and doctors, doctor satisfaction with doctor-patient interactions and the healthcare given, was also assessed. Based on responses from interviews, doctors' measure of satisfaction was based on several factors, including an appreciation of patient challenges; successful diagnosis of patient problem; resolution of patient challenges; successful treatment outcome; satisfaction of patient; and success of the communication interaction.

Dr 3: *So, once you [the doctor] address them [challenges] and you ask them do you have any issue again, they say no with a smile [you are satisfied] (D SS-I 2018/2019).*

Dr B: *So, what makes me satisfied is when I have got an indication that the patient is satisfied that the encounter has been useful. So, if I can make a diagnosis or at least understand the patient to the level that the patient feels understood. It gives me joy… if I can get a solution to what the patient brings, then that brings greater joy. But the critical thing is the patient knowing that she brought a problem, she has been heard, and she has been understood, and an attempt is going to be made. That gives a lot of joy (D SS-I 2018/2019).*

Dr F: *When my patient is happy, I am happy (D SS-I 2018/2019).*

Dr M: *When I feel the patient has been honest with me, and the patient feels we have a plan to help her, then it is satisfying (D SS I 2018/2019).*

Dr 1: *As soon as you [patient] can wake up and walk around and say I am fine (D SS-I 2018/2019).*

On the other hand, doctors are often faced with challenging patient situations. These situations arise from patients' ignorance or inability to express their sexual health challenges, irrespective of the doctor's efforts. As indicated above, some patients believe that a doctor must elicit the level of information and cooperation needed for medical diagnosis and treatment. For these patients, their experience of satisfaction is greater when a doctor can accurately diagnose their condition and recommend appropriate and effective treatment without their help or communication. Despite the availability of effective diagnostic tools, this lack of communication represents a level of frustration for medical doctors.

Dr 1: *You ask one question, and she [patient] tells you what she wants to tell you [hint of disinterest]. It can be annoying. Either the person [patient] is deliberately ignorant about the issue at stake, or she wants you to make magic. She thinks you are a pastor. But these things present signs and symptoms, so, it gets you [the doctor] annoyed. You ask a question; she cites her example. Another thing that gets me annoyed is a woman who does not know her last menstrual period. It gets on my nerves (D SS-I 2018/2019).*

It was evident from the doctor-patient interactions that effective gynaecological consultations are highly dependent on accurate patient history. For instance, information on one's menstrual cycle, sexual experience, sexual discharges are vital in this regard. However, some patients with critical issues were often ignorant or unwilling to share such knowledge. In some cases, the exasperation

of doctors was palpable, particularly following several attempts to help elicit such information. (Participant observation 2018/2019).

6.7 Conclusion

Despite its vital role, the private and intimate nature of health concerns coupled with cultural and religious restrictions make communication challenging in sexual healthcare delivery. The choice of language is crucial in this regard. In the Ghanaian healthcare system, English predominates, spurred by the multiplicity of languages and the apparent ease of its use in sexual communication. In contrast, local languages are considered deficient, ill-equipped, and lacking in the sophistication needed for a detailed description of terms and processes in healthcare. Nonetheless, local languages are required and used to complement patients' understanding particularly when patients are less proficient in the English language.

Also, given that communication aims to elicit understanding, "beautiful" and detailed communication by doctors without the relevant understanding by patients is useless. As such, the use of simple language, whether English or a local language, is crucial in facilitating patient understanding and participation in the interactions.

The findings from this study, therefore, point to doctors and patients attempting to overcome cultural, language, and privacy barriers using a common language that has an appropriate level of detail, but is less intrusive or graphic such that there is minimal discomfort to patients. This may involve the use of code-switching and euphemisms (AVO., PRN-IT., T-E) and other communicative strategies (POL., L-T., EMP-E., C-S., REP, M-J and SIL) to aid in an accommodation process where the participants adjust their conversations consciously, and sometimes unconsciously (Farzadnia & Giles, 2015a; Ogay, Tania, Galloise Cindy, 2005). Integral

to the quest for adequate information by doctors is the use of pleasantries, telling of jokes, and general expression of empathy (EMP-E) in ensuring that patients are more comfortable and can freely express themselves without fear of judgement. The findings suggest that patients receiving gynaecological care in both institutions studied are generally satisfied with the care given based on a generally high-level of trust in the doctors' competence and the communication relationship developed with doctors. Nevertheless, patients decried the lack of continuity of care from doctors leading to the unease of sharing intimate details with several doctors.

CHAPTER SEVEN

CONCLUSION

7.0 Chapter Overview

The influence of language in healthcare is critical in contributing towards healthy doctor-patient relationships. The interpretation of culture in tandem with language in healthcare delivery is essential to optimal health outcomes, reaffirming Napier's assertion that ideas about health are essentially cultural (Napier et al., 2014). This nexus creates an interdependence where the impact of culture is revealed through verbal communication during medical exchange. Thus, culture and language considerations set the context for successful health compliance and therapeutic outcomes.

Culture permeates the perceptions of ill health, beliefs and superstitions about diseases, the varied expressions of illness and pain, as well as the type of treatment plans selected and to be adhered to by patients accordingly. Hence, communication within a culturally defined context becomes a major component of an ongoing process of meaning construction where the process is interactive by nature and participatory at all levels. The study's main objectives were to understand the strategies adopted in negotiating a culturally restricted area of language use, examine the dominant healthcare communicative relationship utilised and assess the perceptions of both doctors and patients on the gynaecological treatment processes.

In line with these objectives, the study employed triangulation of various data sources. This approach facilitated thematic analysis by contributing additional insights into gynaecological care. These data explorations were examined through the lens of Communication Accommodation Theory (CAT). In this concluding chapter, the findings from the research are summarised. This is followed by the theoretical and the societal implications of the study to the medical communities

selected. The study's limitations and recommendations for future research are provided at the end of this chapter.

7.1 Key Findings

Research Question 1: **What dominant communication strategies define the doctor-patient gynaecological interactions and the insights provided to understand the doctor**

This research question was answered with data derived through audio recordings, participant observations and semi-structured interviews. Thematic analysis was explored on data transcripts with the aid of NVivo. The findings are as follows:

I. **Several communication strategies dominate doctor-patient gynaecological interactions.**

The study identified 11 dominant strategies; some of which were employed almost exclusively by medical doctors (the use of medical jargon, the expression of empathy, 'we'- inclusivity, and repetition); whereas others, such as pronoun it (PRN-IT), Euphemisms (T-E), avoidance (AVO), code-switching (C-S), low – tones (L-T) and politeness (POL) strategies were employed by both doctors and patients. The strategy of silence (SIL) was restricted to patients.

It was observed that doctors and patients accommodated each other with the use of these strategies identified. Except for code-switching (C-S) and Euphemisms (T-E), all the identified strategies were observed in all 35 doctor-patient interactions examined. The choice and use of a particular set of strategies were associated with both doctors and patients involved in the interaction, but largely influenced by culture (Schinkel et al., 2019), and seemed to reflect their "unequal" status, varied socio-demographics, and cultural perspectives on ill-health (Ong et al., 1995). These

communicative strategies were not only crucial in overcoming cultural barriers in communication, but also essential in building and enhancing the doctor-patient communication relationship.

The results interpreted an approach to culture as influencing language, style of communication, values and access to healthcare (Claramita et al., 2013; Schinkel et al., 2019). Importantly, the use of CAT demonstrated an effective approach to understanding the dynamics and sociolinguistics of doctor-patient communicative interactions in healthcare (Ahmed & Bates, 2016; Bylund et. al 2012; Farzadnia & Giles, 2015; Street, 1991; 2003). This theoretical angle established all the communicative strategies identified as converging within a sensitive medical context.

Question 2: What communication model is employed in the doctor-patient interactions?

This research question was answered with the aid of transcribed audio-recorded data, run through excel and complemented through visualisation plots with the aid of Discursis. This tool complemented NVivo to represent the reality of the interactions graphically.

I. Paternalism defines the doctor-patient communication relationship model.

A communication relationship is at the heart of the therapeutic process and is essential in influencing the social dynamics at play. Within the examined medical contexts, doctors are regarded highly; therefore, the doctors were accorded reverence and power. This social elevation facilitated doctors' lead in the interactions as a norm. In this model, the doctor is seen as possessing more knowledge about the ailment and giving more explanations and suggestions, but the patients were noted to embrace doctors' dominance by giving terse or emotional responses (Mira et al., 2012).

Modern approaches to healthcare have been largely transformed from paternalism to patient-centred care, where medical decision-making is based on the understanding and cooperation of

patients. Nonetheless, the findings from this study suggest a default paternalistic communication relationship existing between doctors and patients. Patients encouraged this model of communication relationship due to their lower preference or ability to communicate effectively because of contextual influence shaping their level of participation. Generally, patients' responses are terse and seem to reflect contentment with the advice and expertise of doctors without their input. In all instances of data exploration, both textually and visually, doctors dominated in their verbal utterances in the process of the encounters.

