UNIVERSITY OF GHANA

DOCTOR-PATIENT COMMUNICATION IN GHANA: A COMPARATIVE STUDY BETWEEN PUBLIC AND PRIVATE HOSPITALS

BY

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DECLARATION

I hereby declare that this thesis, entitled 'Doctor-Patient Communication in Ghana: A Comparative Study between Public and Private Hospitals', submitted to the University of Ghana, is an original academic work done by me under the supervision of Prof. Aaron Asibi Abuosi and Dr. Anita Asiwome Adzo Baku. This thesis is submitted in partial fulfilment of the requirement for the award of a degree in MPhil Health Services Management. The findings from this thesis have not been submitted to any other university or institution for the award of any degree.

01/09/21

JIMA BAWA KASSIM

DATE

CERTIFICATION

I hereby declare that the preparation and presentation of the thesis was supervised in accordance with the guidelines on supervision of thesis laid down by the University of Ghana.

1/9/2021

PROF. AARON ASIBI ABUOSI — DATE

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DEDICATION

This research work is dedicated to the Almighty God and my Ancestors for making this arduous or tortuous journey successful; my late parents, Mr. Jima Kuborulubi and Madam Abu-Aya Asumani; my virtuous and adorable wife, Zuleha Kassim-Jima and my children, Kanyiti Kassim-Jima and Shunkpa Kassim-Jima.

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LIST OF ABBREVIATIONS

DPC: Doctor-Patient Communication

GHS: Ghana Health Service

PC: Patient Charter

FHM: Four Habits Model

AH: Achimota Hospital

NMC: Nyaho Medical Centre

WHO: World Health Organisation

SPSS: Statistical Package for Social Science

SOP: Standard Operating Procedure

HOD: Head of Department

ERC: Ethics and Research Committee

KP: Kaiser Permanente

EC: Effective Communication

SHS: Senior High School

JHS: Junior High School

ABSTRACT

Effective doctor-patient communication enhances healthcare outcomes such as patient satisfaction and adherence to therapeutic instructions. Globally, poor communication between doctors and their patients has been reported in many studies. In Ghana, it has been reported that patients are confronted with long waiting times without any explanations from providers, abusive attitudes of some healthcare providers, inappropriate communication on the part of providers. Despite the benefits and challenges of effective doctor-patient communication, most studies have focused on general health service quality with little attention being paid to the exploration of communication quality. The main objective of this study was to examine communication among doctors and patients in public and private hospitals in Ghana.

Quantitative research method and convenient sampling technique were used. A total of four hundred and three (403) respondents were recruited. Data were analysed with the help of Statistical Package for Social Science (SPSS), version 20. Quantitative results were presented using descriptive statistics, independent sample t-test, cross tabulation using chi-square test, and hierarchical multiple linear regression analysis.

Though communication quality was found to be satisfactory in both public and private hospitals, it was found to be better in the private hospital than the public one. However, four communication barriers were identified. There was a significant association between overall communication quality and the following: facility type, gender and educational level. Two of the Four Habits Model (Habits 3 & 4) and facility type were found to be significant predictors of overall communication quality. It is recommended that management of health facilities use the Four Habits Model as a blueprint to ensure effective communication.

CHAPTER ONE

1.0 INTRODUCTION

This chapter introduces the background to the study, the problem statement, significance of the study, objectives of the study, research questions, research hypothesis, scope of the study, organisation of the study and definition of terms.

1.1 Background to the study

Globally, effective communication among doctors and patients has been acknowledged as a catalyst for better health services delivery (Ames, Glenton & Lewin, 2017; Davies, 2011; Doherty, Landry, Pate & Reid, 2016; Doyle, Lennox & Bell, 2013; Marcus, 2014). Effective communication is a critical aspect in healthcare delivery as it bridges the relationship gap between doctors and patients. All processes in the delivery of health care, from the attainment of medical history to the conveyance of treatment plan, rely heavily on effective communication among healthcare providers and patients (Wordi, 2019).

In recent years, patients or health services consumers around the world have developed an increased expectation for doctors to communicate well in their quest to deliver satisfactory patient-centred healthcare. Communication among doctors and patients has been linked to positive healing processes, and poor communication leads to negative health outcomes such as morbidity and mortality (Iedima & Manidis, 2013). Iedima and Manidis (2013) further pointed out that a doctor's ability to explore effective communication and place emphasis on patients' involvement in clinical decision-making concerning their own health may have a profound positive impact on the outcomes of biological and functional health as well as on patients' satisfaction, trust and compliance with therapeutic instructions.

The mitigation of communication related-barriers and the quality of communication among patients and healthcare professionals are assured when doctors consistently explore the following key constructs: (1) building rapport or friendliness with patients, (2) eliciting patients' perspectives, (3) demonstrating empathic behaviour, and (4) concluding an encounter with patient-tailored information and engaging in joint decision making. These constructs therefore become major determinants of overall doctor-patient communication quality and collectively serve as a blueprint to management of healthcare facilities and doctors in particular (Grice et al., 2013).

In a study involving 117 patients in Israel, Hochman, Itzhak, Mankuta and Vinker (2008) found that friendly communication (rapport building) had a significant correlation with patients' satisfaction. Mannava, Durrant, Chersich and Luchters (2015) also concluded that establishing rapport with patients is pivotal in delivering quality health services. Also, it is reported that friendly-oriented communication at the outset of the medical encounter had a significant association with overall quality of doctor-patient communication (Mannava et al., 2015). However, lack of rapport building was reported by participants as a militating factor against effective doctor-patient communication (Lefiman, Sinatra & Huberty, 2014).

In the United States, it is reported by Neeman et al. (2011) that patients forget about 40%- 80% of medical information discussed with their doctors after a medical visit, and almost half of the information that is remembered is incorrect. Enhancing communication among patients and doctors can help patients in particular to make more informed decisions about their own health, which in turn can lead to better medical compliance and trust. Neeman et al. (2011) further reported that one of the key reasons for the disparity in the failure of patients to recall and understand therapeutic conversations better was that patients in their care were often not regarded as active partners. They also did not participate in clinical decision-making, and this mostly reduced communication quality, trust and compliance.

Moreover, due to the growing changes and shift from the medical model of health to the era of patient empowerment as co-producers of health, issues relating to doctor-patient communication have, in recent times, received much attention in many geographical areas including Sub-Saharan Africa. In Africa, several studies suggest that empathy, choice of words and the use of non-verbal communication play a significant role in the performance of doctor-patient communication (Birhanu et al., 2010). Thus, positive health outcomes have been reported in situations where there is an adequate exchange of information due to effective doctor-patient communication.

In Ghana, the concept has also gained significant attention as in other countries. Effective doctor-patient communication has become an essential component of health care and a determinant of patient satisfaction. Consequently, it has been reported that effective communication leads to positive health outcomes among patients in public and private hospitals. Factors such as the hospital environment, clinician courtesy, waiting time and communication have been identified as significant in predicting patient satisfaction (Atinga et al., 2011). Efforts have been made by stakeholders in the health sector to foster effective doctor-patient communication across public and private hospitals in Ghana. Stakeholders in the private health sector also uphold doctor-patient communication in high esteem. These efforts include adequate patient education, continuous professional development in communication and patient management techniques, and provision of a favourable environment to enhance doctor-patient communication.

Strategies made to enhance communication have contributed greatly to an improved communication among patients and doctors. Patient education on health-related issues has also improved due to an improvement in the educational system. Notwithstanding these, issues relating to poor doctor-patient communication continuously exist in both public and private health facilities in Ghana. In recent times, a lot of medical errors have been attributed to poor communication among health professionals and patients (Abor, 2019).

Aduo-Adjei (2015) reported that empathy is a significant predictor in patients' satisfaction. Most researchers are of the view that being positive and empathetic towards patients will lead to satisfaction, high quality of doctor-patient communication as well as acknowledgement of value and trust in the healthcare provider (Boateng & Awunyo-Vitor, 2013; Criel et al., 2003; D'souza, 2012). When healthcare professionals are sensitive to factors relating to care, empathy, friendliness and responsiveness during the delivery of their duties, it is seen as an effective communication and may lead to patients' satisfaction (Tucker & Adams, 2001). Similarly, Ojelade et al. (2017) found that patients want healthcare professionals to exhibit empathy, be attentive, respectful, and be discerning in terms of adjusting their communicative behaviours to meet their satisfaction.

In effect, identifying communication gaps, tailoring practical solutions to those gaps, and ensuring the quality of doctor-patient communication in all healthcare facilities by respecting, empathising and involving patients in decision making may have the tendency to improve overall doctor-patient communication quality and health services quality in general. Controlling or mitigating the negative effects of the determinants of effective communication among patients and doctors cannot also be downplayed.

However, factors such as the lack of trust during doctor-patient communication, unfriendly healthcare teams, doctors' failure to adequately elicit patients' health conditions, and too much workload on doctors have been reported as hindrances to effective doctor-patient communication (Abor, 2019). Despite all these, with regard to doctor-patient communication, which is a quality dimension in healthcare, little has been done in Ghana, especially among public and private hospitals. Most studies have rather concentrated on general health services quality (Abuosi, 2015; Aduo-Adjei, 2015; Alhassan, Nketiah-Amponsah & Arhinful, 2016; Atinga, Abekah-Nkrumah & Domfeh, 2011; Awindaogo, 2017; Narkotey, 2015;). Hence, this study seeks to

examine doctor-patient communication in Ghana by comparing effective communication between public and private health facilities.

1.2 Problem statement

Effective Doctor- patient communication has over the years shown several positive outcomes in health care around the world. According to Babalola et al. (2016), effective doctor-patient communication enhances healthcare outcomes such as patient satisfaction, adherence to therapeutic instructions and continued uptake of professional services. It creates a useful opportunity for doctors to inform patients about their health conditions and treatment options, and how to mitigate complications, which could otherwise result in serious consequences. Doctors who adjust their communication by listening to patients, allowing patients to ask questions, involving patients in decision making and communicating clearly to patients, enable the patients to play active roles in their care. Such patients report positive experiences (Baker & Watson, 2015).

Despite the benefits of effective doctor-patient communication globally, poor communication has been reported in many studies, and this has been linked to factors such as lack of adequate and clear information, lack of patients' involvement in decision making, negative attitudes of some doctors and lack of empathy (Asundep et al., 2013; D'Ambruoso et al., 2005; Sumankuuro et al., 2017; Tuncalp et al., 2012).

In Ghana, it is reported that unpleasant communication with doctors discourages patients and their relatives from patronising several healthcare-related services in both public and private facilities (Atinga & Baku, 2013). Also, Avortri and Lebitsi (2018) highlighted that patients were not actively allowed to participate in decision making concerning their own health. Agbenyefia (2017) found poor communication/inappropriate provider attitude, long waiting times, inadequate facilities of modern equipment, unavailability of certain essential drugs,

discrimination and favouritism regarding who should be attended to first at the OPD and consulting rooms and bad treatment during labour as indicators militating against effective doctor-patient communication and patients' satisfaction.

Most studies on healthcare quality in Ghana have focused more on general quality (Atinga et al., 2011; GHS, 2003; MOH, 2007; Osei et al., 2005). From the point of view of both healthcare providers and patients, the quality of health services in Ghana is insufficient (GHS, 2008; MOH, 2007). Furthermore, healthcare quality analysis has mostly documented inadequate service delivery regarding inappropriate communication on the part of healthcare providers, long waiting time and frequent shortage of drugs as indicators against the satisfaction of patients in Ghana (Turkson, 2009).

More importantly, the unwillingness of doctors to critically explore evidence-based communication indicators such as building rapport with patients, seeking patients' perspectives regarding their health conditions, empathising with patients through positive verbal and nonverbal communication, and effectively sharing information or concluding the medical encounter in ways that patients understand better has further compromised communication quality in recent years (Krupat, Frankel, Stein & Irish, 2006; Steinhausen et al., 2000). Also, since the lack of effective communication between doctors and their patients has been one of the major causes of many a medical error, it is wise to promote evidence-based practice to ensure effective communication in all hospitals (Abor, 2019).

Critically identifying doctor-patient communication gaps and determinants in both public and private hospitals, and providing appropriate solutions through scientific investigations or research cannot be downplayed. In this view, the need to find out whether there is a significant difference in doctor-patient communication quality between public and private hospitals or not is necessary. Also, finding out whether the determinants of communication are significant

predictors of effective doctor-patient communication or not is pivotal. Therefore, it is imperative to conduct a comparative research now to unravel doctor-patient communication quality shortfalls for policy actions.

Alhassan, Nketiah-Amponsah and Arhinful (2016) have stated that healthcare quality in Ghana has been viewed as lowest in the provision of timely information to patients. Madula et al. (2018) found that unwillingness of providers to answer questions, verbal abuse and lack of respect for patients, militated against effective doctor-patient communication. Jesha, Sebastian, Haveri and Nath (2016) found that 39% of patients had their expectations unmet. The study further reported that the behaviour of some doctors in the consultation rooms made patients uncomfortable, as adequate information was not given to patients in many instances.

Anecdotally, some patients have frequently complained about some problems they encounter when seeking health care. The complaints include long waiting times without any explanations from providers, abusive attitudes of some healthcare providers, inappropriate communication on the part of providers, unavailability of certain essential drugs, discrimination and favouritism regarding who should be attended to first at the OPD and consulting rooms, and bad treatment during labour.

In spite of the pivotal role that communication plays in all human encounters, the phenomenon has not been critically explored in Ghana. For instance, about 35% of patients who visited the Juaben Government Hospital complained that healthcare providers failed to explain therapeutic instructions clearly to them, and 68% complained of unnecessary delays without any communication or explanation before being attended to by doctors (School of Public Health, University of Ghana, 2018).

The scanty literature on the measurement of doctor-patient communication quality in Ghana has warranted this study. Although the exploration of communication skills in all hospitals is pivotal

in achieving satisfactory delivery of healthcare in Ghana, not much has been done in considering the role played by effective communication in ensuring continuous quality of care in both private and public hospitals. Therefore, the aim of this study was to comparatively measure doctor-patient communication quality in Ghana at Achimota Hospital and Nyaho Medical Centre.

1.3 Objectives of the study

The main objective of this thesis is to examine communication among doctors and patients in public and private hospitals in Ghana.

The specific objectives are:

1. To rate the quality of doctor-patient communication;
2. To identify the barriers to effective doctor-patient communication;
3. To compare doctor-patient communication quality between public and private hospitals;
4. To examine the determinants of effective doctor-patient communication.

1.4 Research questions

1. How do patients rate doctor-patient communication quality?

2. What are the barriers to effective doctor-patient communication?

3. How different is doctor-patient communication quality between public and private hospitals?

4. In which way can communication determinants influence effective doctor-patient communication?

1.5 Research hypotheses

These research hypotheses were formulated based on the research questions, the Four Habits Model and the available literature.

H1: there is a significant difference in doctor-patient communication quality between public and private hospitals.

H2: the Four Habits are significant predictors of effective doctor-patient communication

1.6 Significance of the study

It is hoped that this study would be of great value to healthcare practitioners, research and policy agencies in health services management.

i. **Practice:** the findings of this study will help in the management of health services quality in both private and public hospitals. The study will help medical doctors in particular to identify the communication needs of their patients; and consequently put in place adequate strategies to address those needs. Also, the findings from this study will serve as a guide to strengthen clinical governance or leadership in Ghanaian hospitals, especially Achimota Hospital (AH) and Nyaho Medical Centre (NMC).

ii. **Research:** this research will be useful for current and future scholars within health services management and healthcare quality in general. The study's findings will help researchers better understand health services quality dimensions from communication's point of view. Review of available relevant literature showed that little is known about doctor-patient communication in the Ghanaian healthcare setting. Therefore, this study will bridge the gap in knowledge and may also influence the need for further studies.

iii. **Policy:** Finally, the findings of this study will help policy formulators and policymakers (i.e., Ministry of Health, Ghana Health Service) to develop good policies that will support and guide healthcare quality for national development.

