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AN ANALYSIS OF DOCTOR-PATIENT COMMUNICATION AND PATIENT SSATISFACTION IN THE UNIVERSITY OF MAIDUGURI TEACHING HOSPITAL,MAIDUGURI, BORNO STATE, NIGERIA

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ABSTRACT

Doctors frequently over estimate the amount of information they have provided to patients, and also believe that patients are satisfied with the communication they received during consultation, as it is difficult for patients to convey dissatisfaction in the consultation. Communication and understanding between doctors and patients is an important element in consultation and healing process. Do patients leave the consultation without asking questions about things that are troubling them or do they receive what they regard as a satisfactory response? The study analysed doctor-patient communication and patient satisfaction in the Obstetrics and Gynaecology Department of the University of Maiduguri Teaching Hospital. The main aim of this study is to analyse how patient satisfaction can be achieved through effective doctor-patient communication in the Outpatient Section of the Department. The Blumer's idea of Symbolic Interactions Model of Health and Illness which says that "we act toward things according to the meaning we give them and the meaning we give to things is the result of social interaction" was adopted. The population comprised of out-patients seeking care and treatment of conditions related to obstetrics and gynaecology issues such as ante-natal, post-natal, delivery, gynaecological problems, and family planning in the out-patient section of the Obstetrics and Gynaecology department. The doctors who rendered the services were also interviewed as well as mothers. A total of 164 out-patients were randomly drawn from the population using stratified random sampling. Survey method was used as a primary data employing questionnaires and in-depth interview as the instruments for data collection, using the simple random technique method of selection. The descriptive statistics of frequency distribution and percentage were used for the analysis and results were presented in

tables. Chi Square statistics were used to show whether there was any relationship between doctor-patient communication and patients' satisfaction. The findings indicated that there was no communication problem, there was high level of satisfaction as 75 percent of the patient were satisfied with their doctors' communication; however, patients did not understand their doctors because of lack of adequate explanation' due to visitors' interruptions in the consultation room; Shyness was found to be the major barriers or hindrances of communication between doctors and their patients. Both the doctors and the patient's 100 percent advocated for interpreters when language is impaired. It was recommended that medical interpreters should be trained to make communication easier for both the doctors and the patients to enhance patients' satisfaction.

INTRODUCTION

Communication constitutes an important part of the quality of doctor care and predominantly influences patient satisfaction. Patient's satisfaction is an important dimension of quality of health care and the extent of utilization of health services (Street, 1991). This can only be achieved through effective communication. The exchange of information with the aim of understanding is a central characteristic in communication. Communication is therefore, a process of transferring information from one party to another; it is a dialogue and involves the participation of both parties involved (Street, 1991).Communication is often divided into verbal and nonverbal communication. Nonverbal communication involves all communicative behaviour except the spoken words. This broad definition is also applicable to the transfer of information between the doctor and the patient, that is, the process of reciprocal interaction between doctor and patient during their face-to-face verbal and sometimes non-verbal interaction, aimed at the assessment of the patient's health status. It is a continuous, two-directional and dynamic information exchange. Communication is strongly dependent on the culture, the social status, and reciprocal relationships of the participants (Mathews, 1983).

According to Freidson,(1989), health care delivery from its inception to modern times involves interaction between two kinds of people: one who seeks health care, and a consultant who is believed to be capable of helping. A patient's expression of satisfaction or dissatisfaction is a judgment on the quality of health care in all of its ramifications. It often

involves interaction between individuals in non-equal positions, is often involuntary, concerns issues of vital importance, is therefore emotionally laden with delicate personal issues, and requires close interpersonal cooperation and mutual trust. Street, (1991) believed that, while sophisticated technologies may be used for medical diagnosis and treatment, inter-personal communication is the primary tool by which the doctor and the patient exchange information. This means that, the purpose of medical communication is to enable doctors and patients make decisions about treatment options through communication which eventually leads to satisfaction of either party; on the part of the patient, satisfied about being cured and on the part of the doctor, satisfied for imparting cure to the satisfaction of the patient. Therefore, to understand the patient, the doctor should appreciate the patient as a person; a fellow human being. If satisfaction through communication process and outcome of health care are critical elements of quality care, then the manner in which care is delivered should be evaluated through the eyes of the patients.

The purpose of this study is to identify and analyse how patient satisfaction could be achieved through effective doctor-patient communication in the outpatient section of the Obstetrics and Gynaecology Department of the University of Maiduguri Teaching Hospital (UMTH). This therefore, leads to the statement of problem.

STATEMENT OF THE PROBLEM

There have been various articles on doctor-patient communication; and patient satisfaction. Good doctor-patient communication has been shown to have a positive impact on a number of health outcomes in previous studies. Research has shown that doctors' effective communication is the key determinant of patient satisfaction in health care, (DiMatteo, 1994, Safran and Taira, 1998). Reports in Eastern Ethiopia, Trinidad and Tobago found that satisfaction could be attributed to communication, (Abdosh, 2006 and Singh, *et al.,* 1991).