Question 3: What are the doctor perceptions and patient perceptions of the gynaecological encounters?

This research question was answered with the aid of transcribed data on individual semi-structured interviews on doctor-patient gynaecological encounters. This data source was augmented with participant observations and audio recordings to establish the major findings recorded from participants' real stories of how they construct their experiences of health and illness.

The data findings interpreted patient satisfaction with their care based on the following factors: doctor's age, expertise, language, and empathy. These factors notwithstanding, patients' satisfaction was marred by factors such as lack of continuity of care by the same doctor and lack of privacy. The findings from the study also point to the fact that for most patients, doctors' gender and ethnicity were not important factors influencing medical care.

- **Patients requested one doctor throughout their care**

This concern was expressed based on the lack of privacy that occurred in most encounters. In most consultations, at least, a doctor consults with a consulting room nurse and a house officer (a medical trainee). During the process, doctors were often on rotation; hence, patients had no option

other than to consult with any available doctor. As a result, it becomes challenging for patients to share their intimate concerns with new doctors during each medical visit. A situation which could inhibit and place a burden on patient's personal information to be shared.

- **Patients needed doctors to use empathetic expressions (EMP-E).**

In the patients' responses, the use of empathy made them feel welcome and needed reflecting patient's perspective and emotional state (Hoffman, 2012; Kee et al., 2018; Larson & Yao, 2005). Patients emphasised the doctors' use of eye contact. According to patients, the doctor's use of eye contact affirmed patients 'belongingness' and acceptability. This process increases patients' trust in the doctor without inhibiting the disclosure of information (Ge et al., 2009). Patients' responses emphasised cultural effects transcending language use (Brooks et al., 2019; Paternotte et al., 2015, 2016). From the doctors' perspective, although eye contact reassures patients, due to its cultural restrictiveness, they (doctors) observed and practised it according to patients' demeanour and the level at which patients welcomed the act. Hence, this practice is mostly employed by female doctors, a finding also, supported by literature (Eisenberg & Lennon, 1983; Hojat, Gonnella, & Nasca, 2002; Hojat, Gonnella, Mangione, et al., 2002).

- **Correlation between doctor's age and perceived expertise**

Patients seemed to be more focused on doctors 'age' which they associated with doctors' expertise. While communication seems to be important, doctors' expertise was rated more highly. This aspect was rated by patients according to how their medical challenges were solved with no time. For most patients, the doctors who functioned best to their satisfaction were the elderly OB-GYN doctors. Patient satisfaction with care given was confirmed through high levels of trust in the doctor's competency and the developed communication relationship. Hence, patient satisfaction

was not necessarily linked to the doctor's language, but on the level of expertise or competence displayed as what is of utmost interest to patients.

- **Patient's preference for English or English/Akan (Twi) in communicating sensitive words.**

When communicating sensitive matters, patients prefer using English or English with a local language, usually Akan (Twi) (Code-Switching) (Amuzu et al., 2014; Kajombo, 2021). This language choice positioned English as the preferred medium for communicating with sensitive subjects. This is the case even when both patient and doctor are fluent in a local language. The study demonstrates that even for highly educated patients, the influence of culture and its restrictions on intimate communication contributes to patients' reticence and reluctance to communicate freely and adequately, particularly in a local language (Flamenbaum, 2014).

7.2 Implications of Study: Conceptual Model on the Interactions between Culture, Language, and Health and its Interrelatedness in Doctor-Patient Gynaecological Encounters in Ghana.

Healthcare runs on the wheels of a society's culture. Yet, culture is unconsciously disregarded in the delivery of healthcare and its outcomes. The centrality of culture in the interactions enhances optimal results, particularly for the patients observed, as they are primarily guided by their cultural expectations and perceptions of illness. Based on the findings from this study, Figure 7.1 is proposed as a conceptual model to reflect the doctor-patient gynaecological exchanges contextually emphasising culture as its driving force. In this study, culture is seen as indispensable in shaping sexual healthcare. Culture was found to impact communication in the doctor-patient interactions, relationships, and perceptions. The doctor's clinical awareness of the patient's culture

leads to higher trust levels towards a better communication relationship, adherence to diagnoses, and treatment plans, and significantly higher patient satisfaction rates. This conceptual model agrees with the 2014 Lancets Commission's report on cultural relevance in the attainment of a standard healthcare, globally (Kruk et al., 2018; Napier, 2015).

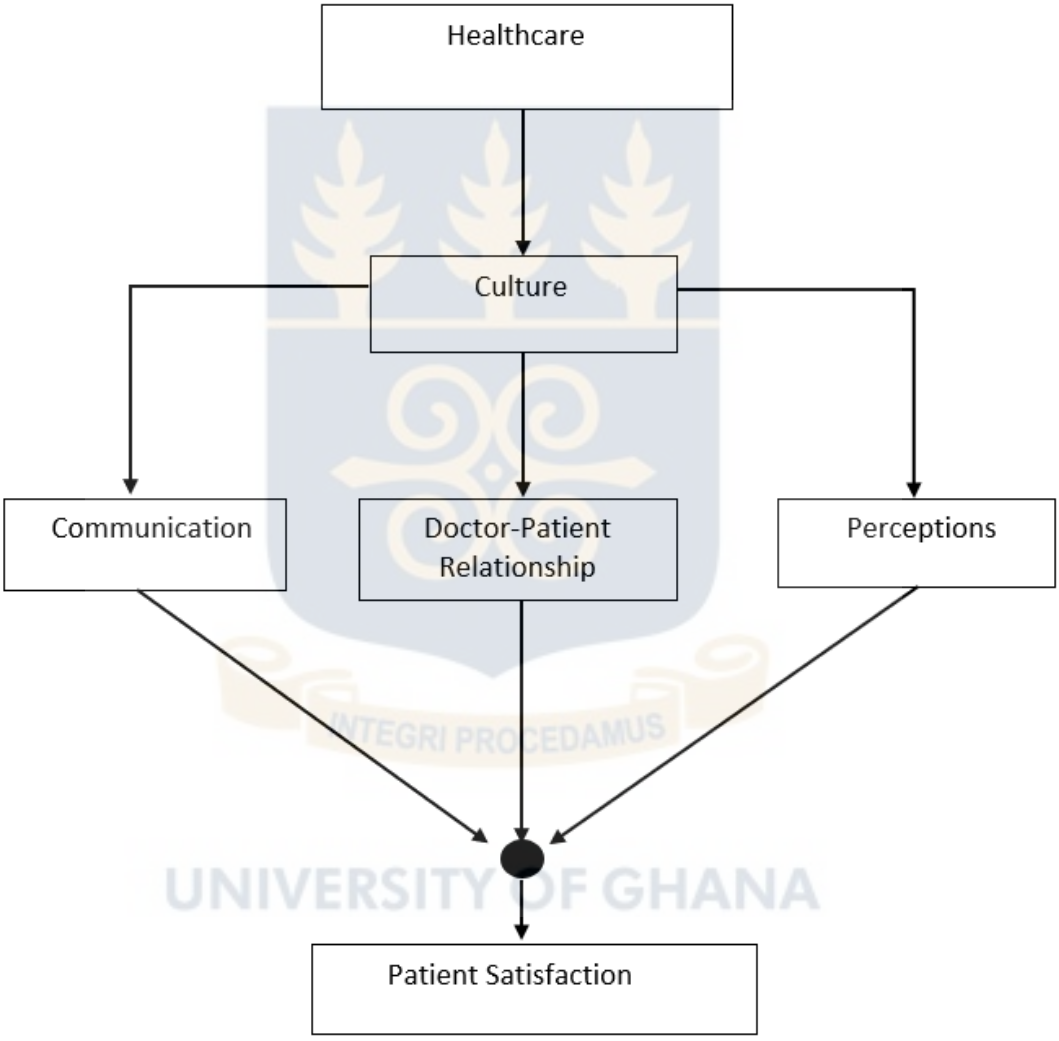

Figure 7. 1: Conceptual Model on the Impact of Culture on Language and Healthcare Outcome

7.3 Contribution to Knowledge

The study makes significant contribution to knowledge in selecting a qualitative and interpretive approach explored in more depth in three major ways. First, the use of methodological and qualitative software triangulation in data analyses is novel. Importantly, these dimensions were applied through the lens of CAT as a theoretical model. CAT allowed an exploration into the meanings patients created around their experiences and how culture defined the interactions (the use of communication strategies) within an intercultural gynaecological medical context. CAT revealed convergence as the main accommodation style even in the use of medical jargon. In a converging approach, the patients also encouraged doctor dominance in the interactions. The confirmation of doctor dominance in the gynaecological setting with the use of Discursis and NVivo and the centralisation of CAT within the process is novel and innovative in the sparse African context of gynaecological analytical methods. CAT with its capacity has significantly contributed to the realisation of the study's set objectives on how communication strategies are being negotiated, the model of the doctor-patient interactive encounters and the provision of in-depth understanding into the interactive behaviour of both doctors and patients in the encounters.