1.7 Scope of the study

This study was limited to the Achimota Hospital and the Nyaho Medical Centre in the Accra Metropolitan Area due to time and financial constraints. The study included patients 18 years and above receiving out-patient cares (OPD). Patients who had been confirmed as mentally and psychologically unfit, and those who were attending the health facilities for the first time and had not had any encounter with doctors in the facilities were excluded. Therefore, generalisation must be done with caution. The outcome of this thesis was not affected in anyway, despite the limitations.

1.8 Definition of terms

Communication: verbal and non-verbal means of channelling information.

Doctor-patient communication: therapeutic-oriented interaction among doctors and patients

Doctors/Clinicians: health personnel responsible for diagnosing and treating patients in hospital settings

Patients: persons who go to health facilities to seek solutions to their health needs.

Satisfaction: patients' evaluative measurement regarding the quality of health services.

Quality: patients' benchmark for satisfactory health services.

Health care: applies to patients' provision of services in hospitals

1.9 Organisation of the study

This study is organised into five chapters. Chapter one encompasses the background to the study, problem statement, objective, research questions, research hypothesis, significance of the study and operational definitions. Chapter two focuses on review of relevant literature, conceptual model and conceptual framework; chapter three comprises research design, population of the

study, sampling, instruments and data collection, instrument for data collection and ethical considerations. Chapter four houses the findings, analyses and discussion of the research. Summary, conclusion and recommendations are housed in chapter five.

1.10 Summary

This chapter examined doctor-patient communication from the global, regional and local levels. Effective communication enhances healthcare outcomes such as patient satisfaction, adherence to therapeutic instructions and repeated patronisation of professional healthcare services. It presents a meaningful opportunity for doctors to tell patients about their health conditions, treatment options and how to mitigate complications, which could otherwise result in serious consequences. However, poor communication has been globally reported in many studies and linked to factors such as lack of adequate and clear information, lack of involvement in decision making, negative attitudes of some doctors and lack of empathy. In Ghana, it is reported that unpleasant communication with doctors discourages patients and their relatives from patronising several healthcare-related services in both public and private facilities. Further research is required to unravel communication quality shortfalls in Ghana.

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 Introduction

The issues discussed here consist of the concept of communication, theoretical literature, conceptual model, conceptual framework, communication between doctors and patients, barriers to effective doctor-patient communication, doctor-patient communication in the Ghanaian context, quality of doctor-patient communication, comparing communication quality between public and private hospitals and the Four Habits Model, and effective doctor-patient communication.

Literature review is a compilation of available materials, followed by a summary, a critical assessment and a comparative examination of each work, with a close relationship to the subject in question (Boateng, 2018; Bowling, 2014). Boateng (2018) further notes that systematic literature review seeks to classify and analyse the included literature systematically and comprehensively, to be impartial in its analysis and to provide reproducible conclusions. It is also reported that literature review is any study that guides the researcher throughout the work, by providing a framework for establishing the importance of a study (Creswell, 2014).

2.2 The concept of communication

The word 'communication' is from 'communis' of Latin origin, meaning normal, suggesting that people seek to understand the knowledge exchanged commonly Gopal (2004). Communication is seen as the transfer from a sender to a recipient of information, concept, viewpoint, attitude, etc. to establish a better understanding of the latter (Khan & Taher, 2012). Communication takes place in various forms: face-to-face, verbal and nonverbal interactions, informal meetings, emails, letters, memos, reports, and many more (Locker, 2000).Communication is the

channelling of verbal and non-verbal messages among two or more persons. It is a complex, context-related, dynamic, and an on-going process whereby the participants' experiences are shared (Sheen, 2011; Sheldon, Barrett & Ellington, 2006; Munodawafa, 2008). The messages being channelled must be well understood by the communicators involved.

The process of communication may be distracted by several indicators which influence the credibility of the intended message. These indicators may be internal and external. External distractors include excessive coldness or heat, sound, sight, smell, etc. A person's mind set and feelings are examples of internal distractors. Lack of self-confidence, deficient or excessive knowledge, excessive shyness and hunger can all influence the effectiveness of message sharing (Munodawafa, 2008). In effect, communication encompasses the mode of channelling a message, a sender who triggers the message, and a receiver who receives it and gives a response or feedback. Communication has the ability to increase an individual's efficiency and can expedite social contact with others. Individuals who underutilize communication, on the other hand, will have a difficult time developing creativity and enhancing their productivity at work (Barseli, Sembiring, Ifdil, & Fitria, 2019). The ability to communicate empowers the communicator to talk in public and to solve problems (Bucur & Ban, 2019).

2.3 Communication between doctors and patients

A review conducted by Chandra, Mohammadnezhad and Ward (2018) found that both trust and communication were positively intertwined with patients' satisfaction and perceived quality of healthcare services with regard to better compliance with medication, and adhering to therapeutic instructions in both developed and developing countries. The study also pointed out that patient-centred communication using open-ended questions improved effective doctor-patient communication. What this means is that collective decision-making enhances better management and improves compliance with treatment plans. The study concluded that patient-centred

approach with effective communication and trust enhanced better management and improved healthcare outcome.

Similarly, another review by Neo (2011) indicated that communication among patients and doctors was pivotal to the health-seeking behaviours of patients, patients' satisfaction and adherence to therapeutic instructions. Effective doctor-patient communication improved healthcare outcomes and a greater satisfaction for not just patients but also physicians. Developing a close rapport or friendliness with patients and eliciting their views cannot, therefore, be downplayed by doctors in ensuring patients' satisfaction.

However, a study conducted in Indonesia by Claramita, Utarami, Soebono, Dalen and Valeuten (2010), and which involved 10 internal medical specialists, 10 internal medical residents, 16 patients and 10 advanced level medical students found that both doctors and patients were not ready for collective decision-making. The study further pointed out that high patient load on doctors as a result of an inefficient healthcare system did not permit adequate time for effective doctor-patient communication. The researchers concluded that despite Southeast Asian healthcare stakeholders being interested in collaborative communication between doctors and patients, paternalistic approach is normally practised, irrespective of the educational background of patients.

In their quest to explore the social gradient in doctor-patient communication in Belgium, Verlinde et al. (2012) conducted a review of 20 articles. In this review, they found that the majority of the articles concentrated on the significance of the reciprocity of communication among doctors and patients. The research also highlighted the importance of patients' perception of effective doctor-patient communication. The study concluded that if doctors prioritise on the importance of effective communication and enable patients to exhibit concerns and preferences, patients would be better satisfied with doctors' communication quality. Furthermore, a research

by Clever, Jin, Levinson and Meltzer (2008) to examine doctor-patient communication and how it affects patients' satisfaction found a significant relationship between overall patients' satisfaction and doctors' willingness to elicit patients' perspectives.

The World Health Organisation (2013) reported that in many developing countries in sub-Saharan Africa, there is a troubling trend for healthcare change in citizens' healthcare. The quality of health services is an important indicator for healthcare advancement and distinction of healthcare institutions. This assertion by WHO buttresses the significance of investigating doctor-patient communication, which forms part of the total component of health services quality and satisfaction.

Sustersic et al. (2018) found that, apart from alleviating anxiety in patients' behaviour and encouraging patients to adhere to medical instructions, effective doctor-patient communication also led to an improvement in symptom relief and positive clinical outcomes. The researchers further pointed out that doctor-patient communication must be underpinned by three constructs: good interpersonal relationship, timely information exchange, and involving patients in decision-making. This is because patients are always the first to suffer from a lack of information. This confirms similar positions held by other studies. For example, some studies have contended that effective communication among clinicians and patients has been linked to better healthcare outcomes (Ames, Glenton & Lewin, 2017; Davies, 2011; Doherty, Landry, Pate & Reid, 2016; Doyle, Lennox & Bell, 2013; Marcus, 2014).

Ha and Legnicker (2010) observed that effective communication between doctors and patients has the ability to help manage the emotions of patients, promote understanding of medical information, and allow the needs, perceptions and expectations of patients to be better established. According to them, patients who report good engagement with their clinicians are more likely to be pleased with their care. In particular, they are more likely to share important

details to correctly identify their issues, to seek recommendations and to stick to the care recommended. It is further reported that the frustration of most patients and many grievances were due to the unwillingness by doctors to exchange information with patients. Bowling (2014), narrated that effective doctor-patient engagement is crucial with regard to quality healthcare delivery and patients compliance (Ha & Longnecker, 2010).

However, no clear evidence of mutual decision making affecting clinical results has been found in systematic reviews (Arora, 2003; Joosten et al., 2008). Some patients have been reported not to be accountable for their treatment plans, a situation which influences the degree of their participation in decision-making processes (Arora, 2003; Deadman, Leinster, Owens, Dewey & Slade, 2001). The inconsistencies in the different literature or results indicate that more research regarding doctor-patient communication is needed.

According to Ogunfowakan et al. (2012), socio-demographic factors such as gender influence healthcare outcomes in many ways. This is linked to how communication among providers and patients is carried out. Erinosho (2005) reported that patients' socio-cultural factors influence the way in which illness is interpreted, perceived and responded to. Not only that, but gender especially influences effective communication among healthcare providers and patients. (Abane & Adu-Gyamfi, 2013; Doyal, 2001; GLSS, 2008; Say & Raine, 2007) It is reported that patients who are less educated, have a lower ranking and poorer health status have an association with lower healthcare satisfaction Also, it is narrated that there is a significant relationship between a person's educational level and healthcare patronisation, with persons of higher educational levels seeking quality healthcare service by engaging doctors positively in the communication process (Correa-de-Araujo et al., 2005; Maurer, 2006; Nicholas et al., 2007).

2.4 Barriers to effective doctor-patient communication

A study conducted by Sun and Rau (2017) involving 182 observations in various consulting rooms in primary healthcare settings in China indicated that doctors failed to properly gather information from patients, build a rapport with them, and include them in the making of decisions. The study also indicated that low medical literacy among patients, high workload on doctors, inadequate communication skills among doctors and inappropriate behaviours by doctors accounted for the communication gaps. The researchers further reported that improper actions of doctors such as interrupting when patients talk (16% of encounters), speaking with irrelevant individuals (7% of encounters), using medical jargons, were some of the indicators militating against effective communication among doctors and patients.

Though Clinical communication is pivotal to doctors, several studies have shown that a large proportion of grievances against doctors were as a result of communication difficulties (Bhasale et al., 1998; Coiera, 2000). It is, therefore, important to provide patients with adequate knowledge and to include them as active partners in their treatment plans in order to deliver high quality healthcare. The researchers further reported that communication errors keep triggering negative events as well as an unaccepted number of clinical morbidity and mortality.

In a study involving 818 patients and 152 hospital managers by Abuosi (2015), it was found that, on the average, there is a wide disparity of what constitutes healthcare quality on the part of patients and what constitutes healthcare quality on the part of healthcare providers. The study pointed out that whereas healthcare providers generally viewed healthcare quality as favourable, patients, on the other hand, only viewed it as only fairly favourable. The study concluded that the inconsistencies in rating healthcare quality by both patients and health professionals is an indication that the quality of healthcare in Ghana is problematic; and that workable solutions need to be employed by hospital leadership or government to mitigate shortfalls of quality in Ghanaian health facilities. In effect, lack of respect for patients' perspectives, inadequate

information sharing and lack of consensus building or active involvement of patients in decision-making could be responsible for this disparity of what constitutes healthcare quality among these important healthcare stakeholders.

Similarly, a research by Agbenyeefia (2017) involving 32 lay caregivers, 12 in-patients, 2 medical doctors and 6 nurses in Eastern Ghana shows that negative attitude or inappropriate communication of some healthcare providers militated against the well-being of patients and their caregivers. The study also found that some patients and their caregivers are mistrustful of healthcare providers. It concluded that emotional satisfaction from caregivers to their sick ones who may not get empathy and tender care from healthcare providers is an outstanding phenomenon. Logically, one may conclude that doctors' inability to use communication indicators such as empathy, seeking patients' perspectives, establish friendliness towards patients and active involvement of patients and their caregivers in decision-making could account for this mistrust, a situation which jeopardises healthcare outcomes or patients' well-being.

2.5 Doctor-patient communication in the Ghanaian context

Quality evaluation and enhancement methods for healthcare in Ghana are mainly technical and dominated by medical experts with little to no participation of clients in the process (Alhassan, Nketiah-amponsah, & Arhinful, 2016). Furthermore, Alhassan, Nketiah-Amposah and Arhinful (2016) further stated that this may be due to the common belief that healthcare clients lack the requisite health knowledge to examine quality healthcare standards critically. It has, however, become evidently clear that the increasing role of patients in healthcare quality evaluation is compelling. In effect, the need for doctors in particular to respect and share information with patients in ways that portray them (patients) as highly valued stakeholders in the healthcare sector cannot be downplayed.

Also, most Ghanaians are of the view that prolonged waiting times, ineffective provider-patient communication and abusive staff behaviour are some of the indicators responsible for the low quality of healthcare delivery in Ghana (Turkson, 2009). The researcher further investigated the quality of rural health care in the Ghanaian context and found that averagely, high healthcare quality perception was outstanding. That is, 90% of respondents were pleased or very pleased with the treatment they received during their visits to the health facility. Nevertheless, the participants acknowledged that ineffective communication among patients and doctors, inappropriate etiquette of some health workers, queuing for long in order to access healthcare, shortage of staff and policy of payment for health services were hindrances to their expectations and satisfaction.

Moreover, Peprah (2014) found that the overall satisfaction of patients regarding how services were delivered in Ghanaian hospitals was good. More importantly, the study recommended strategic policy actions to enhance service delivery in effective communication among patients and doctors. Similarly, Ampah and Ali (2019) found that health service quality adoption among Ghanaian public hospitals was generally fair. The study among other things recommended that there should be effective communication and involvement of key stakeholders such as patients in decision making, adequate funding from government, acquisition of modern healthcare equipment and facilities, and employment of healthcare providers with a high level of both functional and technical skills.

Furthermore, another study by Kugbey, Oppong Asante and Meyer-Weitz (2018) found that an adequate exchange of information between doctors and patients, and collaborative decision-making were important predictors of overall quality of life and domain-specific quality of life among patients, especially women living with breast cancer. In the study, 205 women living with breast cancer in Ghana were sampled. Kugbey et al. (2018) recommended the need to include patients directly in decision making concerning their own health. In effect, one may conclude

that if doctors use communication strategies such as empathy, seeking the perspectives of patients and providing rationale for medical tests, there will be an overall communication quality and patients' satisfaction.

Awindaogo (2017) reported that timely communication between doctors and patients prevent harm to other patients regarding disclosure of medical errors. This implies that if doctors sincerely communicate or disclose their errors to the affected patient and facility management on time, other doctors are less likely to commit those same errors, and this will improve the safety of patients in the future. The study further claimed that public trust in medical doctors, hospital management and medicine in general, increases as a result of doctors' deliberate efforts in communicating sincerely with patients. Effective doctor-patient communication reduces malpractice claims and medico-legal suits against doctors in particular and healthcare facilities in general (Awindaogo, 2017).

A study conducted by Abor (2014) indicated that the quality of healthcare services in Ghana is fairly above average. The study further pointed out that hospitals with governing boards are viewed as the ones that offer better healthcare service quality as compared with those without governing boards. Having a well-structured and effective hospital board is found to enhance the delivery of quality healthcare. Based on these findings, it is logical to state that well-structured and effective governing hospital boards design and enforce standard operating procedures (SOP) to guide provider attitude, including the need for medical doctors to share information with patients timeously, demonstrate empathic behaviours and be friendly towards patients. Among others, the study recommended that public hospitals should be adequately resourced to enable them improve their standard of healthcare quality in line with those of private hospitals.