This study becomes one of the first original studies within the sub-region to use software triangulation, that is NVivo and Discursis to interpret gynaecological consultations in selected hospitals in Ghana. The novelty with the use of NVivo and Discursis allowed for the identification of themes as well as the visualisation of interactional patterns that established doctor dominance in the interactions.

In a study that has an interconnection between language, and health, it was essential to apply the methodological perspectives and the theory of CAT. CAT has been explored severally in varied research approaches, and it brought out insights on doctor dominancy within an intra-cultural

setting where this feature is a norm. Concurrently, embedded within doctor dominancy is the co-construction of meaning between the doctors and the patients using the communication strategies (M-J, EMP-E, PRN-IT, EUP, WE-I, REP, AVO, C-S, POL, L-T and SIL) to negotiate sensitive discourse within the medical contexts. The use of CAT primarily confirmed convergence as the accommodation style.

Again, the study highlights the benefits of triangulation to derive perspectives that add more to the study's key findings. The methods' usefulness and potential have been demonstrated by applying them to a practical dataset (face-to-face doctor-outpatient interactions) in gynaecological care. Critically, the study has drawn attention to the dearth of data on doctor-patient communication in Ghana regarding its form, constructions, sociolinguistics, and anthropological dimensions crucial to improving health within applied linguistic research.

7.4 Future Research

In exploring doctor-patient communication strategies, we have identified the possibility of triangulation. Three main qualitative methodological approaches – audio-recordings, participant observation and semi-structured interviews with the application of two software programmes – NVivo and Discursis aided in exploring the interactive content and forms of communication visualisations influenced by the cultural contexts from which meaning within the two major hospitals in Accra, Ghana was ascertained.

In future, a study that investigates doctor-patient interactions from a purely cultural angle due to context, age, gender, education, and level of doctor professionalism which may unravel insights about the “unspoken cultures” or “unspoken rules” of interactional practice within medical

contexts. Additionally, the study can explore how doctors and patients especially navigate this terrain using CAT and Facework theories would be significant.

Moreover, we suggest studies investigating the influence of same-gender and higher professional status on gynaecological interactions. These findings must be explored to ascertain its immediate and long-term impact on the patients receiving the healthcare.

Also, the cosmopolitan elite settings of data location may have influenced the choice of participants, language, and behaviour. Replicating the study in a rural setting may provide a more holistic picture of doctor-patient communication in sexual health care in the country. Largely, this outcome could enhance Ghana's health communication policy in ensuring equitable access to health care and promotion.

7.5 Limitation

It is projected that the adoption of direct observation as a data collection instrument may have influenced the choices of participants. This is because the presence of the researcher may have influenced the choice of communication style (s) and the tone of the language used during the gynaecological encounters. For instance, a doctor may appear more friendly during communication, but some patients may feel reluctant, shy, or uncomfortable disclosing their gynaecological issues in the presence of 'a third party'. Additionally, it is envisaged that the hospitals' environment serving as the main data sites, may influence patients' perceptions about their doctors following fear of recrimination.

The general restriction of the study to English as a medium of communication may have influenced or limited actual language choice and preference during health communication. This may have been reflected in the prominent level of code-switching observed with English.

7.6 Recommendation

Paternalism, as highlighted by patient behaviour and identified as a key finding in this study, serves as a cornerstone for interventions in healthcare communication. This is due to cultural barriers that often limit patients' active engagement in medical consultations, which contrasts with the principles of patient-centred care prevalent in modern medical practices.

From the findings, culture deeply influences perceptions of illness, beliefs, and superstitions about diseases and healthcare in the Ghanaian context. This underscores the importance of culturally sensitive communication as an integral part of the ongoing process of constructing meaning. Therefore, it is essential for both medical professionals and patients, as well as educational institutions involved in medical discourse, to become platforms for learning. It is recommended that courses emphasising communication should be taught to improve the outcomes of medical interactions, especially in the field of Gynaecology. In line with this, a national policy regarding the languages used in hospital settings should be established. Additionally, training healthcare workers in effective communication, particularly in gynecological care, is crucial.

Academics should also be encouraged to conduct further research in this field, given the critical role of communication in healthcare in general and sexual health in particular, and the need to expand knowledge within the humanistic framework of this study.

Lastly, there is an urgent need for public awareness on the role of healthcare communication in promoting and improving access and safety in healthcare delivery, particularly for vulnerable women during sexual healthcare.

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APPENDIX

APPENDIX A

UNIVERSITY OF GHANA
ETHICS COMMITTEE FOR THE HUMANITIES (ECH)

P. O. Box LG 74, Legon, Accra, Ghana

My Ref. No.....

29th June, 2018

Ms. Beatrice Oforiwaa Dankyi
Department of English
University of Ghana
Legon

Dear Ms. Dankyi,

ECH 169/17-18: CULTURE, LANGUAGE AND HEALTH: A LINGUISTIC INVESTIGATION OF COMMUNICATION STRATEGIES IN GYNAECOLOGICAL CONSULTATIONS IN ACCRA, GHANA

This is to advise you that the above reference study has been presented to the Ethics Committee for the Humanities for a full board review and the following actions taken subject to the conditions and explanation provided below:

Expiry Date:	28/06/19
On Agenda for:	Initial Submission
Date of Submission:	14/05/18
ECH Action:	Approved
Reporting:	Bi-Annually

UG/ISSER/ECH VALID UNTIL 28 JUN 2019 APPROVED DOCUMENT

Please accept my congratulations.

Yours Sincerely,

Rev. Prof. J. O. Y. Mante
ECH Chair

CC: Dr. Jemima Asabea Anderson, Department of English, University of Ghana.

Tel: +233-303933866 Email: ech@ug.edu.gh | ech@isser.edu.gh

APPENDIX B

UNIVERSITY OF GHANA
DEPARTMENT OF ENGLISH
SCHOOL OF LANGUAGES

DE/AC 13/2
Ref. No.:.....

October 29, 2018.

TO WHOM IT MAY CONCERN
LETTER OF INTRODUCTION

I write to introduce to you Mrs. Beatrice Oforiwaa Dankyi, a fourth year PhD. student on our graduate programme. Mrs. Dankyi is writing her thesis on the topic: "Culture, Language and Health Communication: A Linguistic investigation of Gynaecological Consultations, Accra - Ghana".

I would be grateful if she could be given the assistance she needs to collect data for her thesis.

Thank you.

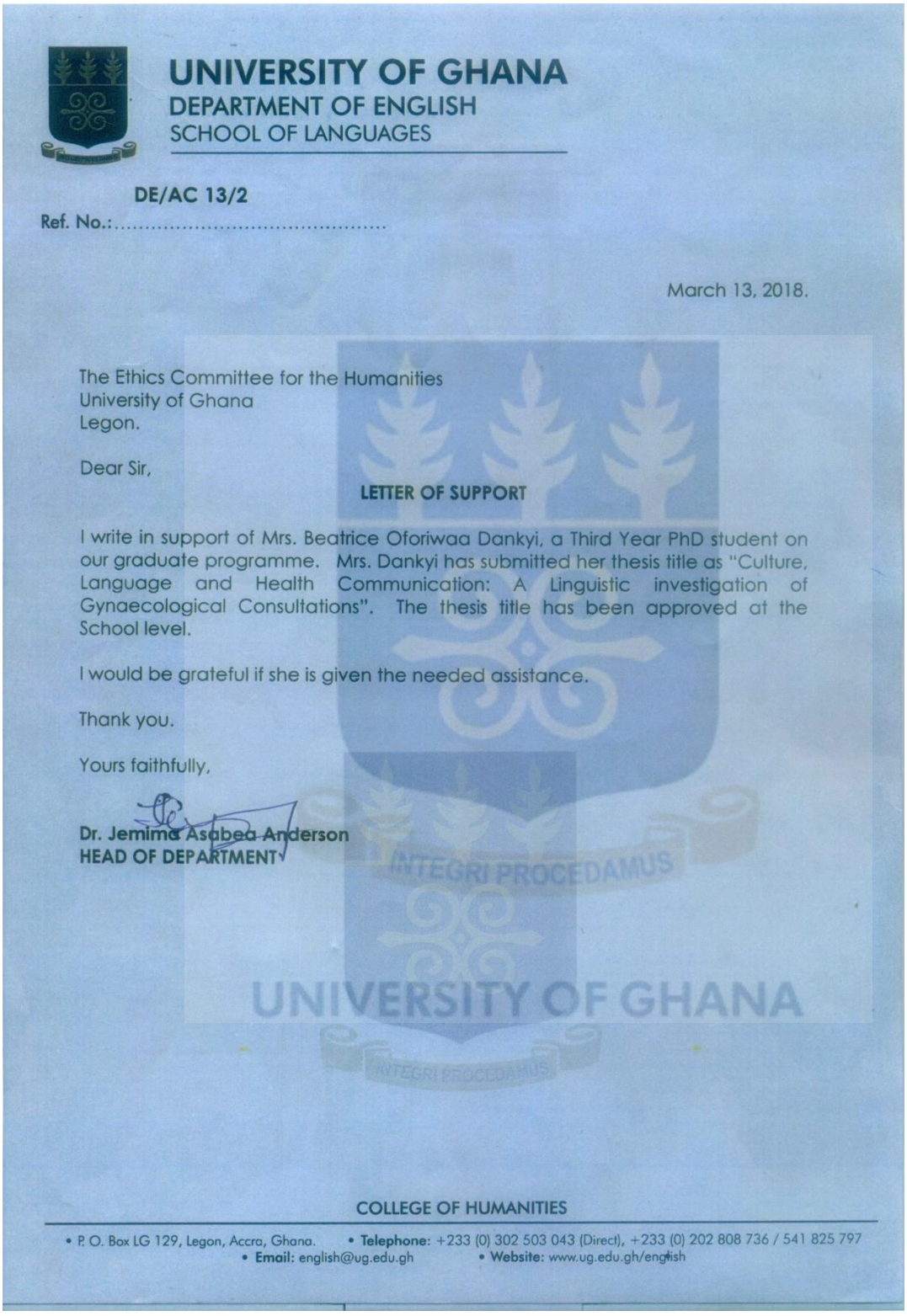
Yours faithfully,

Dr. Jemima Asabea Anderson
HEAD OF DEPARTMENT

COLLEGE OF HUMANITIES

• P. O. Box LG 129, Legon, Accra, Ghana. • **Telephone:** +233 (0) 302 503 043 (Direct), +233 (0) 202 808 736 / 541 825 797
• **Email:** english@ug.edu.gh • **Website:** www.ug.edu.gh/english

APPENDIX C



UNIVERSITY OF GHANA
DEPARTMENT OF ENGLISH
SCHOOL OF LANGUAGES

DE/AC 13/2
Ref. No.:.....

March 13, 2018.

The Ethics Committee for the Humanities
University of Ghana
Legon.

Dear Sir,

LETTER OF SUPPORT

I write in support of Mrs. Beatrice Oforiwaa Dankyi, a Third Year PhD student on our graduate programme. Mrs. Dankyi has submitted her thesis title as "Culture, Language and Health Communication: A Linguistic investigation of Gynaecological Consultations". The thesis title has been approved at the School level.

I would be grateful if she is given the needed assistance.

Thank you.

Yours faithfully,

Dr. Jemima Asabea Anderson
HEAD OF DEPARTMENT

INTEGRI PROCEDAMUS
UNIVERSITY OF GHANA
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• Email: english@ug.edu.gh • Website: www.ug.edu.gh/english

APPENDIX D

Letter of Invitation to the Study

Project Title: ***Culture, Language and Health: A Linguistic Investigation of Communication Strategies in Gynaecological Consultations***

Dear Sir/Madam,

A researcher from the School of Languages, specifically, the department of English at the University of Ghana is conducting a study into the communication strategies employed by both gynaecologists and patients during face-to-face consultations. The study will look at the types and styles of communication strategies, its effectiveness, barriers to it by gynaecologists in a variety of environments by using interviews with both patients and doctors, observing interactions with patients and finally, doing audio-recordings of the doctor-patient interactions.

The following medical facilities: The University of Ghana Health Services (UGHS) and the Korle-Bu Teaching Hospital (KBTH) will serve as the collation sites for the research. We are therefore looking for patients who would be interested in taking part. The researcher will carry out interviews with each respondent. Each interview would last between 30minutes - 1 hour. The interview can be carried out at a place of your (patient's) choosing, including the respondent's home if preferred. The consultation with the doctor would also be observed.

There is no obligation to take part in this study and your treatment will not be affected if you decide not to. If you are willing to take part in this study or would like more information, please, consent to your participation by signing or thumb-printing on the consent form or give us your oral consent. After your given consent, kindly, hand-deliver one of the documents to the researcher who will be at your service within the OB-GYN department with her specific location given.

We are grateful for your time and consideration.

.

Yours faithfully,

Beatrice Oforiwaa Dankyi
(Student Researcher).

APPENDIX E

PATIENTS (KBTH/UGHS) – INFORMATION SHEET

The Department of English,

School of Languages, University of Ghana, Legon.

PhD Project: 2018-2019

"Culture, Language and Health: A linguistic investigation of Communication strategies in gynaecological encounters in Accra, Ghana."

I give my permission for the researcher to contact me using the details given below.

NB: The provided details will assist the researcher to schedule an appropriate interview time with the consented patient on the study above in situations where the participant deems it necessary to be interviewed outside the premises of the hospital being explored – UGHS / KBTH.

Signed: ..... Date: .....

Name: .....
Address: .....

.....

.....

Postcode: ..... Mobile Phone/ Telephone number: .....

Email address: .....

Please, return this form to your doctor through hand delivery, email, or post to the researcher at the following contact address:

Beatrice Oforiwaa Dankyi

The department of English

School of Languages, University of Ghana, Legon – Accra

Alternatively, kindly contact the researcher on +233201610871/+233277761571.

Email: bboforiwaa@gmail.com / bobruku001@st.ug.edu.gh

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APPENDIX F

PATIENTS (KBTH/UGHS) – (SEMI-STRUCTURED INTERVIEW QUESTIONS)

The Department of English,

School of Languages, University of Ghana,

Legon

PhD Project: 2018-2019

Semi-Structured Interview Design Guide on

"Culture, Language and Health: A linguistic investigation of Communication strategies in gynaecological encounters in Accra, Ghana."

Dear Sir / Madam,

Kindly answer the following questionnaire as completely, accurately, and carefully as you can. The information from this study will help Ghana to improve its communication within its health sector. Your opinion is necessary and relevant to this study. Based on the codes of conduct in research, the use of human subjects within this study will eschew the use of any form of personal identification. The identities of all participants will remain confidential, undisclosed, and respected.

In this research, we are especially interested in investigating communication strategies that are instrumental in conducting a successful gynaecological encounter, the key barriers to communication during these encounters, doctor-patient dyads, socio-cultural and the demographic influence on the encounter and the doctor-patient perceptions about the encounter. Our goal is to uncover future research needs in the area, and its social impact especially with regards to the

patients' health delivery outcomes within a multilingual, multicultural, and a multiethnic medical environment, especially in Obstetrics and gynaecological encounters in Ghana.

We appreciate your contribution, time, and assistance in this research.

SEMI-STRUCTURED INTERVIEW GUIDE

Demographic information

a. Name of the health sector: .....

b. Coded name of participant: .....

c. Sex: .....

d. Age in years / Age range: .....

e. Nationality: .....

f. Mother-Tongue: .....

g. Marital Status: .....

h. How many Ghanaian languages (s) do you speak? .....

i. What Ghanaian languages do you write? .....

j. Which part of the country did you grow up? .....

k. School(s) attended? .....

l. What is your educational qualification? .....

m. Other languages written and spoken: .....

n. Which kind (s) of healthcare are you subscribing to? .....

o. Reason (s) for visiting that medical facility: .....

p. Have you ever visited the OB-GYN session prior to this visit? **Yes / No**. If **yes**, how many times do you visit the OB-GYN in a year? .....

q. Are you excited about visiting the OB-GYN, **Yes, or No**? If **yes** or **no** kindly explain the aspects, you enjoy, or you do not enjoy.

PATIENTS - (SEMI-STRUCTURED INTERVIEW DESIGN)

1. Have you had a gynaecological encounter before? Yes or No [Explanation on whatever answer selected]
2. What are your perceptions of OB-GYN consultations?
3. What information sources most importantly shape your views about OB-GYN?
4. Do you prefer to maintain one permanent gynaecologist for your treatment, or do you prefer to maintain several others? Kindly give your reasons .....
5. Over the years, how many gynaecologists have you seen, where are they located and why?
6. Do you prefer a male / a female gynaecologist?
8. What type of relationship do you have with your gynaecologist?
9. Does the age of an OB-GYN Consultant / Specialist matter to you?
10. Do you consider the experience (s) of the OB-GYN doctor before agreeing to the meeting or not?
11. Are you privy to knowing the experiences of the specialist before scheduling an appointment?
12. Do you prefer an OB-GYN doctor who is from the same ethnicity as you or not, and why?

13. What language(s) do you speak, and which one would you prefer to speak to the OB-GYN doctor and vice-versa?

14. During the consultation, are you allowed by the gynaecologist to expressively communicate the details of your issues? If allowed, in what ways do you communicate these issues?