According to Abekah-Nkrumah, Manu and Atinga (2010), most patients and a sizeable number of healthcare providers are ignorant of the current contents of the Patient Charter developed by

the Ghana Health Service; as a result, doctors and other healthcare providers have been unable to adequately function under the Charter as envisaged. The study, however, acknowledged that there exists a mutual relationship among providers and patients, and that advantage could be tapped from this relationship to improve on effective communication or the timely disclosure of information, active patient involvement in decision-making and information seeking. The study recommended that in creating awareness of the Charter, there is the need to employ appropriate communication tools such as the media and culturally or religiously sensitive methods at the local level to educate both patients and healthcare providers about their responsibilities and rights under the Charter. It is prudent to know that the Patient Charter is largely underpinned by a timely exchange of critical information, respecting the views of patients and protecting information related to patients' diagnoses or medical history. No effective healthcare system can do better without effective provider-patient communication; hence, all processes in the delivery of healthcare from the attainment of medical history to the conveyance of treatment plans rely heavily on effective communication among doctors and patients (Wordi, 2019).

2.6 Quality of doctor-patient communication in public and private hospitals

According to WHO (2010), the need for quality healthcare has become a necessity for the global public. It has, therefore, mounted pressure on healthcare providers to live up to expectation. Putting in place policies or mechanisms to ensure that all persons have access to quality healthcare is a basic human right and should, therefore, be taken seriously. Donabedian (1980) pointed out that providing quality healthcare has the tendency to minimise risks and maximise benefits of health services. However, quality healthcare cannot be achieved without critically exploring communication indicators such as exchanging information effectively with patients, respecting the concerns of patients, and demonstrating empathic behaviours.

Chahal and Kumari (2010) found that communication quality, physical environment and outcome quality are significant predictors of overall service quality. Arasli *et al*. (2008) narrated that health service quality is underpinned by five service quality dimensions: prioritising patients' needs, empathy, professionalism, friendliness or building rapport with patients and physical environment. Duggirala *et al*. (2008) understood health service quality as the availability of friendly and empathic healthcare professionals, well-structured administrative procedures, safety, clinical care process, and total medical care experience.

Scholz et al. (2019) reported that clarity of therapeutic-related communication is seen as an important factor in patients' satisfaction. The study further pointed out that patients' satisfaction ratings varied significantly by type of hospitalisation, perceived type of communication, and gender of patient. In ensuring doctor-patient communication quality, patients expect their doctors to listen to them, maintain eye contact, share detailed information within a reasonable amount of time, exhibit sincere and empathetic verbal and nonverbal communication. Healthcare professionals have two ways of fulfilling these expectations: build rapport and seek patients' perspectives at the outset of the medical encounter and engage patients in effective information sharing at the end of the visit (Gordon & Zimmerman, 2016; Stone, 2003).

Duberstein, Meldrum, Fiscella, Shields and Epstein (2007) found that doctors' ability to establish friendliness with patients and show empathic behaviour have a positive relationship with how patients rate doctor-patient communication quality. Patients have been reported to be more satisfied with doctors who show more commitment to rapport building and are adequate in showing empathy. The study concluded that patients' ratings of doctors' quality of communication is multi-dimensional.

Also, timely doctor-patient communication, data-gathering abilities, degree of empathy, prioritising on clarity and summary of information, information exchange and interactive patient

educational strategies, have a strong positive influence on patients' expectations and satisfaction of healthcare quality (Zabar et al., 2019). In a study involving 27 reviews in Italy regarding how patients expect their doctors to communicate with them, Deledda, Moretti, Rimondini and Zimmermann (2012) narrated that patients expected their doctors to have a pleasant communication with them during and after the medical encounter.

Moreover, as a result of changes in society as well as the practice of medicine, more patients now have the courage to participate in medical consultations. All over the world, patients are encouraged to ask relevant questions and also expected to be actively involved in decision-making in order to attain much better satisfaction (Jones, 2010). Jones (2010) further reported that the outcomes of attempts to investigate the effect of increased patient participation in consulting rooms are mostly disappointing, and available evidence shows that some doctors respond to increased patient participation with nonverbal blocking behaviours. In effect, patients' expectations of doctors' communication behaviours may be high before the medical encounter and low after the medical encounter as a result of some doctors' unwillingness to positively communicate verbally and non-verbally.

A study involving 105 patients in India by Jesha et al. (2016) showed that 39% of the patients had their expectations unmet. The study further revealed that the behaviours of some doctors in the consultation rooms, such as their unwillingness to provide adequate information to patients, made patients uncomfortable. The study concluded that it is prudent for management of healthcare facilities and doctors in particular to have enough time to communicate with patients. Doctors should also be friendly and exhibit more empathy towards their patients by employing simple language instead of medical jargons and calming down anxieties. Furthermore, they should not be money conscious and but should rather strive to protect patients' privacy.

It is instructive to note that some studies have shown the impact that doctor-patient communication has on the loyalty of patients. For example, a study conducted in a teaching hospital in the Ashanti Region of Ghana found that doctor-patient communication had a positive and significant effect on patients' loyalty (Kwarteng, 2016). The study concluded that much effort is needed to enhance doctor-patient communication and the degree of healthcare service quality in order to meet patients' expectations, retention and loyalty.

In Ethiopia, a study by Asifere et al. (2018) indicated that whereas 70.8% of patients were satisfied because healthcare providers gave timely information, 54.7% of some patients were dissatisfied with the effectiveness of information sharing. Giving detailed information and allowing patients to ask questions make them (patients) feel important and worthy, thereby improving effective doctor-patient communication (Travaline, Ruchinskas, & D'Alonzo, 2005). Dougherty, Stammer and Valente (2018) conducted a study in the Upper West Region of Ghana involving 1,606 women. The study reported that healthcare providers' ability to seek the perspectives of patients, their friends and family members positively influenced the quality of health services. In Ethiopia, respect for patients' perspectives was found to have a significant association with effective doctor-patient communication (Lera, Admasu & Dirar, 2017).

Again, healthcare providers who adjust their communication by listening to patients, allowing them to ask questions, involving them in decision making and communicating clearly to them enable the patients to play active roles in their care. Such patients report positive experiences (Baker & Watson, 2015). Giles (2008) narrated that when a healthcare provider explains a health-related problem and recommends therapeutic instructions in a manner or language that can be easily understood by the patient, it is most likely that the patient will also adjust his or her communicative behaviour to resonate with that of the provider. This is known as convergence. On the contrary, when a doctor employs the use of medical jargons, disrespectful and

intimidating behaviour, or chastises patients, divergence is established. Here, both parties rather display behaviours that emphasise their differences.

Patients go to health facilities in search of healthcare services that are most suitable in solving their health needs as well as receiving respect-oriented communication. (Pakdil & Harwood, 2005; Pollack, 2008). It is reported that the a number of patients at various health facilities may not be in their right mood as a result of multiple factors such as pain. They therefore, anticipate positive customer-oriented communication in their quest for cure, which is a fundamental healtcare service expectation (Conway & Willcocks, 1997). Oluwadiya, Olatoke, Ariba, Omotosho & Olakulehin (2010) pointed out that patient satisfaction is directly linked to providers' ability to sincerely communicate concern, attitude, courtesy and provision of privacy during provision of care. The study further reported that 21% of the respondents recounted being shouted at by providers, 7% experienced rudeness while 5% encountered caregivers who hit them. The level at which patients are satisfied with the services rendered to them is a pivotal phenomenon underpinning their health behaviour and level of healthcare utilisation (Rizyal, 2012). Logically, effective communication among healthcare professionals and patients, therefore, cannot be separated from the entire package of patients' satisfaction.

It is imperative for health services management to embark on relentless efforts to maintain an effective communication with patients in order to appropriately serve today's complex patients. Thus, it is pivotal for healthcare leaderships to continuously evaluate their communication strategies (Zideldin, 2006).

2.7 Comparing doctor-patient communication quality between public and private hospitals

In developing economies such as Ghana, both public and private hospitals are responsible for providing quality health services to the citizens. However, no two health facilities are exactly the same regarding their level of operation, efficiency, structure, work culture and background

(Shrivastava & Purang, 2011). Despite the uniqueness or differences of any hospital, the overriding goal of every health facility is to save lives and provide quality health services to its clients, because the health of a country's citizens is directly linked to its economic growth (Andaleeb, 2000; Karydis et al., 2001). It is reported that in order for patients to enjoy quality health services from health facilities, it is imperative that they assess the differences in healthcare quality offered by both public and private hospitals, as patients perceptions directly influence their decisions towards the choice of a hospital (Arasli et al., 2008).

In effect, no health service organisation may be able to deliver quality service without using effective communication strategies such as respecting the views of patients, empathising with patients, involving patients in the decision making process concerning their own health conditions, and effectively sharing information in ways that patients understand better. Also, a research conducted in Cyprus by Yasilada and Direcktor (2010) indicated that with regard to patients' satisfaction or healthcare quality, unlike public healthcare facilities, private hospitals had relatively fewer quality gaps. The study concluded that research investigation is needed to unravel the causes of the disparities of healthcare quality among private and public hospitals.

However, a comparative study conducted in India, by Swain (2018) involving 340 respondents found that whereas public hospitals performed better than private hospitals in areas such as treatment of diseases, private hospitals performed better than public hospitals in areas such as provider-patient communication quality.

Moreover, a study by Ramez (2014) involving 235 respondents in Bahrain found that health service quality, especially empathy, was better practised at private health facilities as compared with the public ones. The study concluded that despite the disparity of service quality among public and private health facilities, both patients at the public and private hospitals are dissatisfied with the quality of healthcare services.

A research by Tateke, Woldie and Ololo (2012) involving 5 public and 5 private hospitals in Ethiopia found that 18.0% of patients at public hospitals were very satisfied, with 47.9% being only satisfied. The corresponding percentages in the private hospitals, however, were marginally higher. The study further noted that adequacy of consultation duration, rapport building or friendliness of doctors towards patients and nonverbal communication were determinants of satisfaction at both public and private hospitals. The researchers concluded that even though patients at the private hospitals were better satisfied with health services quality than those at the public hospitals, most of the predictors of patients' satisfaction remained common to both public and private health facilities. Adesanya et al. (2012) conducted a comparative study in Nigeria and found that significant differences existed between the performance of public and private hospitals, with the private hospitals being ahead of their public counterparts regarding service quality.

Further, in a comparative study involving 200 patients in Pakistan, Khattak, Alvi, Yousaf & Zain-ul-(2012) found that health services quality in private hospitals was significantly better than what pertained in the public hospitals. The study further reported that developing countries have witnessed several changes in patients' care trends in recent years. As a result, the urge for patients to receive quality health services such as empathy, eliciting patients' perspectives, involving patients in decision making, respecting patients and their families or friends is high. Patients' satisfaction is a complex, multidimensional issue that must be approached through quality driven management policies such as effective communication and friendly attitudes from healthcare professionals. Al-borie (2011) conducted a comparative study in Saudi Arabia and found that sex, education, income and occupation were statistically significant in influencing inpatients' satisfaction in both public and private health facilities; with private facilities being perceived as better regarding service quality such as empathy.

In a comparative study by Yousapronpaiboon (2013) involving 400 patients in Thailand, it was indicated that the quality of health services was better in private health facilities than in public health facilities. Also, health services quality dimensions such as seeking patients' perspectives, providers' knowledge of clients' relationship, personality and experience, trust, politeness of healthcare professionals, responsiveness, empathy, verbal and nonverbal attitude of healthcare providers, convenient timing for patients, and up-to-date equipment are significant predictors of health services quality (Andaleeb, 2000; Arasli et al., 2008; Polsa et al., 2011).

2.8 The Four Habits Model (FHM) and effective doctor-patient communication

Velez et al. (2017) reported that the Four Habits Model is a validated instrument that measures doctors' communication skills according to four constructs: investing in the beginning, elicit the patients' perspectives, demonstrate empathy and investing in the end. The study concluded that there was a significant association between the Four Habits Model and overall doctor-patient communication quality.

According to Bohmer (2011), though high-value healthcare institutions differ in structure, resources and culture, they often have remarkably similar approaches to care management. In other words, though the Specific tactics of healthcare facilities may vary, their "habits", i. e repeated behaviours and activities towards the attainment of healthcare quality may be similar. What underpins this corporate strategy and ensures quality healthcare delivery is effective communication.

Steinhausen et al. (2000) reported that type and quality of communication between doctors and patients have a significant impact on treatment success. Doctors occupy a key position in health care with special communication challenges. Globally, doctor-patient communication is still in need of rapid enhancement. Undoubtedly, the "Four Habits Model" has proven to be a tool capable of improving and sustaining effective communication in any healthcare setting when

doctors consistently apply these key constructs: (1) establishing rapport with the patient, (2) eliciting the patients' perspectives, (3) demonstrating empathic behaviour, and (4) concluding an encounter with patient-tailored information and engaging in joint decision making. Similarly, doctors' ability to consistently execute evident-based communication skills such as the Four Habits Model will lead to an enhancement of overall doctor-patient communication quality (Krupat et al., 2006).

In their study conducted in the St. Louis College of Pharmacy in the United States, Grice et al. (2013) pointed out that the performance of student pharmacists significantly improved from the beginning of 2009 to the end of 2010 in most of the Four Habits assessed. The study further reported that using the Four Habits Model in educating students of pharmacy can lead to the development of positive relationships with patients. With the Four Habits Model as a blueprint to pharmacists and other care providers such as doctors, the tendency to improve the utility of this communication framework is high. Consistent use of the Four Habits Model over time is most likely to sustain effective communication among healthcare professionals and patients.

Scholl et al. (2014) found a significant correlation between physicians' shared decision-making behaviours and the four dimensions of the Four Habits Model. In a multiple linear regression, the four dimensions of the Four Habit Model explained substantial amounts of variation in the doctors' shared decision making scores ($R2 = .42$, $P < .001$). The study further concluded that the Four Habits Model can be used in research and medical education. Hence, applying it in further studies within a different context is necessary.

Krupat et al. (2006) found that the correlation between the ratings of the Four Habits Model and other scales served as an indication that the validity of the construction of the instrument (Four Habits Model) was assured. Furthermore, the research concluded that the Four Habits Model combines descriptive and evaluative parameters of doctors' communication behaviours. Again,

as a conceptually driven teaching model, it can be useful to scholars and public health professionals as well as evaluators and doctors. Therefore, the Four Habits Model provides a blueprint to management of healthcare facilities and doctors in particular.

In Norway, a study conducted by Finset (2015) to develop a teachable consultation model for medical interviews with patients in emotional distress, expanded the original Four Habit Model within three key psychological domains: emotion, cognition and coping. The study further noted that the expanded Four Habits Model further strengthened doctors' communication behaviours with patients in emotional distress. This implies that even though the Four Habits Model had been used successfully across contexts, expanding or modifying it to suit a particular clinical communication may still not compromise its measurement strength.

A study conducted by Stein, Frankel and Krupat (2005) in Kaiser Permanente (KP), a large healthcare organisation in the USA, found that the Four Habits Model served as a strategic blueprint for sustainable doctor-patient communication quality. The study further noted that high improvement in patients' satisfaction scores had been demonstrated in the organisation. Improving doctors' communication with patients is a complex task requiring critical planning and organisational commitment. The experience in KP attests that it is feasible for management of healthcare organisations to bring requisite skills of effective communication to large numbers of busy doctors. The study concluded that management wishing to embrace doctor-patient communication quality should consider using consistent communication models such as the Four Habits Model.

Frankel and Finset (2011) set out to test the hypothesis that a 20-hour communication skills course based on the Four Habits Model can improve doctor–patient communication among doctors across specialties. Their study found an increase in the Four Habits Coding Scheme of 7.5 points ($p = 0.01$, 95% confidence interval 1.6–13.3), fairly distributed on subgroups.

Utilising an outpatient-clinic training model developed in the United States, the researchers demonstrated that a 20-hour course could be generalised across medical and national cultures, indicating an improvement in communication skills among hospital doctors. The study concluded that in order to meet patients' satisfaction, the Four Habit Model is suitable for medical interview or encounter and training of medical doctors in communication skills.

Krupat, Saltyte and Garratt (2008) found that the Four Habits Model is the first larger generic clinical communication programme to have a documented effect. The study further stressed that participants' medical encounters with doctors improved as a result of the Four Habits short course training they (participants) received. It is worth mentioning, however, that some constructs of the Four Habits Model (Habit 2 and 3) were not perceived as relevant for all types of encounters. The study concluded that the Four Habits Model is applicable outside the USA.