15. Are you anxious about visiting a gynaecologist? If **yes,** how do you know? Can you describe what happens in this state?

16. What are your expectations with regards to your sexuality issues with the gynaecologist?

17. What makes you satisfied during these encounters, and what does not?

18. What is your view (s) on the nature of the gynaecological examinations?

19. When thinking about your own decision to have/not have a gynaecological encounter whose opinion do you most value?

20. In your experience as a regular patient or a first-time patient, how would you describe your gynaecological encounters?

21. Which period of the day do you anticipate seeing your gynaecologist, and why?

22. What type of language do you normally adopt during your gynaecological sessions to get your issues on sexuality, or reproductive health challenges across?

23. When you use that language does your doctor respond to it comfortably or confidently or does, he or she change the language? How does he do this? Does he or she seek any assistance?

24. If he does change the language, what does he use, and how does he communicate it to your understanding?

25. If you are pleased, or displeased with what is happening, are you able to express your feelings to your doctor? Are you given your rights to do so?

26. Do you have knowledge of what a taboo language is about? If **yes**, what is it?

27. Growing up in Ghana, which aspects of the socialization process (s) - (home, school, church, friends, media (internet, TV, radio), others)) impacted your sexology education? And how did this institution help in this direction?

28. Do you say vagina, clitoris, and vulva etc.? **Yes** or **No**, if **yes**, what inspires you to say them as they are? If **No**, what word would you use for example for a. Vagina b. Clitoris and c. Vulva during these encounters and explain why?

29. What do the doctors use to refer to for example the Labia, Vagina, Breast, and Discharge?

30. In your interaction with the doctor, do you fear any kind of judgment from the doctor if you use words like vagina, anus, and clitoris, **yes** or **No**? If **yes,** what views do you think your doctor will have on you?

31. How does your doctor explain the treatment plan to you if you do not know where for instance what a cervix is and how it is positioned in your body?

32. Is your gynaecologist explicit or implicit when they are doing an internal examination of your vagina, **yes**, or **No**? If **yes**, what word(s) used by the doctors during the vaginal examination proves to that?

33. Doing physical examination, how do you feel?

34. Given that there was no explicit communication, how do you feel about the examinations? a. Sexually assaulted b. Perfectly OK c. Doctor's job d. other

35. If the gynaecologist happens to be female, and she employs explicitness or taboos (implicitness) in language, how would you feel?

36. Do the doctors (male & female) encourage you to use the so-called taboo terms to express yourself, in what ways and in which language?

APPENDIX G

GYNAECOLOGICAL CONSULTANT/SPECIALIST (UGHS/KBTH) – (SEMI-STRUCTURED INTERVIEW QUESTIONS)

The Department of English,

School of Languages, University of Ghana,

Legon

PhD Project: 2018-2019

Semi-Structured Interview Design Guide on

"Culture, Language and Health: A linguistic investigation of Communication strategies in gynaecological encounters in Accra, Ghana."

Dear Sir / Madam,

Kindly answer the following questionnaire as completely, accurately, and carefully as you can. The information from this study will help Ghana to improve its communication within its health sector. Your opinion is necessary and relevant to this study. Based on the codes of conduct in research, the use of human subjects within this study will eschew the use of any form of personal identification. The identities of all participants will remain confidential, undisclosed, and respected.

In this research, we are especially interested in investigating communication strategies that are instrumental in conducting a successful gynaecological encounter, the key barriers to communication during these encounters, doctor-patient dyads, socio-cultural and the demographic influence on the encounter and the doctor-patient perceptions about the encounter. Our goal is to

uncover future research needs in the area, and its social impact especially with regards to the patients' health delivery outcomes within a multilingual, multicultural, and a multiethnic medical environment, especially in Obstetrics and gynaecological encounters in Ghana.

We appreciate your contribution, time, and assistance in this research.

Demographic Information

1. Name of health sector: .....
2. Coded name of participant: .....
3. How do you see yourself in terms of gender? .....
4. Age range: .....
5. Mother-Tongue: .....
6. Ghanaian languages spoken: .....
7. Ghanaian languages written: .....
8. Other languages spoken: .....
9. Language (s) commonly used during OB-GYN consultations:
10. Nationality: .....

SEMI-STRUCTURED INTERVIEW GUIDE

1. What type of OB-GYN specialist are you?
2. What is your level of qualification?
3. How long have you been practicing?

4. Have you changed medical facilities to practice over the years? Why or why not?

5. What is your best time to work?

6. How many patients do you normally attend to in a day, and what types of women do you normally attend to?

7. What language (s) do you prefer to use with your patients?

8. In dealing with these sensitive issues, how best does your preferred language(s) aid the communication processes?

9. Cumulatively, how many have you attended to in your estimations over the years?

10. What major language (s) do you usually use to communicate to your patients?

11. Have there been instances where neither you, nor your patients have an uncommon language? In such instances, what alternatives do you resort to?

12. What is the role of your patient in your consultations?

13. What is your understanding of the risks, and benefits of gynaecological consultations for the patient? What about the risks of repeated encounters?

14. Do you fear any kind of judgment from the patient if you use words like vagina, anus, and clitoris, **yes** or **No**? If **yes**, kindly explain.

15. Kindly, describe what makes you satisfied with your consultation with a patient.

APPENDIX H

UNIVERSITY OF GHANA

ISSER

Knowledge for Development

Official Use only
Protocol number

Ethics Committee for Humanities (ECH)

PROTOCOL CONSENT FORM

Section A- BACKGROUND INFORMATION

Title of Study:	Culture, Language and Health: A Linguistic Investigation of Communication Strategies in Gynaecological Encounters in Accra, Ghana.
Principal Investigator:	Beatrice Oforiwaa Dankyi – Doctoral Student.
Certified Protocol Number	**ECH 169/17 - 18**

Section B – CONSENT TO PARTICIPATE IN RESEARCH

General Information about Research

Purpose of Research

This research aims to assess the current situation in doctor-patient gynaecological consultations with regards to the communication strategies employed, its effectiveness, its barriers, the impact of culture and demographic factors of the patients on the encounter. This study is explorative, descriptive, analytical and interpretive. The findings derived may guide further research and training to provide the highest quality of communication during doctor-patient gynaecological encounters in Ghana.

The study design employs ethnography of participation, semi-structured interviews, consulting room audio-recordings and possibly focused group discussions as its methodological approaches to collate data from the consented participants. The methodological designs to be adopted will eschew any form of experimentation. Each respondent is expected to spend a minimum time of 45minutes and a maximum time of an hour on the study.

Methods and Procedures

1. If the doctors and the patients permit, there will be an interview to detail the aim(s) and expectation(s) of the patient and the gynaecologist before or after their gynecological encounter.

2. The researcher will focus primarily on the obstetrics and gynaecological consultants and the (resident medical officers) if needed in the medical institutions selected. Due to the research's focus on the doctor-patient dyads, about nine doctors will be used. This number will have a combination of male and female OB-GYN consultants as well as resident medical officers from both institutions. Ten (20) or more doctor-patient recordings will be taken from each of the consultants and used for the study.

3. Observation and audio (tape)-recording of the consultation between the doctor and the patient will be made. The recording will be made by the researcher also in the consulting room as she observes the consultation. This procedure will last approximately 30mins – 1hour

NB:

- Although the researcher may be present in the consulting room after being granted permission by the patient to observe the process, her presence will not affect the consultation in any way and the researcher will not be involved in the consultation.
- Interviews can be arranged to take place at a time and location to suit you (out-patient), including your home or a place local to you. All interviews will be conducted in a confidential manner and venue consented to by the respondent.
- Audio-taping of the consultation will allow the researcher to look at the communication in the consultation in a detailed manner. Also, direct quotations may be used in the analysis. However, any direct quotations used will be fully anonymised prior to publication. All personally identifying information from any data collected will be removed before publication of any material.
- If possible, Focused Group Discussions (FGD) will be conducted to further augment the data collation processes due to the triangulation approach adopted in the study design.
- Data will be stored securely in the archived file of the researcher during the study for 10 years after the study has ended. All data will then be destroyed. Any data stored electronically will be fully password protected.
- The researcher (s) will **NOT** have access to patient medical records during the study.

Benefits / Risks of the study

It is not anticipated that there will be any risks associated with the study. Although, the interviews (i.e. individualized and identifiable data about living people) may cover intimate issues such as sexuality and sexual reproductive health issues, the out-patient who has consented to the study will not be forced, coerced or lured to answer any questions he or she may feel uncomfortable with.
As a scientific design, seeking to answer scientific questions, there will be insignificant risks and the benefits will be reasonable in relation to the knowledge gained by the study, which may be generalisable.
It is certain that with the communication gaps in healthcare delivery in Ghana, this study will aid to improve communication between doctors in, especially OB-GYN care delivery and their patients now and in the nearest future.

Confidentiality

Absolutely, your confidentiality is being safeguarded during and after the study in the following ways. Procedures for handling, processing, storage and destruction of data are compliant with the Data Protection Act, 2012 of Ghana.

- Data for interviews and consultations will be audio-taped and transcribed verbatim.
- Observational notes will be made during the consultation.
- Data will be stored securely in the archived project file of the researcher during the study.
- Each participant will be allocated an identification code. The list linking participants' name and codes will only be available to the (principal) investigator. It will be stored in a locked drawer away from the data itself and destroyed at the end of the study.
- Data will be used for critical discourse analysis (CDA) in the researcher's PhD project.
- Data may be used for further detailed discourse or conversation analysis in a future study.
- Only authorised researchers will have access to view identifiable data.
- Any data stored electronically will be fully password protected.
- Data will be stored in the secure researcher file for 10 years after the study has ended. All data will then be destroyed.
- All information which garnered about you (respondent) during the course of the research will be kept strictly confidential. Participants have the right to check the accuracy of data held about them and correct any errors.

Compensation

It is not expected that you (patient) will incur any additional costs due to this study; however, if you wish to be interviewed at the University of Ghana or any other location, any reasonable travel expenses will be reimbursed. ***Please retain all receipts/tickets.***

Again, 5 Ghana Cedis worth of call credits will be given to you (data respondent) at the specific research site where the specific data is collated due to the valuable minutes the respondent spends on the research. This information will be kept private until the data is collated from the respondent.

Finally, results of this study will be used for analysis in the researcher's PhD thesis and for publication of papers in appropriate relevant scientific journals. A summary of the results will be available to research participants upon request. Research respondents will not be identified in any report or publication unless they have consented to release such information.

Withdrawal from Study

We would be grateful to have you serve as one of our respondents however, it is to be emphasized that participation in the study is voluntary and participants may withdraw at any time without penalty. The decision, therefore, lies with you (respondent) whether to take part. If you do, you will be given a copy of your consent form signed / thumb-printed to be kept in your own archives for future records. Despite your consented participation, you are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect the standard of care you receive. Any data collected from you will be destroyed upon your command if you decide to withdraw from the study. In addition, the respondent's legal representative will be informed in a timely manner if information becomes available that may be relevant to the participant's willingness to continue participation or to withdraw entirely.

Contact for Additional Information

If you have a concern about any aspect of this study, you should ask to speak with the student researcher who will do her best to answer your questions. Her contact is as follows:

Beatrice Oforiwaa Dankyi (Mrs.)
The Department of English
The University of Ghana,
Legon, Accra
bobruku001@st.ug.edu.gh
bboforiwaa@gmail.com
0201610871/ 0277761571

Alternatively please contact the following persons:

Professor Nana Aba Amfo (Principal Supervisor):
Dean, School of Languages,
University of Ghana, Legon
E-mail: namfo@ug.edu.gh
Tel: **0264728324**

OR:

Dr Timothy **Komla** Senunyeme (Consultant Gynaecologist and Project Mentor),
University of Ghana Hospital,
Legon-Accra
E-mail: tsenunyeme@ug.edu.gh
Tel: **0202930468**

NB: **If your complaint is regarding your treatment, you should follow the standard National** Health Service's complaint procedure by contacting PALS (Patient Advice and Liaison Service) in your trust.

Finally, if you have any questions about your rights as a research participant in this study you may contact the Administrator of the Ethics Committee for Humanities, ISSER, **the** University of Ghana at ech@isser.edu.gh / ech@ug.edu.gh or 00233- 303-933-866.

Section C- PARTICIPANT AGREEMENT

"I have read or have had someone read all of the above, asked questions, received answers regarding participation in this study, and am willing to give consent for me **(patient/respondent)**, to participate in this study. I will not have waived any of my rights by signing this consent form. Upon signing this consent form, I will receive a copy for my personal records."

[redacted]

Name of Participant

Signature or mark of Participant

03/12/18

Date

If participant cannot read and or understand the form themselves, a witness must sign here:

I was present while the benefits, risks and procedures were read to the volunteer. All questions were answered and the volunteer has agreed to take part in the research.

[redacted]

Name of witness

GRACE

Signature of witness / Mark

03/12/18

Date

I certify that the nature and purpose, the potential benefits, and possible risks associated with participating in this research have been explained to the above individual.

BEATRICE OFORIWAA DANKYI

Name of Person who Obtained Consent

Signature of Person Who Obtained Consent

03/12/18

Date

APPENDIX I

CODING PATTERN/DERIVATIONS

Nodes

Name	Description	Files	References
Communication Accommodation Theories	Theoretical underpinning of subject matter. It has both converging and diverging constructs.	0	0
Convergence (CON)	When the participants accommodate towards each other's speech to establish social distance, acceptance, agreement, in gestures, postures and speech rate.	7	38
Divergence (DIV)	When participants in speech draw apart due to different opinions. In This interaction, there are no attempts to display any form of communicative similarities	4	7
Communication Strategies	Communicator style profiles consciously or unconsciously adopted during doctor-patient gynaecological interactions to get enough information from patients. Furthermore, are how these strategies enhancing the patients to divulge all information or not.	7	53
Medical Jargons (M. J's)	A situation that usually hinders the understanding of the patients due to the use of certain medical terms in the doctor-patient interactions.	3	14
Code-Switching (C-S)	The predominant, and spontaneous use of Akan and other local languages in tandem with English during the consultations. In this study, Akan, more than any of the other local languages was used more with English in such circumstances.	6	54

Name	Description	Files	References
Context Terms	The use of localised terminologies in the consultations that was understood by the doctor and patient since they have lived in Ghana for at least 10 years.	7	25
Empathy (EMP)	The ability to understand, share and be sensitive to the feelings, thoughts, and experiences of another.	8	131
Politeness (POL)	The practical application of good manners and etiquette. A culturally defined phenomenon. What is rude or unacceptable in one culture can be eccentric in another.	7	109
Repetitions (REP) - KBTH Doctors and patients	The number of occurrences of repeated words in the gynaecological consultations by mostly the doctors at the KBTH, although a few patients also employed it.	4	42
Repetitions (REP) -UGHS Doctors and patients	The number of occurrences of repeated words, in the gynaecological consultations by mostly the doctors at the UGHS, although a few patients also employed it.	3	17
We-Inclusivity (WE-I)	The use of the pronoun *We* as a collective pronoun by the doctors during the consultations. The doctors in almost all their encounters observed used *We* instead of *I* to include their colleagues, and the facility in managing healthcare.	7	88
Female Gynae Preference	A situation where the patient voices out their preference for a female OB-GYN in their medical care delivery.	0	0
Indirection	Exploring the varied ways, the doctors, and patients say, but unsay as they negotiated the encounters.	0	0

Name	Description	Files	References
Avoidance (AVO)	Doctors and patients omit saying anything sexual during the consultation.	7	49
Pronoun IT (PRN-IT)	When the doctors use *IT* in place of the following: *menses, discharge, fibroid, candida* instead of using its exact term during the interactions.	8	68
Noun Phrase Expressions (NP-E)	Doctors or patients describing *the vagina (female reproductive organ)* as the following: *The place, down there, there, inside, outside* without deliberately not saying *the vagina.*	7	38
Low-Tones (L-T)	In the process of the doctor-patient interactions, patients usually speak in low tones, or inaudibly when they feel threatened or uncomfortable by the topic under discussion.	7	66
Silence (SIL)	A situation when during the doctor-patient encounters the doctors and the patients resort to 'saying nothing at all' to register their displeasure at what is being discussed. This strategy is employed when one is a bit confused, disturbed or displeased with what is being discussed.	7	24
KBTH Dr S-S Interviews	Semi-structured individual interviews on 4 doctors used at KBTH for the study.	0	0
Age impacts	How the various age groups communicate with the doctor during the consultation and its results?	2	2
Basic Medical Principles	These are principles adhered to by the doctors in their daily businesses within the hospital set-ups.	4	4

Name	Description	Files	References
Best Consultation Practices	Doctors' views on the best form of consultation practices.	3	3
Consultation satisfaction	Factors that encourage doctors to become satisfied during their consultation with a patient?	4	12
Cultural impacts	The significance of culture in the consultation processes.	4	16
Culturally Appropriate Language	How the patients speak when it has to do with matters concerning their *vagina* in a consultation with the doctor?	1	3
Descriptive Communication	Doctors using Akan as a medium of communication with the patients and adopting more descriptive phrases for the patient to understand. The doctors try to avoid using an exact form of communication.	1	2
Doctor's Gender (Impact)	The level of impact the gender of the doctor has on the consultation during the encounters.	1	1
Drs English	English language serving as the main functional language for the doctors with the help of a few local languages they know already, mostly their L1.	4	8
Eye Contact (Drs)	The use / or non-use of eye contact, and the doctors' or patients' reasons to that effect during the consultation. Both doctors and patients see it as a necessary part of the encounter.	1	1
Judgemental reactions	How doctors feel being treated by patients as they mention the parts of their body which they (patients) deem as sensitive, and private.	3	3