Catani et al. (2018) conducted a study in Brazil and found that the Four Habits Model is a culturally, conceptually, semantically and operationally sound instrument for measuring communication quality, as it may represent an important blueprint for strengthening doctor-patient communication in Brazilian healthcare system.

2.9 Conceptual model

This section presents a detailed explanation and application of the four dimensions of the Four Habits Model (FHM), which include habits 1, 2, 3 and 4. The Four Habits Model has been used successfully across contexts and has proven to be a better model for evaluating doctor-patient communication.

2.9.1 The Four Habits Model (FHM)

Frankel and Stein (2001) developed the Four Habits Model based on previous empirical and conceptual work on medical interview and their own clinical and teaching experiences. The

benefits of the Four Habits Model are that families of skills are intertwined, which lead to successful medical interview and patients' satisfaction. Frankel and Stein (2001) used the term Habit to denote an organised way of thinking and acting during the clinical encounter between doctors and patients. The Four Habits are investing in the beginning, elicit the patients' perspectives, demonstrate empathy, and investing in the end. The main aims of the Four Habits are to establish rapport and build trust rapidly, demonstrate empathy or concern, facilitate the effective exchange of information, and increase the likelihood of adherence and positive health outcomes. Previous studies have shown that both patients and doctors derive considerable satisfaction from interpersonal aspects of care and suggest that certain behaviours of doctors affect the likelihood of achieving the desired healthcare outcomes (Frankel & Stein, 2001).

In the doctor's consulting room, the interview of the medical encounter mostly lays the core component of the visit. In other words, a well conducted medical encounter or interview between doctor and patient has the tendency to positively influence the patient's satisfaction, compliance and accuracy of diagnosis. The Four Habits Model is a strategic blueprint that can be effectively applied by healthcare professionals, and doctors in particular, to improve medical interview (Abor, 2019).Undoubtedly, the Four Habits Model has shown to be a tool capable of improving and sustaining effective communication in any healthcare setting (Grice et al., 2013).

2.9.2 Habit 1: Investing in the beginning

Investing in the beginning comprises quickly building rapport with patients, eliciting patients' perspectives and planning the medical visit (Krupat et al., 2006). Before a rapport can be developed, doctors must introduce themselves to everyone in the consulting room, shake their hands, say something about a previous visit or problem to make it obvious that the patient's record is known or bring up a current issue or social topic. It is necessary for doctors to consider asking patients open-ended questions when eliciting the patients' concerns. Doctors need to

appreciate and show concern after hearing from patients and find out if there is more. They must be interested in both the main complaint of patients and the need to investigate broad spectrum of concerns. The use of phrases such as “I see,” “go on,” and “tell me more,” gives a hint about doctors’ interest and this influences patients’ narrations (Krupat et al., 2006).

2.9.3 Habit 2: Elicit the patient's perspective

Here, the need to elicit the point of view of the patient by the doctor regarding his or her health problems or symptoms is core. This is a sign of respect to the patient and it also serves as a technique for gathering information (Krupat et al., 2006). It is possible for doctors to be successful under habit 2 by finding out from the patients themselves what they believe may be causing the symptoms of the disease(s) they are suffering from, or find out from the patients what worries them the most. Context may be built by seeking patients’ opinion regarding how far a condition is affecting their daily lives, work or families. Getting input from friends and families in the consulting room should also be considered by doctors (Frankel & Stein, 2001; Krupat et al., 2006).

2.9.4 Habit 3: Demonstrate empathy

Demonstrating empathy and responding to issues in a culturally appropriate manner towards patients must be prioritised by doctors. In order to achieve this aim, doctors need to pause, touch or show facial expressions. Doctors may also choose to praise patients for the efforts they have exerted to combat the problem. By demonstrating empathy, the relationship between patients and doctors is reinforced, a situation which may further help doctors to better acknowledge the patients’ situations (Frankel & Stein, 2001; Krupat et al., 2006). Ability to know and understand is an aspect of being scientific; to feel known and understood is an aspect of caring and being cared for (Frankel & Stein, 2001). Empathy has characterised doctor-patient relationship

throughout history. If caring and compassion form the core conceptual basis of the doctor-patient relationship, empathy is the core skill for enacting it (Frankel & Stein, 2001).

2.9.5 Habit 4: Investing in the end

This last habit is underpinned by effective information sharing. Doctors should endeavour to share information by framing it in the terms that patients understand. They should equally give reasons for any tests or treatments that are recommended, talk about any possible side effects and expected course of therapy. Doctors may also provide resources to help patients and assess a patient's ability and motivation to adopt a recommended action to be taken. At the end of the visit, doctors should gather key notes of the visit and review the next steps. Here, doctors should endeavour to answer all questions that may be posed by patients, or the family and friends of the patients in the room are adequately answered (Frankel & Stein, 2001; Krupat et al., 2006).

2.10 Conceptual framework

The conceptual framework was adapted by the researcher based on the Four Habits Model, which was developed by Frankel and Stein (2001). The Four Habits are habit 1: investing in the beginning; habit 2: elicit the patients' perspectives; habit 3: demonstrate empathy and habit 4: investing in the end. According to Frankel and Stein (2001), these habits are families of skills necessary for a successful medical encounter between patients and doctors.The researcher conceptualised that the Four Habits, acting collectively and consistently, will lead to or influence effective doctor-patient communication. In other words, if medical doctors consistently apply the content of the Four Habits Model, a successful medical interview and consequently patients' satisfaction will be attained at the end of the medical visit. Furthermore, the review of available literature indicates that the Four Habits Model has been successfully used across contexts. According to Abor (2019), the Four Habits Model was successfully used to explore clinical communication in Northern Ghana.

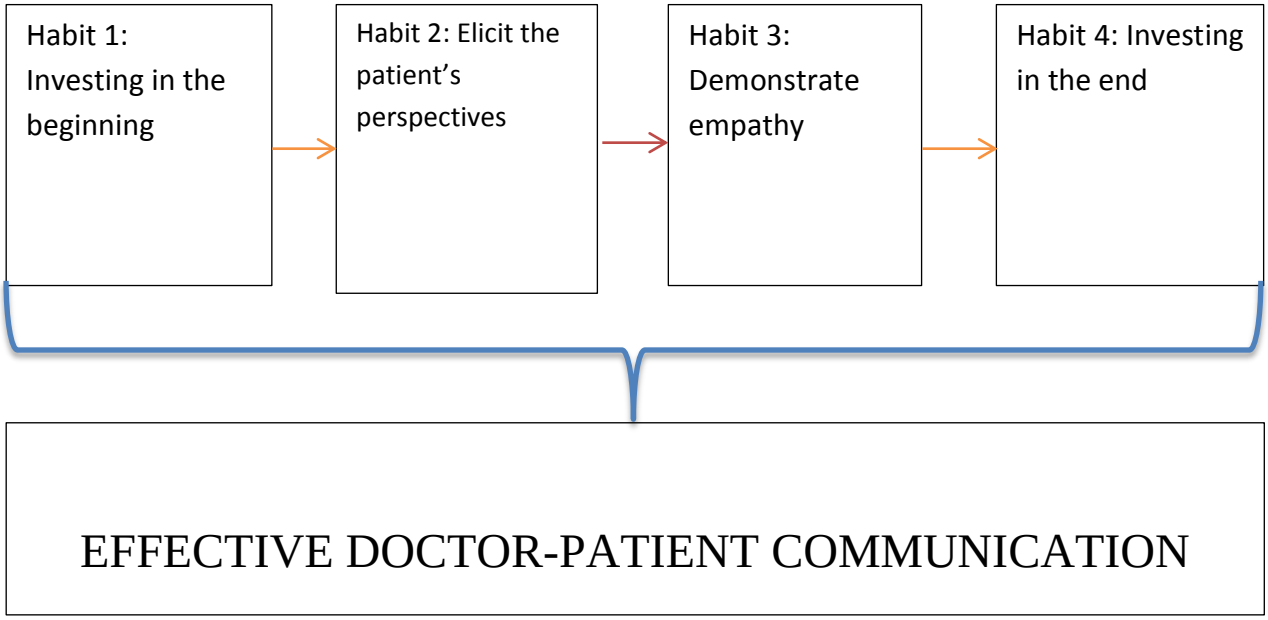

Figure 2.1: Conceptual framework for doctor-patient communication

Source: Author's development (2020)

2.11 Summary

In a nutshell, this study adapted the Four Habits Model, which is a validated instrument for measuring doctor-patient communication in clinical settings. The researcher conceptualised that the Four Habits acting collectively, will lead to or influence effective doctor-patient communication. The review of empirical literature was based on past and current trends of doctor-patient communication quality.

CHAPTER THREE

3.0 METHODOLOGY

3.1 Introduction

This chapter presents the research design, describes the research settings, the inclusion and exclusion criteria, the target population, sample size and sampling method, data collection instrument, data collection procedure the method used for data analysis, and ethical consideration.

3.2 Research design

The study adopted a comparative case study approach. This is because doctor-patient communication in a typical private healthcare facility in Ghana is likely to differ from doctor - patient communication in a public healthcare facility. A comparative case study would help bring out these differences and help understand what is working for either of the health facilities and what strategies can be implemented to improve doctor-patient communication quality in Ghana.

This study employed the quantitative method of research. Quantitative research examines relationships between variables, which are measured numerically and analysed using a range of statistical and graphical techniques (Saunders, Lewis & Thornhill, 2016). The Quantitative method of research is interested in determining the existence of a relationship between aspects of a phenomenon by quantifying the variations. This method ensures that there is a "distance'' between the researcher and the research participants (Boateng, 2018). Quantitative researchers adopt a deductive approach to research. What this means is that they concentrate on testing hypotheses, theories and measuring relationships between variables (Creswell, 2013). The decision to use this approach was informed by the fact that it enabled the researcher to examine the experiences of patients regarding doctors' communication behaviours.

3.3 Research Settings

The study was conducted in a public health facility (Achimota Hospital) and a private health facility (Nyaho Medical Centre). The hospitals were selected based on convenience and their willingness to participate in the study. The choice of a private and a public hospital was made because the dynamics of doctor-patient communication could differ because of the long queues experienced in public healthcare facilities, relative to private healthcare facilities, amongst others.

Also, whereas Nyaho Medical Centre operates as a sophisticated secondary healthcare facility in an elite neighbourhood with over a thousand patients in the OPDs daily, Achimota Hospital operates as a sophisticated secondary healthcare facility on the campus of a prestigious and one of the oldest government secondary schools (Achimota School) in Ghana with over a thousand patients (people from all walks of life) in the OPDs daily. These unique characteristics among the two health facilities and the socio-demographic characteristics of their patients in particular, have reinforced the need to compare doctor-patient communication quality among the hospitals. In other words, doctor-patient communication procedures in a public health facility are likely to differ from doctor-patient communication procedures in a private health facility in Ghana.

3.3.1 Nyaho Medical Centre

Nyaho Medical Centre (NMC) is a private healthcare facility which seeks to be in the forefront of quality healthcare delivery in Ghana and beyond. It was established in March, 1970, by the late Dr. Kwami Nyaho Tamakloe. The main aim of the Centre is to provide quality healthcare to its patients while bringing the best international standard to Ghana. Mrs. Janet Tamakloe successfully managed the hospital from 2001 until 2015, during which time she maintained its legacy through a continued mission statement. In April, 2015, Dr. Elikem C. Tamakloe took over

as the managing director. He now serves the hospital with a commitment to achieve the vision of providing the best medical and nursing care in Ghana.

3.3.2 Achimota Hospital

Achimota Hospital (AH) was established in 1927 by the Achimota School authorities, ten (10) years after the school was founded. It is located within the school and was purposely put up to take care of the health needs of the students and members of other institutions within the catchment areas. In 1973, the Ministry of Health took over the hospital but it attained the status of a public health facility in 1983, and became a District Hospital in 1985 (Afrifa et al., 2019).It is an eighty-eight-bed capacity hospital, with a children's ward, male and female wards, very important personality (VIP) ward, and a theatre/recovery ward. General outpatient care operates day and night. Among others, the hospital provides a wide range of services such as general OPD, emergency services, obstetric care, dental clinic, and ear, nose and throat (ENT) care.

3.4 Study population

The population of this study included all patients seeking healthcare services at Achimota Hospital and Nyaho Medical Centre. The two facilities, Achimota Hospital and Nyaho Medical Centre are both located in a cosmopolitan environment (Accra, Ghana) rendering sophisticated healthcare services to all manner of people.

3.5 Inclusion and exclusion criteria

The study included patients 18 years and above receiving out-patient care (OPD) at the two health facilities: Achimota Hospital and Nyaho Medical Centre. Patients who had been confirmed as mentally and psychologically unfit were not included. Those who were attending

the health facilities for the first time and had not had any encounter with doctors in the facilities were also not included.

3.6 Sample size

The size of the sample of this study was calculated using the (Cochran, 1977) formula as indicated below:

$$n=\frac{Z^2 p(1-p)}{e^2}$$

$$n=\frac{1.96^2 0.5(1-0.5)}{0.05^2} = 384$$

Where:

n = is the minimum sample size required

Z = standard normal deviation at 95% confidence interval

e = is the margin of error

P = is the estimated proportion of patients that are present in the population, which was assumed to be 50% since the current proportion of patients is unknown;

A 5% non-response rate is considered to cater for incomplete and invalid responses.

384+19 = 403

Therefore, four hundred and three (403) patients were recruited for the study.

3.7 Sampling method

The sampling technique used in this study for recruiting participants was convenience. This sampling technique is used in complex valuations such as health utility (Bowling, 2014).

According to Saunders, Lewis and Thornhill (2016), convenience sampling involves selecting cases because they are easily available for a researcher to obtain his or her sample.

The researcher approached the respondents individually at the exiting points of Achimota Hospital and Nyaho Medical Centre and explained the rationale for the study to them. This was after patients had completed their visits to the various units or consultation rooms. Those who consented to participate were given the questionnaire to fill at places near the hospitals for the sake of privacy. This sampling technique was used because of the patients' convenience. Also, patients who freshly visited the doctors' office or consultation room had better experiences regarding doctors' communication behaviours. Out of the 403 participants, 200 were drawn from Nyaho Medical Centre while 203 were drawn from Achimota Hospital respectfully.

3.8 Data collection tools

Based on the research design and the objectives of the study, the appropriate research instrument for data collection was a structured questionnaire. The questionnaire was adapted from the Four Habit Model. The Four Habits Model contains 23 items or questions which have been validated by Krupat et al. (2006). The questionnaire was adapted to assess doctor-patient communication quality rating in public and private hospitals, to identify barriers to effective communication, to compare doctor-patient communication quality between public and private hospitals and to examine the influence of the Four Habits Model on effective doctor-patient communication. Two questions (one closed-ended and one open-ended) were added to the questionnaire. The final questionnaire had thirty (30) items put into two main sections: background information and patients' communication experiences.

The background information section asked questions related to age, gender, educational level, number of visits to the hospital within the last twelve (12) months and employment status. The second section assessed patients' experiences with doctors' communication behaviours based on

four dimensions from the Four Habits Model, namely: Habit 1: investing in the beginning; Habit 2: eliciting the patients' perspectives; Habit 3: demonstrating empathy and Habit 4: investing in the end. Also, patients were asked to rate overall doctor-patient communication quality based on four dimensions: very Poor [ ] average [ ] Good [ ] very good [ ]. Finally, the opinions of patients on how doctor-patient communication quality could be improved in Ghana were asked. The most dominant of some of these opinions were used as recommendations.

3.9 Validity of Instrument

The Four Habit Model, which has been validated by Krupat et al. (2006), has 23 items or questions. The review of literature indicated that most studies used the instrument across contexts successfully (Grice et al., 2013; Scholl et al., 2014; Steinhausen et al., 2000; Velez et al., 2017) . Besides, in the context of developing countries, the Four Habits Model was successfully used in exploring clinical communication in Northern Ghana (Abor, 2019). Therefore, as a result of the rigorous process the instrument passed through, its validity was assured.

3.10 Data collection procedure

Data was collected from respondents in a face-to-face approach through the administration of questionnaires. Patients who had completed their visits to the consulting rooms and other units were approached at the main exiting points. Those who agreed to participate were individually interviewed at convenient places near the exiting points for the sake of privacy. The rationale for the study was explained to respondents before administration of questionnaires. Also, written consent of participants was taken before the questionnaires were administered. Participants who could not provide signatures were made to thumb print.

Though the questionnaires were written in English, the researcher translated the questions into Hausa, Twi, Ewe and Ga for participants who could not read and write in English. Participants

were made to complete questionnaires on their own but those who had challenges in completing them were assisted by the researcher. Every completed questionnaire was cross-checked by the researcher and follow-ups were carried out on unclear responses. Averagely, 10 – 15 minutes were spent with each respondent.

3.11 Ethical considerations

Creswell (2013) refers to ethics in research as the correctness of the attitude of the researcher with regard to the rights of participants of the study or people who may be affected by it. To adhere to the principles of ethics in research, the researcher submitted introductory letters which had been endorsed by the Head of the Department of Public Administration and Health Services Management and the supervisor for this study to the Ethics and Research Committee (ERC) of the Ghana Health Service (GHS) and the Management of Nyaho Medical Centre and Achimota Hospital. The researcher was given approval letters from all these institutions before the commencement of data collection. To ensure higher ethical standards, names of respondents were not asked and information given remained confidential. More importantly, before the actual administration of the questionnaires, participants were asked to sign consent forms. Those who could not read and write were made to thumb print.

3.12 Data analysis and management

Each completed questionnaire was coded and keyed in the Statistical Package for Social Science (SPSS) software, version 20. In order to correct errors and omitted responses, data were cleaned. All data were stored on a personal computer with a secure password. Only the researcher and the supervisors had access to the data. Socio-demographic characteristics were analysed using descriptive statistics.

In order to assess doctor-patient communication quality rating in public and private hospitals; and also to identify barriers to effective doctor-patient communication, the mean scores were

compared using descriptive statistics. In this view, the 5-likert scale on the questionnaire was converted to a 3-likert scale: where 1 – 3 = poor; 3.01 – 4 = satisfactory; and 4.01 – 5 = good. Thus, in the view of the researcher, poor constitutes a barrier to communication, satisfactory is seen as satisfactory (not poor and not good) and good represents good communication.

To compare doctor-patient communication quality between public and private hospitals, independent sample t-test was performed at 0.05 significant level. The researcher tested the hypothesis that: *H1: there is a significant difference in doctor-patient communication quality between public and private hospitals.*

In order to measure the magnitude of the mean differences in doctor-patient communication quality between Achimota Hospital and Nyaho Medical Centre, the researcher calculated the effect size using the formula below Pallant (2010).

Eta squared $= \frac{t^2}{t^2+(N1+N2-2)}$

The guideline proposed by Cohen (1988) for interpreting effect size is:

.01 = small effect

.06 = moderate effect

.14 = large effect

Also, cross tabulation using chi-square test was used to test for significant association between socio-demographic variables and overall doctor-patient communication quality at 0.05 significant level. Also, patients were asked to rate overall communication quality (dependable variable) based on four dimensions: very poor [ ] average [ ] good [ ] very good [ ].

To examine the influence of the determinants of effective communication, a hierarchical multiple linear regression was computed to test for significant predictors. Model (1) contained only the

independent variables and model (2) had the independent variables with socio-demographic variables as control. The determinants of effective communication in this study were the Four Habits. In view of this, the researcher tested the hypothesis that: *H1: the Four Habits are significant predictors of effective doctor-patient communication.*

In this study, the independent variables were the Four Habits (habit 1: investing in the beginning; habit 2: elicit the patients' perspectives; habit 3: demonstrate empathy and habit 4: investing in the end) and the dependent variable was overall communication quality.

The regression model for models 1&2 and the estimated regression values are as follows:

Model 1: Regression model: $OCQ = \beta 0 + \beta 1\ IIB + \beta 2\ EPP + \beta 3\ DE + \beta 4\ IIE + \varepsilon$

(Where: OCQ–overall communication quality; IIB–investing in the beginning; EPP–elicit the patients' perspectives; DE– demonstrate empathy; IIE–investing in the end; β-beta; ε-error term).

Estimated regression values: $OCQ = \beta 0 + .060IIB + .078EPP + .0149DE + .0321IIE$

Model 2: Regression model: $OCQ = \beta 0 + \beta 1\ IIB + \beta 2\ EPP + \beta 3\ DE + \beta 4\ IIE + \beta 5FT + \beta 6SR + \beta 7ELR + \beta 8NVH + \beta 9EMP + \beta 10AGE + \varepsilon$

(Where: OCQ–overall communication quality; IIB–investing in the beginning; EPP–elicit the patients' perspectives; DE– demonstrate empathy; IIE–investing in the end; FT–facility type; SR–sex of respondents; ELR–educational level of respondents; NVH–number of visits to hospital; EMP–employment status of respondents; AGE–age of respondents; β-beta; ε-error term).

Estimated regression values: $OCQ = \beta 0 + .050IIB + .078EPP + .045DE + .136 + .3021IIE + .213FT + .041SR + -.005ELR + -.002NVH + .027EMP + .003AGE$

3.12.1 Reliability of data

Reliability is pivotal in terms of selecting any scale for data collection (Creswell, 2013). The ability of a scale to attain consistent results when applied at different times or locations makes it reliable. Pallant (2005) indicates that the reliability of a scale is its ability to be free from random error. In order to examine the reliability of the scale (Four Habits Model), a reliability test was

conducted, using the Cronbach Alpha. Under the dictate of Cronbach Alpha, a coefficient of 0.700 is ideal. The Cronbach Alpha coefficient used in this study was 0.904. Therefore, the instrument for the data collection was statistically reliable.

Table 3.1: Reliability statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardised Items	Number of items
0.904	0.902	23

3.12.2 Multiple linear regression

The objective of this section of the data analysis was to identify significant predictors of effective doctor-patient communication. Hence, a multiple linear regression was conducted (hierarchical multiple linear regression).

3.12.3 Assumptions of multiple regression

It is imperative to satisfy certain statistical assumptions before the computation of multiple regression. Key among the assumptions is the scale of measurement. Pallant (2005) found that multiple regression can be used when the dependent variable is continuous and the independent variables are either categorical or continuous. This assumption was satisfied.

3.12.4 Sample size

The sample size is another principal assumption of multiple regression that should not be downplayed. Tabachnik and Fidel (1996) found that sample size should be determined using the following formula: N>50+8m (m= Number of Independent Variable). If you have 2IVs then you have 50+16 = 66. Therefore, in this study, N>50+8m (m=4IVs). 50+32 = 82. Hence, this study satisfies this assumption.

3.12.5 Multicollinearity

Pallant (2005) states that multicollinearity exists when the independent variables are highly correlated (r= 0.9 and above). Multiple regression is inconsistent with multicollinearity. In this study, the highest correlation coefficient between the independent variables was r= 0.636, which is less than r=0.9; therefore, this assumption was not downplayed.

3.13 Summary

The study employed the quantitative method. Also, convenient sampling technique was used to select participants. A validated instrument was used to collect data for this study. All patients 18 years and above at both Achimota Hospital and Nyaho Medical Centre formed the research target population. With the use of Statistical Package for Social Science (SPSS), version 20, data was analysed using descriptive statistics and cross tabulation using chi-square test. Independent sample t-test and hierarchical multiple linear regression were also used in analysing the data. All ethical considerations under this study were duly observed.

CHAPTER FOUR

4.0 RESULTS AND DISCUSSIONS

4.1 Introduction

This chapter presents the results and discussion of the study. It encompasses the background information of the research respondents, doctor-patient communication quality rating, the barriers to effective doctor-patient communication, comparison of doctor-patient communication quality between public and private hospitals, socio-demographic characteristics and doctor-patient communication quality rating, and influence of the Four Habits Model on effective doctor-patient communication.

4.2 Background information of research respondents

Table 4.1 presents the results of the background characteristics of respondents. A total of 403 respondents were recruited for this study, representing a 100% response rate. Two hundred and three (203) (50.4%) were selected from Achimota Hospital and 200 (49.6%) were selected from Nyaho Medical Centre.

Table 4.1 Background characteristics of respondents.

Demographic Variable	Categories	Frequency	Percentage
Facility type (Hospitals)	Achimota	203	50.4
	Nyaho	200	49.6
Age	30 years or below	150	37.2
	31 – 40 years	110	27.3
	41 – 50 years	74	18.4
	51 years or above	69	17.1
Gender	Male	191	47.4
	Female	212	52.6
Educational Level	None	28	6.9
	Primary/JHS	111	27.5
	Secondary	120	29.8
	Tertiary	144	35.7
Number of Visits to hosp.	Once	37	9.2
	Twice	156	38.7
	Three times or above	210	52.1
Employment Status	Unemployed	12	3.0
	Farmer	30	7.4
	Trader	109	27
	Government	59	14.6
	Private	57	14.1
	Student	48	11.9
	Other	88	21.8

Source: Field Data (2020)

Regarding the ages of respondents, 150 (37.2%) were 30 years or below, 110 (27.3%) were between the ages of 31and 40, 74 (18.4%) were between the ages of 41 and 50, and 69 (17.1%) were 50 years or above. In addition, 212 of the respondents, representing 52.6%, were females while 191 (47.4%) of them were males. The majority (93.1%) of the respondents had attained some level of formal education. Also, (27.5%; 29.8% and 35.7%) of the respondents had attained primary, secondary and tertiary education respectively. With regard to the number of times respondents had visited the two hospitals within the last 12 months, the majority (52.1%) had visited three times or more. Respondents who had visited twice were 156 (38.7%), while those who had visited once were 37 (9.2%). Concerning the issue of employment status, 12(3%) of the respondents were unemployed, 30 (7.4%) of them were into farming and 109 (27%) were into trading. Moreover, 59 (14.6%) of the respondents were employed by the government whilst 48 (11.9%) were students.

4.3 Quality of doctor-patient communication in public and private hospitals

Table 4.2 presents the results of doctor-patient communication quality rating. The mean scores of the four dimensions (habits 1, 2, 3 & 4) ranged from 3.13 - 3.46. Thus, the result shows that doctor-patient communication quality was generally satisfactory, but not good.

Table 4.2: Descriptive statistics for doctor-patient communication quality rating

Indicators of the Four Habits Model						**Communication Interpretation**		
Investing in the beginning	N	Min.	Max.	Mean	Std. Dev.	Poor	Satisfactory	Good
Doctor indicates clear familiarity with my history/previous records	403	1	5	**3.33**	1.238		✓	
Doctor greets me in a way that is personal and warm (e.g. I was asked how I like to be addressed)	403	1	5	**3.43**	1.214		✓	
Doctor makes non-medical jargons, in an attempt to put me at ease.	401	1	5	**3.53**	1.147		✓	
Doctor attempts to identify the problem(s) using primarily open-ended questions (asks questions in a way that allows me to tell my own story with minimal interruptions).	403	1	5	**3.54**	1.127		✓	
Doctor encourages me to expand in discussing my concerns (e.g., using various continuers such as aha, tell me more, go on).	403	1	5	**3.40**	1.140		✓	
Doctor attempts to elicit the full range of my concerns by probing further than simply pursuing my first stated complaint (s).	403	1	5	**3.51**	1.109		✓	
Mean score				**3.46**			✓	
Elicit the patients' perspectives								
Doctor shows great interest in exploring my understanding of the problem (e.g., asks me what the symptoms mean to me).	403	1	5	**3.26**	1.194		✓	
Doctor is interested about what I hope to get out of the visit	401	1	5	**3.38**	1.184		✓	
Doctor attempts to find out in details how the problem is affecting my lifestyle (work, family, daily activities).	403	1	5	**3.36**	1.210		✓	
Mean score				**3.33**			✓	
Demonstrate empathy								
Doctor openly encourages the expression of emotion (signals verbally or nonverbally that it is okay to express feelings).	403	1	5	**3.22**	1.224		✓	
Doctor makes comments clearly indicating acceptance of my feelings (e.g., I feel the same way ... I can see how that worries you ...).	403	1	5	**3.23**	1.203		✓	
Doctor makes clear attempt to explore my feelings by identifying or labelling them (e.g., So how does that make you feel? It seems to me that you are feeling quite anxious about ...).	402	1	5	**3.21**	1.215		✓	
Doctor displays nonverbal behaviours that express great interest, concern and connection (e.g., eye contact, tone of voice, and body language) throughout the visit.	403	1	5	**3.23**	1.254		✓	

Mean score				**3.22**			✓	
Invest in the end								
Doctor frames diagnostic and other relevant information in ways that reflect my initial presentation of concerns.	402	1	5	**3.22**	1.201		✓	
Doctor pauses after giving information with intent of allowing me to react to and absorb it.	403	1	5	**3.06**	1.269		✓	
Information is stated clearly and with little or no use of jargons.	401	1	5	**3.22**	1.345		✓	
Doctor clearly explains the rationale behind current, past, or future tests and treatments so that I can understand the importance of these to diagnosis and treatment.	402	1	5	**2.85**	1.396	✓		
Doctor effectively tests my understanding regarding treatment plans	402	1	5	**2.88**	1.332	✓		
Doctor clearly encourages and invites my input into the decision-making process.	403	1	5	**2.93**	1.394	✓		
Doctor explores acceptability of treatment plan, expressing willingness to negotiate if necessary.	402	1	5	**2.89**	1.372	✓		
Doctor fully explores barriers to implementation of treatment plan.	403	1	5	**3.42**	1.236		✓	
Doctor openly encourages and asks for additional questions from me (and responds to them in some detail).	403	1	5	**3.30**	1.224		✓	
Doctor makes clear and specific plans for follow-up to the visit.	402	1	5	**3.55**	1.164		✓	
Mean score				**3.13**			✓	

Source: Field Data (2020)

Doctors' familiarity with patients' medical history was perceived to be satisfactory (M = 3.33, SD = 1.238). Similarly, the results show that the respondents were warmly welcomed (M = 3.43, SD = 1.21) and put at ease (M = 3.53, SD = 1.15) by doctors. Further, patients were encouraged by doctors to express their concern (M = 3.4, SD = 1.14). Concerning eliciting patients' perspectives, doctors' attitudes towards understanding patients' problem were perceived to be satisfactory (M = 3.26, SD = 1.19).The respondents indicated that the doctors were interested in understanding the impact of the illness on their wellbeing (M = 3.51, SD = 1.12). Regarding demonstrating empathy, the results show that doctors encouraged patients to express their emotions (M = 3.22, SD = 1.22), demonstrated acceptance of patients' emotions (M = 3.23, SD = 1.20), explored patients' emotions (M = 3.21, SD = 1.21) and expressed concern about the emotions of the patients (M = 3.23, SD = 1.25). In addition, the results show that doctors communicated clearly to patients (M = 3.22, SD = 1.34) in addition to giving them an opportunity to ask questions (M = 3.06, SD = 1.26). However, doctors' explanation to the

rationale behind diagnoses was perceived to be poor (M = 2.85, SD = 1.34). It was also found that doctors ineffectively tested patients' understanding about treatment plan (M = 2.93, SD = 1.39) as well as poorly explored patients' acceptability of treatment plan (M = 2.89, SD = 1.37).

4.4 Identification of doctor-patient communication barriers

Even though results from table 4.2 above show that doctor-patient communication quality was generally satisfactory, no good communication quality was recorded. More importantly, four doctor-patient communication barriers were identified under habit 4. These include the following: doctors did not clearly explain the rationale behind medical test (M = 2.85, SD = 1.39); doctors did not effectively test patients' understanding regarding treatment plans (M = 2.88, SD = 1.33); doctors did not clearly encourage and invite patients' inputs into the decision-making process (M = 2.93, SD = 1.39), and doctors did not explore acceptability of treatment plan (M = 2.89, SD = 1.37) respectively.