Name	Description	Files	References
Language Strategy	How the doctors meet the demands of the patients in their language use.	2	2
Number of patients	The number of patients seen in a day at the hospital by each doctor.	2	4
Other Communication Forms	Other means used by the doctors to communicate to the patients for a better understanding of their disease.	3	4
Other Languages (Drs)	Situations when doctors use other languages apart from the English language.	1	1
Patient involvement	This is to find out whether the doctors involve the patients in their medical plans or not.	1	1
Patient Language determination	Ways the doctors select the type of language to use for each of their patients.	2	4
Patient Language Preference	How the doctors know which type of language is preferred by the patient during the consultation period.	2	2
Patient sexual reproductive organ (SRO) Language	Language used by patients in describing their sensitive parts during the consultation.	1	2
Patient Type	Type of patients seen by the doctors daily.	1	1
Patients' role	In the communication process, we try to find out how significant is the patient role in the entire process, especially to the doctor.	4	5
Working hours	The best time doctors prefer to work or work at the hospitals.	4	5

Name	Description	Files	References
KBTH Patient S-S Interviews	Individual Semi-structured interviews by five (5) patients at the KBTH in 2018/2019.	0	0
Appreciation	Patients' expression of how pleased they are with the hospital's (doctors) management of their condition.	1	1
Body parts names	Terminologies used by the patients to refer to their personal body parts	5	7
Cultural Impact	This expresses show how the patients refer to their vagina, and the cultural notions they associate to it as Ghanaians.	4	7
Doctor-patient relationship	The type of relationship that exists between the doctor and the patient.	0	0
Drs Explicitness	How the patients feel when the doctors use the terms *vagina* without any forms of embellishment?	3	5
Drs Implicitness	How the patients react if the doctor is implicit in language about their condition?	2	2
Examination discomfort	When the patient feels her privacy has been trampled upon.	3	3
Languages for Consultation	The patient gives their perspectives on the types of languages that must be used in the hospitals for consultations.	4	5
Nature of the D-P Consultation	Environment of the consultation from the perspective of the patient	5	21

Name	Description	Files	References
Patient Concerns	The gaps in the facility's efficient management of their patients within the shortest possible time.	5	11
Eye Contact	This question seeks to find out if the doctors maintain eye contact with their patients, and its significance to the patients.	3	3
Feelings Derived from Eye Contact	How the patients feel when doctors maintain eye contact with them.	3	3
Hospital Management	Disease / procedure being managed at the hospital.	5	9
Impact of Drs Expertise	This question teases out the relevance of doctor's professionalism to the patient.	3	4
Expertise- Neutral Position	When the patient is indifferent towards the doctor's professionalism as a major factor to her healing or the consultation.	1	1
Influence of Drs Age	This expresses whether the age of the doctor has any influence over the patient, or the ability to treat the patient efficiently.	0	0
Age-Neutral	When the age is not a major factor for the patient consenting to see the doctor. Age as a variable is neutral.	3	4
Old Age	The meanings associated with the Doctors age, especially if the doctor is old.	2	3
Young Age	The associated meanings to a doctors young age.	2	2

Name	Description	Files	References
Influence of Gender	How the gender of the doctor influences how the patient feels in the consulting room or in dealing with them.	5	9
Influence on ethnicity	Whether the patients are affected by the doctor's ethnicity in the consulting room.	2	2
Language Choices	The language (s) patient speaks with the doctor	4	7
Language History	The language dynamics (medical information) of the patients being interviewed.	5	5
Language Preference	The language or languages preferred by patients when they encounter their doctors.	4	6
Languages Spoken	All the languages spoken by the patients who were interviewed at KBTH	5	11
Languages written	All the languages which could be spoken and written by the patients.	5	6
Level of Expectation	Whether the expectations of the patient were met.	5	6
Name of Vagina	Different words used to describe the vagina by the different patients in the study.	5	7
Instances of mentioning Vagina	Instances which compel patients to mention vagina without any fear or favour to their doctors.	5	7

Name	Description	Files	References
Number of Doctors	This information establishes the number of doctors each patient would like to maintain throughout their medical management.	4	7
Other forms of communication	Other means the doctors use to communicate to the patients during the consultation.	1	2
Patient Satisfaction	Observed elements about the interactions that enhances the patient's motivation during the interactions to continue with the medical facility.	5	12
Period	Timeframe of being with the hospital for management.	5	9
Unwritten Languages	Languages that the patients cannot write but can only speak.	5	6
MEDICAL JARGONS KBTH DOCTORS	The number of medical jargons used by each of the doctors at the KBTH.	0	0
Dr B	A male OB-GYN Gynaecologist, and all the M. J's, used with 5 of his patients under study.	1	233
PAT'S B	Exploring all the patients under this set and their use of M. J's	1	28
Dr F	A female OB-GYN Consultant and the number of M. J's she uses with her 5 patients in total.	1	147
PATS' F	Exploring all the patients under this set, and their use of M. J's	1	39
Dr F1 .	A female OB-GYN Specialist and the number of M. J's used with all her 5 patients under study.	2	165

Name	Description	Files	References
PAT F1	Exploring all the patients under this sets use of M. J's	1	26
Dr M	A male OB-GYN specialist and the overall number of M. J's used with 5 of his patients.	1	149
PAT'S M	Exploring the number of M. J's used by all the patients under Dr M.	1	46
MEDICAL JARGONS UGH DOCTORS AND 15 PATIENTS IN ALL	All the medical jargons (M. J's) used by the three (3) selected doctors, and their patients under study.	0	0
Dr 1	An OB-GYN Consultant and his patients understudied on M. J's.	1	186
PATS' 1	Exploring the patients under this set use of M. J's.	1	24
Dr 2	An OB-GYN Consultant understudied and his patients use of M. J's.	2	211
PATS' 2	Exploring the patients under this set use of M. J's.	1	33
Dr 3	An OB-GYN Specialist understudied with his patients' use of M. J's.	1	307
PATS' 3	Exploring the patients under this set use of M. J's.	1	33
Dominant communicator	This communicator talks frequently and takes charge in the interactions. They are experienced and knowledgeable in the topics being discussed. They are observed to come on strong, as they control all aspects of the interactions.	7	168

Name	Description	Files	References
Dr M	A male OB-GYN specialist and all the M. J's used with his 5 patients under study.	1	156
PATS' M	Exploring the patients under this set use of M. J's	1	54
UGH Drs S-S Interviews	Semi-structured individual interviews on doctors at the gynaecological unit of the UGHS in Accra, Ghana.	0	0
Age impacts	How the age of the doctors influences the process.	3	4
Best Communication Practices	Varied ways doctors employ to get relevant information from their different patients with varied socio-cultural backgrounds.	3	4
Impact factor	How the rotational procedures add to the doctor's expertise.	1	1
Consultation Dissatisfaction	What impacts on the consultation, making the doctor dissatisfied.	3	6
Consultation Language	Main language used for medical consultation.	3	5
Consultation Satisfaction	Information on how the doctors arrive at the satisfaction level during the consultation.	3	4
Cultural clash	The influence of culture during the process.	3	8
Culturally Appropriate Language	Language used to discuss sensitive parts of a patient's body.	3	5
Drs Eye Contact	How eye contact shapes the consultation process.	3	4

Name	Description	Files	References
Drs. English	The English language serving as the doctors first and primary language.	3	5
Empathy	The emotional level the doctors operate from during the consultation.	3	3
Impact of Gender	The relevance of gender in the OB-GYN interactions.	3	3
Judgemental reactions	How some patients react when sensitive parts of the body are being mentioned by the doctors?	3	3
Language Strategy	Other ways doctors employ to get relevant information from their patients.	3	5
Nature of Examinations	Doctors' views on the nature of examinations done, and how the patients respond to such procedures.	3	3
Number of patients	Number of patients seen by the doctors	3	4
Other Communication Forms	Other ways doctors communicate apart from their use of English, and their mother-tongue, especially, when they cannot speak the patient's language very well.	3	5
Other languages (Drs.)	Other languages adopted by the doctors as they consult.	3	3
Patient Language Determination	How doctors determine which languages patients would readily respond to by employing several means.	3	3
Patient language Preference	The language most acceptable by patients during the consultation.	3	5

Name	Description	Files	References
Noun Phrase (NP) - Expressions	This is the language patients use when they are talking about their most sensitive relational organs with the doctor.	3	3
Role of Patients	How the doctors see the patients during the consultation.	3	3
Type of patients	The type of patients being taken care of at the hospitals observed.	2	3
Working hours	Hours doctors use in working at the medical facilities, especially, the Gynaecological units.	3	4
UGH Patient S-S Interviews	5 patient individual semi-structured patient interviews at the UGHS.	0	0
Appreciation	Patients' expression of how pleased they are with the hospital's (doctors) management of their condition.	5	10
Body parts names	Terminologies used by the patients to refer to their personal body parts	4	7
Cultural Impact	This expresses how the patients refer to their vagina and the cultural notions they associate to it as Ghanaians.	5	8
Dr-patient relationship		0	0
Drs Explicitness	How the patients feel when the doctors use the terms *vagina* just as they are without any forms of embellishment.	5	10
Drs Implicitness	The reaction of patient when the doctors use implicit language for their conditions?	3	3

Name	Description	Files	References
Examination Discomfort	When the patient feels her privacy has been trampled upon.	1	1
Languages for Consultation	The patient gives their perspectives on the types of languages that must be used in the hospitals for consultations.	5	7
Nature of the D-P Consultation	Environment of the consultation from the perspective of the patient.	5	27
Patient Concerns	The gaps in the facility's efficient management of their patients within the shortest possible time.	4	7
Eye Contact	This question seeks to find out if the doctors maintain eye contact with their patients and its significance to the patients.	4	5
Feelings Derived	How the patients feel when doctors maintain eye contact with them.	4	5
Hospital Management	Disease / procedure being managed at the hospital.	5	7
Impact of Drs Expertise	This question teases out the relevance of doctor's professionalism to the patient.	1	1
Expertise- Neutral position	When the patient is indifferent towards the doctor's professionalism as a major factor to her healing or the consultation.	2	2
Influence of Drs Age	This expresses whether the age of the doctor has any influence over the patient, or the ability to treat the patient efficiently.	3	5
Age-Neutral	When age is not a major factor for the patient consenting to see the doctor. Age as a variable is neutral.	3	3

Name	Description	Files	References
Language preference	The language (s) preferred by patients when they encounter their doctors.	4	4
Level of expectation	Whether the expectation of the patient is met or not.	5	8
Name of Vagina	Different words used to describe the vagina by the different patients in the study.	5	7
Instances of mentioning vagina	Instances which compel patients to mention vagina without any fear or favour to their doctors.	3	4
Number of Doctors	This information gives the number of doctors each patient would like to maintain throughout their medical management period.	5	5
Other Forms of Communication	Other means the doctors use to communicate to the patients during the consultation	3	3
Patient Satisfaction	Observed elements about the interactions that enhances the patient's motivation during the interactions for them to continue with the medical facility.	5	9
Period	Timeframe of being with the hospital for management.	5	9
Spoken Languages (UGHS)	All the languages spoken by the patients who were interviewed at UGHS	5	12
Unwritten Languages (UGHS)	Languages that the patients cannot write but can only speak.	4	5
Written Languages (UGHS)	All the languages which could be spoken and written by the patients.	5	6

APPENDIX J

ACT

OF THE PARLIAMENT OF
THE REPUBLIC OF GHANA
ENTITLED

DATA PROTECTION ACT, 2012

AN ACT to establish a Data Protection Commission, to protect the privacy of the individual and personal data by regulating the processing of personal information, to provide the process to obtain, hold, use or disclose personal information and for related matters.

DATE OF ASSENT: 10*th May, 2012*

PASSED by Parliament and assented to by the President:

Data Protection Commission

Establishment of Data Protection Commission

1. (1) There is established by this Act a Data Protection Commission. (2) Where there is hindrance to the acquisition of property, the property may be acquired for the Commission under the State Property and Contracts Act, 1960 (C.A.6) or the State Lands Act, 1962 (Act 125) and the costs shall be borne by the Commission.

Object of the Commission

2. The object of the Commission is to

(a) protect the privacy of the individual and personal data by regulating the processing of personal information, and

(b) provide the process to obtain, hold, use or disclose personal information.

protect a data subject who is affected by the unauthorised access or acquisition of data, the Commission may direct the data controller to publicise in the specified manner, the fact of the compromise to the integrity or confidentiality of the personal data.

Access to personal information

32. (1) A data subject who provides proof of identity may request a data controller to

(a) confirm at reasonable cost to the data subject whether or not the data controller holds personal data about that data subject,

(b) give a description of the personal data which is held by the party including data about the identity of a third party or a category of a third party who has or has had access to the information, and

(c) correct data held on the data subject by the data controller.

(2) The request shall be made

(a) within a reasonable time;

(b) after the payment of the prescribed fee, if any;

(c) in a reasonable manner and format; and

(d) in a form that is generally understandable.

Correction of personal data

33. (1) A data subject may request a data controller to

(a) correct or delete personal data about the data subject held by or under the control of the data controller that is inac- curate, irrelevant, excessive, out of date, incomplete, misleading or obtained unlawfully, or

(b) destroy or delete a record of personal data about the data subject held by the data controller that the data controller no longer has the authorisation to retain.

(2) On receipt of the request, the data controller shall comply with the request or provide the data subject with credible evidence in support of the data.

(3) Where the data controller and the data subject are unable to reach an agreement and if the data subject makes a request, the data con- troller shall attach to the record an indication that a request for the data has been made but has not been complied with.

(4) Where the data controller complies with the request, the data controller shall inform each person to whom the personal data has been disclosed of the correction made.

(5) The data controller shall notify the data subject of the action taken as a result of the request.

Manner of access

34. The provisions of any legislation relating to the right to information of any data subject shall be additional to data subject rights under this Act.

Right of access to personal data

35. (1) A data controller shall

(a) inform an individual who is the data subject of the processing of the individual's personal data by the data controller or another person on behalf of the data controller;

(b) give to the data subject, a description of

(i) the personal data of which that individual is the data subject;

(ii) the purpose for which the data is being or is to be processed; and

(iii) the recipient or class of recipients to whom the data may be disclosed;

(c) communicate in an intelligible form to the data subject

(i) information which constitutes personal data of which that individual is the subject;

(ii) information which is available to the data controller as to the source of the data; and

(d) inform the individual who is the data subject of the logic or rationale behind the decision that was made based on the processing where the processing constitutes the sole basis for the taking of a decision which significantly affects that individual.

(2) Where the data constitutes a trade secret, the provision of data related to the logic or rationale involved in any decision taken does not apply.

(3) A data controller shall not comply with a request under subsec- tion (1) unless the data controller is supplied with the data that the data controller may reasonably require to identify the person making the request and to locate the data which that person seeks.

(4) Where a data controller is unable to comply with the request without disclosing data related to another individual who may be identi- fied from the information, the data controller shall not comply with the request unless

(a) the other individual consents to the disclosure of the data to the person who makes the request, or

(b) it is reasonable in all the circumstances to comply with the request without the consent of the other individual.

(5) A reference to data related to another individual in subsection (4) includes a reference to data which identifies that individual as the source of the data requested.

(6) A data controller shall not rely on subsection (4)(b) to fail to communicate the information sought that may be communicated without the disclosure of the identity of the individual concerned.

(7) The data controller may make the communication under subsection (6)

by omitting or deleting the names or other identifying particulars of the other individual.

(8) For the purposes of subsection (4)*(b)*, to determine whether it is reasonable to comply with the request without the consent of the other individual concerned, regard shall be had in particular, to

(a) any duty of confidentiality owed to the other individual,

(b) any steps taken by the data controller to seek the consent of that other individual,

(c) whether the other individual is capable of giving consent, and

(d) any express refusal of consent by the other individual.

(9) An individual who makes a request under this section may specify that the request is limited to personal data of any description.

(10) Subject to subsection (5), a data controller shall comply with a request under this section promptly and in any event within forty days from the date of receipt of the request.

(11) Where the commission is satisfied on the application or a complainant in relation to matters under subsections (1) to (10) that the data controller has failed to comply with the request, the Commission may order the data controller to comply with the request.

(12) The obligation imposed on a data controller to provide the data subject with information under section 20 to 26 is fulfilled by supplying the data subject with a copy of the data in permanent form.

(13) Where a data controller has previously complied with a request by a data subject, the data controller shall not comply with a subsequent request which is identical or similar unless a reasonable interval has elapsed between the time of compliance with the previous request and the making of the new request.

(14) For the purposes of subsection (13), to determine whether a request for data by a data subject to a data controller has been made at a reasonable interval, regard shall be had to

(a) the nature of the data,

(b) the purpose for which the data is processed, and

(c) the frequency with which the data is altered.

(15) The data which is supplied pursuant to a request may take into account an amendment or deletion made between the time of the request and the time when the data is supplied.

(16) For the purposes of this section another individual may be identified from the data disclosed if that individual can be identified

(a) from that data, or

(b) from that data and any other data which in the reasonable belief of the data controller are likely to be in, or come into