4.5 Comparison of doctor-patient communication quality between public and private hospitals

Table 4.3 presents the results of the independent sample t-test of doctor-patient communication quality between public and private hospitals. The results show that there is a significant difference in doctor-patient communication quality between public and private hospitals.

Table 4.3: Independence sample t-test for doctor-patient communication quality between public and private hospitals

	Facility type	N	Mean	SD	Mean difference	t-test	p-value
Overall communication quality	Achimota Hospital	199	2.52	0.764	0.06	7.082	.000
	Nyaho Medical Centre	200	3.12	0.914			

Source: Field Data (2020)

The result indicates that there is a significant difference in doctor-patient communication quality between Achimota Hospital - public (M= 2.52, SD=0.764) and Nyaho Medical Centre - private (M=3.12, SD=0.914) with t=7.08 and p<0.05. In order to measure the magnitude of the mean differences in doctor-patient communication quality between the two facilities, the researcher calculated the effect size.

$$\text{Eta squared} = \frac{t^2}{t^2+(N1+N2-2)}$$

$$\text{Eta squared} = \frac{7.08^2}{7.08^2+(199+200-2)}$$

Eta squared = 0.10

The effect size of (Eta squared = 0.10) implies that there was a moderate difference in doctor-patient communication quality between public and private hospitals. Thus, the researcher accepted the hypothesis that: *H1: there is a significant difference in doctor-patient communication quality between public and private hospitals.* Therefore, the findings show that doctor-patient communication quality at Nyaho Medical Centre was moderately better than Achimota Hospital. In spite of this fact, the effect size or the magnitude of the difference is only moderate (Eta squared = 0.10).

4.6 Socio-demographic characteristics and doctor-patient communication

Table 4.4 presents the results of the socio-demographic characteristics and doctor-patient communication quality rating and overall communication quality. The results show that out of the six (6) socio-demographic variables, there was a significant association between three (3) of them and overall communication quality.

Table 4.4: Socio-demographic characteristics and doctor-patient communication quality rating

Characteristic	n	Very poor %	Average %	Good %	Very good %	X^2	p-value
Facility type							
Achimota Hospital	199	8.1	40.7	42.7	8.5	71.880	< 0.001
Nyaho Medical Centre	200	2.5	29	23	45.5		
Age in years							
≤ 30	146	5.5	34.2	30.8	29.5		
31-40	110	3.6	34.5	33.6	28.2	3.139	0.959
41-50	74	6.8	36.5	36.5	20.3		
≥ 51	69	5.8	34.8	31.9	27.5		
Sex							
Male	190	8.9	29.5	32.6	28.9	12.828	0.005
Female	209	1.9	39.7	33	25.4		
Education							
None	28	3.6	25	28.6	42.9		
Primary/JHS	111	10.8	23.4	37.8	27.9	21.815	0.009
Secondary	119	4.2	41.2	31.9	22.7		
Tertiary	141	2.1	40.4	30.5	27		
Number of visits							
Once	37	8.1	40.5	35.1	16.2		
Twice	154	4.5	32.5	35.7	27.3	4.051	0.670
Three or more	205	5.4	35.6	30.2	28.8		
Employment							
Unemployed	12	8.3	25	33.3	33.3		
Farmer	29	6.9	31	24.1	37.9	17.673	0.477
Trader	109	5.5	34.9	29.4	30.3		
Government worker	58	3.4	32.8	32.8	31		
Private sector worker	57	1.8	36.8	29.8	31.6		
Student	46	2.2	43.5	32.6	21.7		
Others	88	9.1	33	42	15.9		

Source: Field Data (2020)

A cross-tabulation was performed among socio-demographic characteristics and doctor-patient communication quality ratings using chi-square test at 0.05 significant level. The results are presented in table 4.4 above. The results show that (8.1%) of the respondents at Achimota Hospital rated doctor-patient communication quality as very poor, (40.7%) rated it as average, (42.7%) rated it as good and (8.5%) rated it as very good. On the other hand, (2.5%) of the respondents at Nyaho Medical Centre rated communication quality as very poor, (29%) rated it as average, (23%) rated it as good and (45.5%) rated it as very good. There is a statistically significant association between type of hospital and doctor-patient communication quality (X^2 = 71.88, $p < 0.001$).

With regard to age, (5.5%) of respondents who were 30 years or below rated doctor-patient communication quality as very poor, (34.2%) rated it as average, (30.8%) rated it as good and (29.5%) rated it as very good. Respondents between the ages of 31 and 40 years rated doctor-patient communication quality as follows: (3.6%) as very poor, (34.5%) as average, (33.6%) as good and (28.2%) as very good. There was no statistically significant association between age and overall doctor-patient communication quality ($X^2 = 3.139$, $p = 0.959$).

The results reveal that among male respondents, (8.9%) rated doctor-patient communication quality as very poor, (29.5%) rated it as average, (32.6%) rated it as good and (28.9%) rated it as very good. Among female respondents, (1.9%) rated doctor-patient communication quality as very poor, (39.7%) rated it as average, (33.00%) rated it as good and (25.4%) rated it as very good. A statistically significant association was found between gender and doctor-patient communication quality ($X^2 = 12.83$, $p < 0.005$).

Regarding educational status, among respondents with no formal education, (3.6%) rated doctor-patient communication quality as very poor, (25%) rated it as average, (28.6%) rated it as good and (42.9%) rated it as very good. Among respondents with primary/JHS education, (10.8%) rated doctor-patient communication quality as very poor, (23.4%) perceived it to be average, (37.8%) rated it as good and (27.9%) perceived it to be very good. Among respondents with tertiary education, (2.1%) rated doctor-patient communication quality as very poor, (40.4%) rated it as average, (30.5%) rated it as good and 27.00% rated quality as very good. Educational level was significantly associated with doctor-patient communication quality ($X^2 = 21.82$, $p < 0.009$).

In terms of the number of times respondents had visited the hospitals within the last 12 months, (8.1%) of respondents who had visited once rated doctor-patient communication quality as very poor, (4.5%) rated it as average, (35.1%) rated quality as good and (16.2%) rated it as very good.

In addition, (4.5%) of respondents who had visited twice rated doctor-patient communication quality as very poor, (32.5%) rated it as average, (35.7%) rated it as good and (27.3%) rated it as very good. The results show that there was no significant association between employment status and doctor-patient communication quality ($X^2 = 17.673$, $p = 0.477$).

4.7 The influence of the Four Habits Model on effective doctor-patient communication

Table 4.5 presents the predictors of effective doctor-patient communication. The results show that two of the Four Habits (habit 3 & 4) were significant predictors of overall communication quality with or without control variables. Also, one of the control variables (facility type) emerged as a significant predictor of overall communication quality.

Table 4.5: Hierarchical multiple linear regression analysis of doctor-patient communication

Model (1)	Unstandardised Coefficients B	Unstandardised Coefficients Std. Error	Standardised Coefficients Beta	t	Sig.
Model fit: R=.516, R2=.266, Adjusted R2=.258 , P=.000 < 0.01					
1 (Constant)	.791	.197		4.018	.000
Investing in the beginning	.071	.066	.060	1.065	.288
Elicit the patients' perspectives	.076	.058	.078	1.315	.189
Demonstrate empathy	.140	.057	.149	2.444	.015
Investing in the end	.341	.062	.321	5.511	.000
Model (2)	Unstandardized Coefficients B	Unstandardized Coefficients Std. Error	Standardized Coefficients Beta	t	Sig.
Model fit: R=.553, R2=.306, Adjusted R2=.287, P=.000 < 0.01					
1 (Constant)	.315	.351		.898	.370
Investing in the beginning	.059	.067	.050	.884	.377
Elicit the patients' perspectives	.043	.059	.045	.739	.461
Demonstrate empathy	.127	.057	.136	2.237	.026
Investing in the end	.320	.064	.302	4.990	.000
Facility type	.381	.084	.213	4.561	.000
Sex of respondents	.072	.083	.041	.870	.385
Educational level of respondents	-.005	.043	-.005	-.116	.908
How many times have you visited this hospital within the last 12 months?	-.003	.062	-.002	-.042	.966
Employment status of respondents	.014	.024	.027	.560	.576
Age of respondents	.003	.037	.003	.067	.946

Source: Field Data (2020)

The objective of this study was to examine the influence of the Four Habits Model on overall communication quality. In order to achieve this, a hierarchical multiple linear regression model was performed at 0.05 significant level. Table 4.5 above (model 1) had only the Four Habits (independent variables), whilst model 2 had the independent variables with age, sex of respondents, educational level of respondents, employment status, number of visits to the hospital within the last 12 months, and facility type as control variables.

Model (1) exhibited R2 value of (.266x100=26.6%). The R square value was .26.6, which means that 26.6% of variation in the dependent variable is being explained by the predictors. Two of the four independent variables (demonstrate empathy (β = 0.149, p= 0.015) and investing in the end (β = .321, p = 0.000) were significant predictors of overall communication quality (dependent variable). Therefore, the hypotheses that the Four Habits are significant predictors of overall communication quality were supported by the data.

Model (2) exhibited R2 value of (.306x100=30.6%). Overall, 30.6% of the variation in the dependent variable was explained by the independent variable controlling for respondents' characteristics. Consequently, two of the four independent variables (demonstrate empathy (β = 0.136, p = 0.026) and investing in the end (β = 0.302, p = 0.000) and one of the control variables (facility type (β = 0.213, p = 0.000) emerged as significant predictors of overall communication quality (dependent variable). Therefore, the hypotheses that the Four Habits are significant predictors of overall communication quality were supported by the data. This implies that the Four Habits have an influence on effective doctor-patient communication with or without controlled variables. Thus, the researcher accepted the hypothesis that: *H1: the Four Habits are significant predictors of effective doctor-patient communication.*

4.8 Implications of the conceptual framework on the study findings

Using a scale of 1 – 3 = poor; 3.01 – 4 = satisfactory; and 4.01 – 5 = good, the study found that doctor-patient communication quality was satisfactory in both Achimota Hospital and Nyaho Medical Centre under all the dimensions measured: (habit 1: investing in the beginning, mean = 3.46; habit 2: elicit the patients' perspectives, mean = 3.33; habit 3: demonstrate empathy, mean = 3.22 & habit 4: investing in the end, mean = 3.13) respectively. Despite the satisfactory performance of Achimota Hospital and Nyaho Medical Centre, none of the two facilities recorded good communication.

With a scale of 1 – 3 = poor; 3.01 – 4 = satisfactory; and 4.01 – 5 = good, the study identified four doctor-patient communication barriers: (1) doctors did not clearly explain the rationale for medical tests (mean = 2.85); (2) doctors did not effectively test patients' understanding regarding treatment plans (mean = 2.88); (3) doctors did not clearly encourage and invite patients' inputs into the decision making process (mean = 2.93) and (4) doctors did not explore acceptability of treatment plan (mean = 2.89) respectively. Also, the results of the study indicate that a large proportion of participants were neutral in both hospitals.

Furthermore, the study found that there was a significant difference in doctor-patient communication quality between Achimota Hospital - public (M= 2.52, SD=0.764) and Nyaho Medical Centre - private (M=3.12, SD=0.914) with $t=7.082$ and $p<0.05$. The effect size of (Eta squared = 0.10) implies that doctor-patient communication quality is moderately better in private hospitals than in public hospitals.

This study revealed that there was a statistically significant association between socio-demographic characteristics and doctor-patient communication quality rating in both Achimota Hospital and Nyaho Medical Centre at 0.05 significant level. There was a significant association between overall communication quality and the following: facility type – Achimota Hospital and Nyaho Medical Centre ($X2=71.88$ & $p<0.001$); gender ($X2=12.83$ & $p<0.005$) and educational level ($X2=21.82$ & $p<0.009$) respectively.

More importantly, the study found (habit 3: demonstrate empathy), (habit 4: investing in the end) and facility type as statistically significant predictors of effective doctor-patient communication after a hierarchical multiple linear regression model was performed at 0.05 significant level.

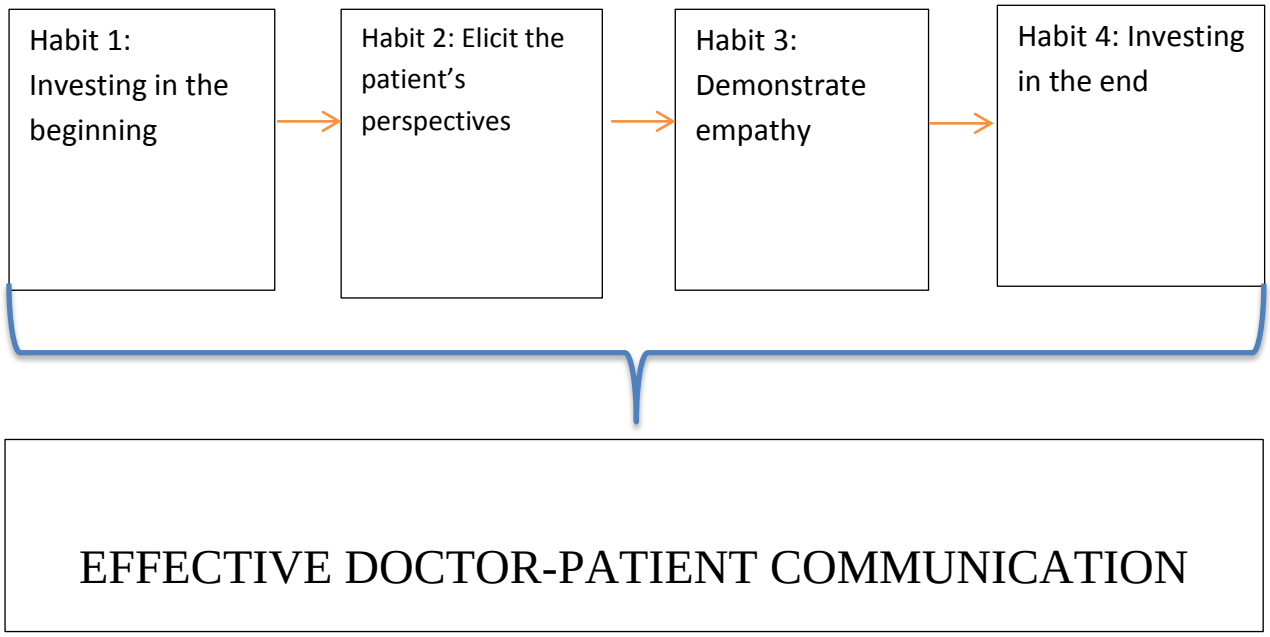

Figure 4.1: Conceptual framework for doctor-patient communication based on study findings

Source: Author's Development (2020).

Finally, regarding the appropriateness of the application of the Four Habits Model in the context of developing countries, it was successfully used in exploring clinical communication in a teaching hospital in Northern Ghana by Abor (2019). Therefore, based on the findings of this study and the consistency of previous studies on the Four Habits Model, it is imperative to conclude that the framework explained the study. Hence, the researcher did not revise the framework.

4.9 Discussion of the results

This section discusses the findings of the study in relation to the research objectives. Moreover, the results were compared with existing literature on doctor-patient communication to ascertain whether the results confirm or contradict previous studies.

4.10 Background information of participants

It was found that females dominated in utilising the services of the two facilities. This finding was buttressed by previous studies. For instance, it was noted that globally, health services patronisation is influenced by several factors such as gender, educational level and economic status (Abane & Adu-Gyamfi, 2013; Doyal, 2001; GLSS, 2008; Say & Raine, 2007) . It was also found that patients with a higher level of education patronised healthcare services of both hospitals. This was confirmed by Correa-de-Araujo et al. (2005), Maurer (2006), and Nicholas et al. (2007) when they concluded that there is a significant relationship between educational level and healthcare patronisation.

In assessing the quality of a service, the consistency at which customers patronise that service is pivotal to evaluation of the service (Porter et al., 2014). Furthermore, the majority of the respondents had three times or above visits. This shows that the majority of the patients had rich and multiple levels of communication experiences with doctors in these facilities. What this means is that they were well-positioned to objectively assess the quality of doctor-patient communication in the two health facilities.

4.11 Doctor-patient communication quality rating in public and private hospitals

The results of this study indicate that doctor-patient communication quality was satisfactory in both Achimota Hospital and Nyaho Medical Centre under all the dimensions. Abor (2014) buttressed this when she found that the quality of healthcare services is fairly above average in Ghana. Peprah (2014) confirmed this when he concluded that the overall satisfaction of patients regarding how services were delivered in Ghanaian hospitals was good. More importantly, the study recommended policy action to enhance service delivery in effective provider-patient communication. Similarly, it was reported that satisfaction among patients of public hospitals is satisfactory (Ampah & Ali, 2019).

4.10 Identification of barriers to effective doctor-patient communication

Notwithstanding the satisfactory performance of the two hospitals, four communication barriers were found: (1) doctors did not clearly explain the rationale for medical tests; (2) doctors did not effectively test patients' understanding regarding treatment plans; (3) doctors did not clearly encourage and invite patients' inputs into the decision making process and (4) doctors did not explore acceptability of treatment plan respectively. This finding is not surprising since it has been corroborated by previous studies. For instance, Sun and Rau (2017) found that doctors lacked the will to involve patients in decision-making. Madula et al. (2018) found that unwillingness of providers to answer questions, verbal abuse and lack of respect for patients, militated against effective doctor-patient communication.

Also, despite the satisfactory performance of Achimota Hospital and Nyaho Medical Centre, none of the two facilities recorded good communication. This implies that better strategies and commitments are needed in both public and private health facilities in order to improve doctor-patient communication quality. Patients are more likely to be satisfied when doctor-patient communication quality is improved and sustained. This finding is not surprising because it has been attested in some available literature. For instance, Ramez (2014) found that despite the disparity of service quality among public and private health facilities, patients at both the public and private hospitals were dissatisfied with the quality of healthcare services.

It was again reported that healthcare quality in Ghana was viewed as lowest regarding provision of timely information to patients (Alhassan, Nketiah-Amposah & Arhinful, 2016). Jesha et al. (2016) showed that 39% of patients had their expectations unmet. The study further reported that the behaviours of some doctors in the consultation rooms made patients uncomfortable. Adequate information was not given to patients in many instances. Going forward, it will be

necessary for doctors to have enough time to communicate with patients. Doctors should be friendly and exhibit more empathy and employ simple language instead of medical jargons.

The findings of this study indicate that a large proportion of participants were neutral in both hospitals. The reason for this neutrality could either be that most patients did not care about doctor-patient communication quality or were ignorant about their rights and responsibilities. This is buttressed by Claramita et al. (2010) when they concluded that irrespective of the educational levels of patients, both doctors and patients are not ready for collective decision-making. The study further pointed out that high patient load on doctors as a result of inefficient healthcare systems does not permit adequate time for effective doctor-patient communication.

Abekah-Nkrumah et al. (2010) also confirmed this result when they reported that most patients and a sizeable number of healthcare providers are ignorant of the current contents of the Patient Charter developed by the Ghana Health Service. They, however, admitted that there exists a mutual relationship among providers and patients; and that advantage could be tapped from this relationship to improve on effective communication or timely disclosure of information, active patient involvement in decision-making and information seeking.

4.12 Comparison of doctor-patient communication quality between public and private hospitals

The findings from this study show that there was a significant difference in doctor-patient communication quality between public and private hospitals. Doctor-patient communication quality was better in the private hospital than in the public hospital. This result is not surprising as it has been attested in previous studies. It was reported that unlike public healthcare facilities, private hospitals have relatively fewer quality gaps (Yasilada & Direcktor, 2010). Adesanya et al. (2012) conducted a comparative study in Nigeria and found that significant differences

existed between the performance of public and private hospitals, with private hospitals being ahead of public hospitals regarding service quality.

However, a comparative study involving 340 respondents by Swain (2018) found that public hospitals performed better than private hospitals in areas such as treatment of diseases; while private hospitals performed better than public hospitals in areas such provider-patient communication quality.

4.13 Socio-demographic characteristics and doctor-patient communication quality rating

A statistically significant association was found between socio-demographic characteristics and doctor-patient communication quality rating. There was a significant association between facility type and overall communication quality; gender and overall communication quality; and educational level and overall communication quality. This finding has been attested in earlier studies. For example, it was reported that healthcare patronisation is influenced by several factors such as gender, educational level, and economic status (Abane & Adu-Gyamfi, 2013; Doyal, 2001; GLSS, 2008; Say & Raine, 2007). Similarly, it was found that there is a significant association between educational level and healthcare utilisation; with people of higher levels of education exhibiting higher levels of healthcare patronisation. What this means is that better educated persons in societies are conscious of their health and, therefore, more likely to make higher investment in their health (Correa-de-Araujo et al., 2005; Maurer, 2006; Nicholas et al., 2007).

4.14 The influence of the Four Habits on effective doctor-patient communication

The study found two of the Four Habits (demonstrate empathy, investing in the end) and facility type (control variable) as statistically significant predictors of effective doctor-patient communication. In a similar study involving multiple linear regression, Scholl et al. (2014) found that the four dimensions of the Four Habits Model explained a substantial amount of variation in

the doctors' shared decision-making scores. The study further concluded that the Four Habits Model can be used in research and medical education. Also, it was reported that, globally, doctor-patient communication is still in need of rapid enhancement (Steinhausen et al., 2000). Moreover, it was found that perceptions of quality are driving many patients to private hospitals (Andaleeb, 2000).

4.15 Summary

The findings show that females dominated in utilising health services. It was found that doctor-patient communication quality was satisfactory in both hospitals. That notwithstanding, patients were confronted with four doctor-patient communication quality shortfalls. No good communication was recorded at both health facilities. Again, doctor-patient communication quality was moderately better in private hospitals than in public hospitals. There was a significant association between facility type and overall communication quality, gender and overall communication quality, and educational level and overall communication quality. Two out of the four dimensions of the Four Habits Model and one control variable (facility type) were statistically significant predictors of effective doctor-patient communication.

CHAPTER FIVE

5.0 SUMMARY OF FINDINGS, RECOMMENDATIONS AND CONCLUSION

5.1 Introduction

Effective communication is a critical aspect in healthcare delivery as it bridges the relationship gap between doctors and patients. All processes in the delivery of healthcare, from the attainment of medical history to the conveyance of treatment plan, rely heavily on effective communication among healthcare providers and patients (Wordi, 2019). This study set out to assess doctor-patient communication quality in public and private hospitals, examine the barriers to effective doctor-patient communication, compare doctor-patient communication quality between public and private hospitals and to examine the influence of the Four Habits Model on effective doctor-patient communication.

Different scholarly works were reviewed to broaden the outlook of this academic work whereby the quantitative approach was used to enhance the analysis of the study. In this chapter, highlights on the summary of key findings, conclusions, contributions to knowledge and recommendations have been presented.

5.2 Summary of the main findings

The results of the background information of respondents reveal that women greatly patronised health services in Ghana. Also, the results show that patients with a higher level of education, that is, those from senior high (SHS) level upwards patronised out-patient (OPD) services of both Achimota Hospital and Nyaho Medical Centre more than those with a lower level of education. Most of the patients had visited both hospitals either twice or three times and above within the last 12 months.

The study found that doctor-patient communication quality was satisfactory in both Achimota Hospital and Nyaho Medical Centre. This notwithstanding, four communication barriers were identified: (1) doctors did not clearly explain the rationale for medical tests; (2) doctors did not effectively test patients' understanding regarding treatment plans; (3) doctors did not clearly encourage and invite patients' inputs into the decision making process and (4) doctors did not explore acceptability of treatment plan respectively. Also, the results of the study indicate that a large proportion of participants were neutral in both hospitals. Additionally, no good communication was recorded in both Achimota Hospital and Nyaho Medical Centre.

One other finding the study made is that doctor-patient communication quality was moderately better in the private hospital studied than in the public hospital (Eta squared = 0.10). The result of this study indicates that there was a statistically significant association between facility type – Achimota Hospital and Nyaho Medical Centre ($X2=71.88$ & $p<0.001$) and overall communication quality; gender ($X2=12.83$ & $p<0.005$) and overall communication quality, and educational level ($X2=21.82$ & $p<0.009$) and overall communication quality respectively. The study found habit 3 (demonstrate empathy), habit 4 (investing in the end) and facility type as statistically significant predictors of effective doctor-patient communication after a hierarchical multiple linear regression model was performed.

5.3 Conclusion

The objectives of this study were to assess the quality of doctor-patient communication in public and private hospitals, examine the barriers to effective doctor-patient communication, compare doctor-patient communication quality between public and private hospitals, and to examine the influence of the Four Habits Model on effective doctor-patient communication.

The study found that both public and private health facilities performed satisfactorily regarding communication quality. In spite of this, the study identified four doctor-patient communication

barriers in both hospitals. Furthermore, it was found that communication quality was moderately better in private hospitals than in public hospitals. Again, it emerged from this study that there was a significant association between facility type and overall communication quality; gender and overall communication quality; and educational level and overall communication quality. Also, the Four Habits Model was found to have a significant influence on effective doctor-patient communication. Habits 3 (demonstrate empathy) & habit 4 (investing in the end) and facility type were found to be significant predictors of effective doctor-patient communication.

However, patients were still confronted with doctor-patient communication challenges, especially in public health facilities in Ghana. Consistent use of reliable communication models such as the Four Habits Model is required by management of healthcare facilities in order to improve communication quality gaps in all hospitals.

In a nutshell, despite the shortfalls of doctor-patient communication at Achimota Hospital and Nyaho Medical Centre, overall communication quality was found to be satisfactory.

5.4 Limitations and opportunities for future research

Academic works of this nature have the tendency to be limited in some regard. However, since academic works are ideally meant to contribute to, instead of consummate or terminate knowledge, the limitations of this study, which have been highlighted here, present opportunities for further research in advancing knowledge on effective doctor-patient communication in the Ghanaian context and beyond.

As a result of time constraint and the challenges of the novel covid-19 pandemic, this study could not tap doctor-patient communication experiences from medical doctors' point of view. Therefore, there is the need for future studies to concentrate on eliciting communication experiences from both doctors and patients. Also, since qualitative studies allow participants to freely narrate their previous accounts or experiences, future studies may concentrate on

qualitative approach in order to unravel communication-related narrations of patients and doctors.

Finally, due to the scarcity of resources, only two hospitals (Achimota Hospital – public and Nyaho Medical Centre – private) got chosen for this academic work. However, future studies should concentrate on other private and public hospitals in Ghana.

5.5 Recommendations for policy and practice

The following are recommended for policy and practice:

1. Doctors should clearly explain the rationale for medical tests. Trust, respect and a sense of care are likely to be established between patients and doctors when doctors clearly explain the rationale for medical tests.
2. Doctors should effectively test patients' understanding regarding treatment plans. This may ensure that patients stick to correct therapeutic instructions and projects trust among patients and doctors.
3. Doctors should clearly encourage and invite patients' inputs into the decision-making process. In this view, patients are likely to see themselves as major stakeholders in their own care and this may give doctors some relevant cues regarding patients' health conditions.
4. Doctors should explore acceptability of treatment plans. If patients are well informed about alternative care, including expected cost of therapy, they can make informed choices and become satisfied clients.
5. Reliable communication models such as the Four Habits Model should be used as a strategic blueprint by healthcare management. This will help reduce anxiety in patients, encourage patients to positively engage doctors and portray doctors as being empathic in

their caring. Also, it may serve as a standard operative procedure (SOP) for doctors to increase patients' satisfaction irrespective of which doctor is on duty.

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APPENDICES

Appendix A

UNIVERSITY OF GHANA

DEPARTMENT OF PUBLIC ADMINISTRATION AND HEALTH SERVICES MANAGEMENT

Dear Sir/Madam,

My name is Jima Bawa Kassim, a final year student of the University of Ghana Business School offering Master of Philosophy in Health Services Management. This questionnaire seeks to elicit responses on the topic, "*Doctor-patient Communication in Ghana: A Comparative Study between Public and Private Hospitals*." Information provided for the purposes of this research will be handled confidentially and used for academic purposes only.

Please take a few minutes to fill out this questionnaire by ticking where appropriate. For any clarifications or questions, please contact me via my details provided below:

Email: ntingnpinfo@gmail.com

SECTION A: BACKGROUND INFORMATION OF PARTICIPANTS

1. What is your age? …….
2. Sex: Male [ ] Female [ ]

3. What is your level of formal education: None [ ] Primary [ ] Junior High [ ] Senior High/Vocational [ ] Tertiary [ ]

4. How many times have you visited this hospital within the past twelve months? Once [ ] Two times [ ] Three times or more [ ]

5. Employment Status: Unemployed [ ] Farmer [ ] Trader/businessman [ ] Government employee [ ] Private sector employee [ ] Student [ ] Other (please specify) ……..

SECTION B: PATIENTS' COMMUNICATION EXPEREINCES WITH DOCTORS

This part of the questionnaire requires participants to use a 1-5 scale by ticking the appropriate box that corresponds with each question about patients' communication experiences with doctors. The possible choices of answers are represented by: Strongly Disagree (SD), Disagree (D), Neutral (N), Agree (A) and Strongly Agree (SA).

PATIENTS' COMMUNICATION EXPERIENCES		SD	D	N	A	SA
HABIT 1: INVEST IN THE BEGINNING						
6	Doctor indicates clear familiarity with my history/previous records					
7	Doctor greets me in a way that is personal and warm (e.g. I was asked how I like to be addressed)					
8	Doctor makes non-medical jargons, in an attempt to put me at ease.					
9	Doctor attempts to identify the problem(s) using primarily open-ended questions (asks questions in a way that allows me to tell my own story with minimal interruptions).					
10	Doctor encourages me to expand in discussing my concerns (e.g., using various continuers such as aha, tell me more, go on, etc.).					
11	Doctor attempts to elicit the full range of my concerns by probing further rather than simply pursuing my first stated complaint(s).					
HABIT 2: ELICIT THE PATIENTS' PERSPECTIVES						

12	Doctor shows great interest in exploring my understanding of the problem (e.g., asks me what the symptoms mean to me).					
13	Doctor is interested about what I hope to get out of the visit					
14	Doctor attempts to find out in details how the problem is affecting my lifestyle (work, family, daily activities).					
HABIT 3: DEMONSTRATE EMPATHY						
15	Doctor openly encourages the expression of emotion (signals verbally or nonverbally that it is okay to express feelings).					
16	Doctor makes comments clearly indicating acceptance of my feelings (e.g., I feel the same way ... I can see how that worries you ...).					
17	Doctor makes clear attempt to explore my feelings by identifying or labelling them (e.g., So how does that make you feel? It seems to me that you are feeling quite anxious about ...).					
18	Doctor displays nonverbal behaviours that express great interest, concern and connection (e.g., eye contact, tone of voice, and body language) throughout the visit.					
HABIT 4: INVEST IN THE END						
19	Doctor frames diagnostic and other relevant information in ways that reflect my initial presentation of concerns.					
20	Doctor pauses after giving information in order to allow me to react to and absorb it.					
21	Information is stated clearly and with little or no use of jargons.					
22	Doctor clearly explains the rationale behind current, past, or future tests and treatments so that I can understand the importance of these to diagnosis and treatment.					

23	Doctor effectively tests my understanding regarding treatment plans.					
24	Doctor clearly encourages and invites my input into the decision-making process.					
25	Doctor explores acceptability of treatment plan, expressing willingness to negotiate if necessary.					
26	Doctor fully explores barriers to implementation of treatment plan.					
27	Doctor openly encourages and asks for additional questions from me (and responds to them in some detail).					
28	Doctor makes clear and specific plans for follow-up to the visit.					

29. How will you rate the entire doctor-patient communication quality in this hospital? Very Poor [ ] Average [ ] Good [ ] Very good [ ]

30. What would you suggest to improve doctor-patient communication in Ghana?

……
……
……
……
……..

Appendix B

CONSENT FORM

STUDY TITLE: DOCTOR-PATIENT COMMUNICATION IN GHANA: A COMPARATIVE STUDY BETWEEN PUBLIC AND PRIVATE HOSPITIALS

PARTICIPANTS' STATEMENT

I acknowledge that I have read or have had the purpose and contents of the Participants' Information Sheet read and satisfactorily explained to me in a language I understand (English, Twi, Hausa and Ga). I fully understand the contents and any potential implications as well as my right to change my mind (i.e. withdraw from the research) even after I have signed this form.

I voluntarily agree to be part of this research.
Name or Initials of Participant…….. ID Code ……..

Participants' Signature ……...or Thumb Print……

Date:…….

INTERPRETER'S STATEMENT

I interpreted the purpose and contents of the Participants' Information Sheet to the afore-named participant to the best of my ability in the (Hausa, Ga, Twi) language to his/her proper understanding.

All questions and appropriate clarifications sought by the participant were also duly interpreted to his/her satisfaction.

Name of Interpreter……

Signature of Interpreter…….. Date:……

Contact Details

STATEMENT OF WITNESS

I was present when the purpose and contents of the Participant Information Sheet were read and explained satisfactorily to the participant in the language he/she understood (….*name of language*)

I confirm that he/she was given the opportunity to ask questions/seek clarifications and same were duly answered to his/her satisfaction before voluntarily agreeing to be part of the research.

Name:……

Signature…….... or Thumb Print …….....

Date:……

INVESTIGATOR'S STATEMENT AND SIGNATURE
Brief statement or declaration that the investigator has given enough information to participants to make informed decisions.

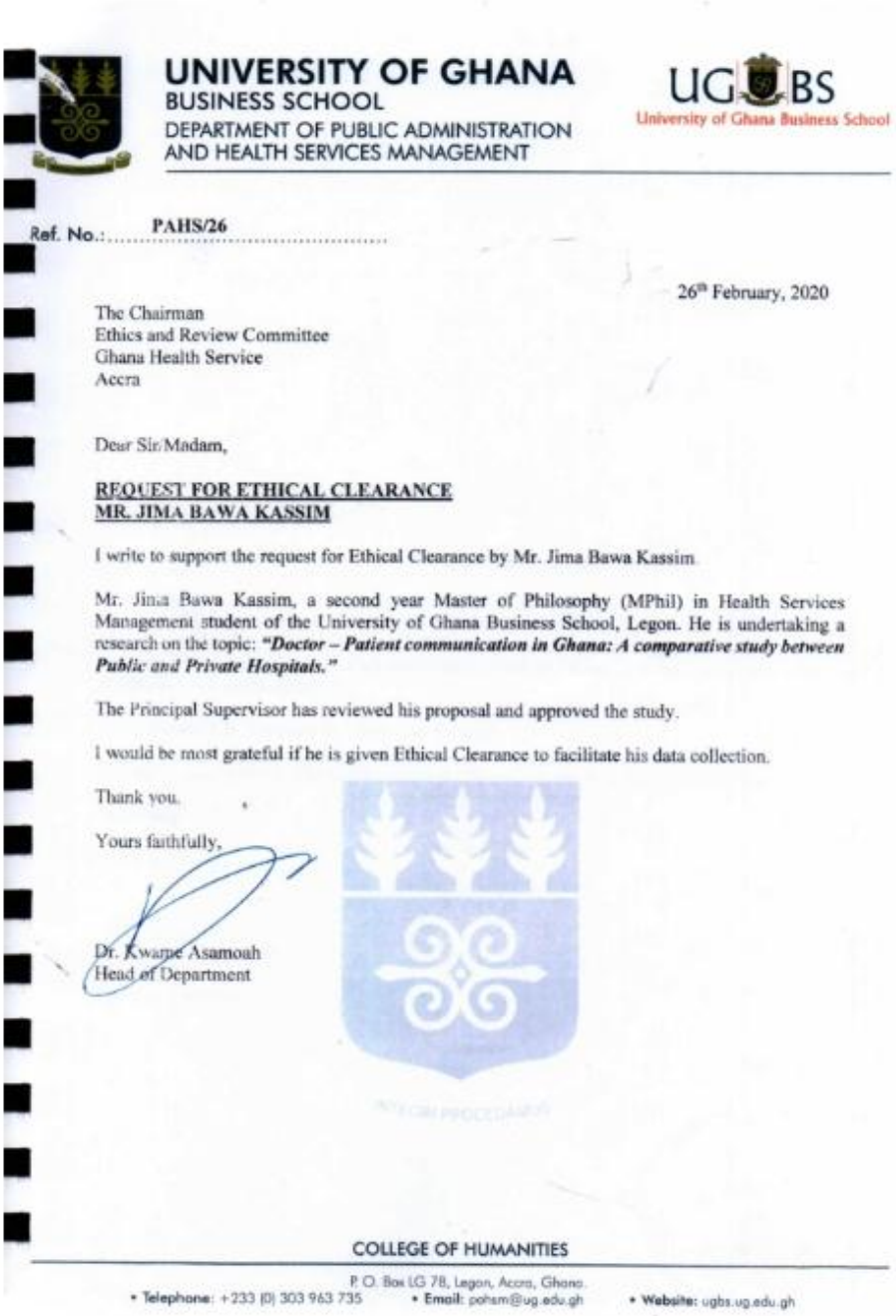
I certify that the participant has been given ample time to read and learn about the study. All questions and clarifications raised by the participant have been addressed.

Researcher's name…….

Signature …….

Date…….

Appendix C: INTRODUCTORY LETTER



UNIVERSITY OF GHANA
BUSINESS SCHOOL
DEPARTMENT OF PUBLIC ADMINISTRATION
AND HEALTH SERVICES MANAGEMENT

UGBS
University of Ghana Business School

Ref. No.: PAHS/26

26th February, 2020

The Chairman
Ethics and Review Committee
Ghana Health Service
Accra

Dear Sir/Madam,

REQUEST FOR ETHICAL CLEARANCE
MR. JIMA BAWA KASSIM

I write to support the request for Ethical Clearance by Mr. Jima Bawa Kassim.

Mr. Jima Bawa Kassim, a second year Master of Philosophy (MPhil) in Health Services Management student of the University of Ghana Business School, Legon. He is undertaking a research on the topic: ***"Doctor – Patient communication in Ghana: A comparative study between Public and Private Hospitals."***

The Principal Supervisor has reviewed his proposal and approved the study.

I would be most grateful if he is given Ethical Clearance to facilitate his data collection.

Thank you.

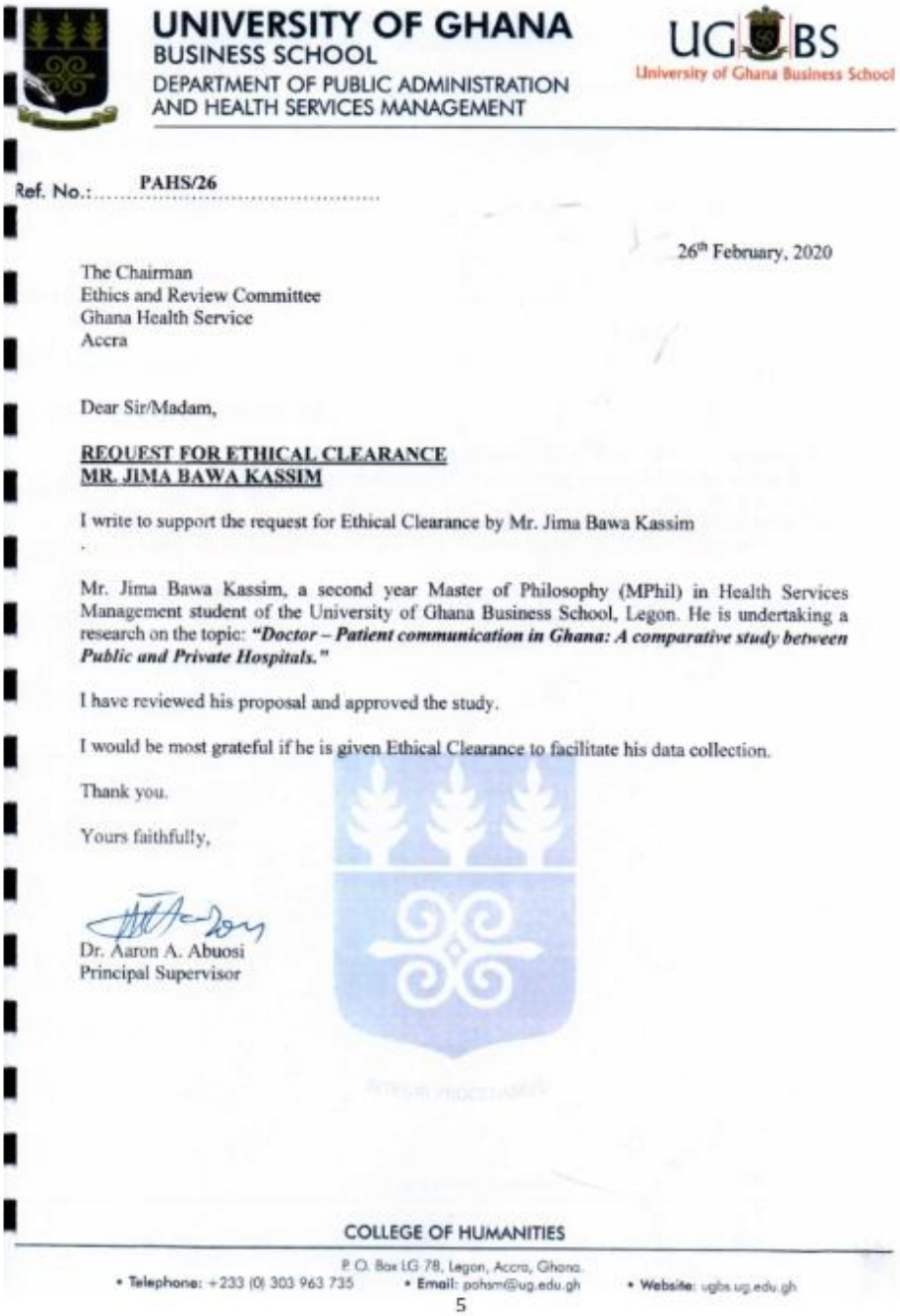
Yours faithfully,

Dr. Kwame Asamoah
Head of Department

COLLEGE OF HUMANITIES

P. O. Box LG 78, Legon, Accra, Ghana.
• Telephone: +233 (0) 303 963 735 • Email: pahsm@ug.edu.gh • Website: ugbs.ug.edu.gh

Appendix D: INTRODUCTORY LETTER



UNIVERSITY OF GHANA
BUSINESS SCHOOL
DEPARTMENT OF PUBLIC ADMINISTRATION
AND HEALTH SERVICES MANAGEMENT

UGBS
University of Ghana Business School

Ref. No.: **PAHS/26**

26th February, 2020

The Chairman
Ethics and Review Committee
Ghana Health Service
Accra

Dear Sir/Madam,

REQUEST FOR ETHICAL CLEARANCE
MR. JIMA BAWA KASSIM

I write to support the request for Ethical Clearance by Mr. Jima Bawa Kassim
.

Mr. Jima Bawa Kassim, a second year Master of Philosophy (MPhil) in Health Services Management student of the University of Ghana Business School, Legon. He is undertaking a research on the topic: ***"Doctor – Patient communication in Ghana: A comparative study between Public and Private Hospitals."***

I have reviewed his proposal and approved the study.

I would be most grateful if he is given Ethical Clearance to facilitate his data collection.

Thank you.

Yours faithfully,

Dr. Aaron A. Abuosi
Principal Supervisor

COLLEGE OF HUMANITIES

P. O. Box LG 78, Legon, Accra, Ghana.
• Telephone: +233 (0) 303 963 735 • Email: pahsm@ug.edu.gh • Website: ugbs.ug.edu.gh

5

APPENDIX E: APPROVAL LETTER (GHANA HEALTH SERVICE)

GHANA HEALTH SERVICE ETHICS REVIEW COMMITTEE

In case of reply the number and date of this Letter should be quoted.

Research & Development Division
Ghana Health Service
P. O. Box MB 190
Accra
GPS Address: GA-050-3303
Tel: +233-302-681109
Fax + 233-302-685424
Email: ethics.research@ghsmail.org

MyRef. GHS/RDD/ERC/Admin/App/20/214
Your Ref. No.

23rd June, 2020

Jima Bawa Kassim
University of Ghana
Department of Public Administration and Health Services Management
P. O. Box LG78
Legon, Accra

The Ghana Health Service Ethics Review Committee has reviewed and given approval for the implementation of your Study Protocol.

GHS-ERC Number	**GHS-ERC 065/05/20**
Project Title	Doctor-Patient Communication in Ghana: A Comparative Study between Public and Private Hospitals
Approval Date	23rd June, 2020
Expiry Date	22nd June, 2021
GHS-ERC Decision	**Approved**

This approval requires the following from the Principal Investigator

- Submission of yearly progress report of the study to the Ethics Review Committee (ERC)
- Renewal of ethical approval if the study lasts for more than 12 months,
- Reporting of all serious adverse events related to this study to the ERC within three days verbally and seven days in writing.
- Submission of a final report after completion of the study
- Informing ERC if study cannot be implemented or is discontinued and reasons why
- Informing the ERC and your sponsor (where applicable) before any publication of the research findings.

You are kindly advised to adhere to the national guidelines or protocols on the prevention of COVID -19

Please note that any modification of the study without ERC approval of the amendment is invalid.

The ERC may observe or cause to be observed procedures and records of the study during and after implementation.

Kindly quote the protocol identification number in all future correspondence in relation to this approved protocol

SIGNED.....
Dr. James Akazili
(Head, Ethics & Research Management Department)

Cc: The Director, Research & Development Division, Ghana Health Service, Accra

APPENDIX F: APPROVAL LETTER (ACHIMOTA HOSPITAL)

In case of reply the number and the date of this letter should be quoted.

My Ref. NO. GHS/AH/RRI/G-58

Your Ref. No.

GHANA HEALTH SERVICE

Your Health-Our Concern

ACHIMOTA HOSPITAL

GHANA HEALTH SERVICE
P. O. BOX AH 15
ACHIMOTA, ACCRA
TEL: 0302400212 / 0302400553
Email: achimotahosp.bmc@gmail.com

MEMORANDUM

TO • UNITS CONCERNED

FROM • HEALTH SERVICE ADMINISTRATOR

DATE • 26TH FEBRUARY, 2020

SUBJECT: APPROVAL TO UNDERTAKE A RESEARCH

The bearer of this memo, **Mr. Jima Kassim**, is a final Year (MPhil) student of the University of Ghana, Legon undertaking a study on the topic: "**Doctor-Patient communication in Ghana: A comparative study between Public and Private Hospitals**".

He has been given approval to undertake the study and so your assistance is being sought to enable him to glean the relevant data for the study.

Thank you.

PHILIP AFETI KORTO
PRIN. HEALTH SERVICE ADMINISTRATOR
(FOR: MEDICAL SUPERINTENDENT)

Philip Afeti Korto
Head of Administration
Achimota Hospital
Accra

Core Values: People-Centered, Professionalism, Teamwork, Innovation, Discipline, Integrity

APPENDIX G: APPROVAL LETTER (NYAHO MEDICAL CENTRE)

NYAHO
HEALTHCARE LIMITED

June 20, 2020

To whom it may concern

SUBJECT: APPROVAL TO UNDERTAKE A RESEARCH

The bearer of this memo, Mr. Jima Kassim, is a final year (MPhil) student of the University of Ghana, Legon undertaking a study on the topic"Doctor-Patient communication in Ghana: A comparative study between Public and Private Hospitals."

He has therefore been given approval to undertake the study at Nyaho Medical Centre and so your assistance is being sought to enable him to glean the relevant data for the study.

Thank you.

Yours faithfully,

Amanda Slagle
Quality Director