In Nigeria, studies have been carried out on patients' satisfaction in teaching hospitals in Kano by Iliyasu, *et al.,* (2010); in Enugu by Eze, (2006); in Benin City by Ofili and Ofovwe (2005); and in Ibadan by Olusina, *et, al.,* (2004). Their studies were on satisfaction with patient

waiting time, hospital facilities and environment, services in outpatient clinics respectively. These studies did not look at communication as a factor to patients' satisfaction.

In the University of Maiduguri Teaching Hospital, studies have been carried out on maternal and child mortality and little or nothing has been done on doctor-patient communication and patient satisfaction in Obstetrics Gynaecology Department of the Hospital. Have patients been experiencing the dual directional flow of communication they require from the doctors during consultation? How does communication affect patient's satisfaction? The extent of these experiences remains largely unknown and filling this gap is the concern of this research. Therefore, this research is interested in finding out whether patients are actually satisfied with the level of communication they needed from their doctors. In view of this, the study examined doctor-patient communication in typical Obstetrics and Gynaecology consultations, and how it relates to patient satisfaction.

OBJECTIVES OF THE STUDY

The broad objective of the study is to Analyse Doctor-Patient Communication and Patient Satisfaction in the Outpatients Section in the Obstetrics and Gynaecology Department of the University of Maiduguri Teaching Hospital (UMTH), while the specific objectives are to:

i. examine doctor-patients communication;
ii. assess the level of patients satisfaction with their doctors;

Research Questions

In order to achieve the objectives of this study, the following questions are considered:

i. Is communication a challenge between doctors and patients?
ii. How satisfied are patients with their doctors' effective communication?

SIGNIFICANCE OF THE STUDY

The information gained from this study will be of use to detect deficiencies in lines of communication between doctor and patient, and make necessary adjustments to maximize patients' satisfaction. Conducting research in this area may help clinicians, educators, and

health service administrators to better understand doctor-patient communication and patient satisfaction.

The study will provide clues on how patient's satisfaction is met through effective communication between the doctor and the patient. Health policy administrators can use this study to formulate suitable strategies for doctors concerned in improving health care service delivery despite the constraints of limited available resources that are being competed for by other sectors, as they are ethically under professional obligation to care for the sick. It is also hoped that the study will add to existing literature on doctor-patient communication, and also serve as a base line reference for future studies concerning the Outpatients Section of the Obstetrics and Gynaecology Department of the University of Maiduguri Teaching Hospital.

Scope and Limitation of the Study

The study was carried out in the University of Maiduguri Teaching Hospital (UMTH) in the outpatient section of the Obstetrics and Gynaecology Department of the hospital. It assessed doctor-patient communication and how it brings about satisfaction to the patients. The UMTH was selected because it is located within the metropolis where all patients of different illnesses, ethnic, educational, socio-economic and religious backgrounds seek medical care. The outpatient of Obstetrics and Gynaecology Section was chosen because they are among the most likely complainants in the event of an adverse medical outcome.

The study only focused on the patients who visited the hospital on out-patient basis, that is, patients who came for Obstetrics and Gynaecology consultation and the doctors who rendered these services. The Nurses and other workers were excluded from this study because they were not relevant in this study due to the fact that this study was based on doctor-patient communication during consultation.

In the course of this research, some problems were encountered before and during data collecting. Some of these included difficulties in obtaining permission from the Research and Ethical Committee of the University of Maiduguri Teaching Hospital to allow the researcher conduct the research in the Obstetrics and Gynaecology Department of the hospital and as such, several visits were made before the permission was granted.

There was problem in getting some of the respondents to fill the questionnaires because some of the pregnant women were not willing to cooperate. It was not easy to get the doctors attention either for this research because they were very busy and so, it required a lot of waiting and patience before getting their attention for the interview.

Although majority of the respondents filled the questionnaires, there were some who could not read or write, therefore, there was difficulty in communicating in their local language (Kanuri) and so, a female research assistant who understood Kanuri was trained to assist.

LITERATURE REVIEW

Doctor-Patients Communication

Doctor's communication is an important contributor to patient satisfaction in the outpatient setting, but doctors frequently overestimate the amount of information they have provided to patients, and also believe that patients are satisfied with the communication they receive during the consultation. Communication is becoming increasingly relevant in the health care service.

Because research has shown that patient satisfaction through communication with doctors is an important component of health care delivery for patients. It is important because it captures the patients' experience of health care outside of direct effects on health and acknowledges the role of the patients as partners in health care, and as such reflects the patient-centeredness of care.

In a review of 21 randomized controlled trials and analytic studies on the effects of doctor-patient communication on patient health outcomes in USA by Flocke *et al.*(2002), the quality of communication in both history taking and discussion of the management plan was found to be associated with better health outcomes(Stewart *et al.,* 1995). Better doctor-patient communication was shown to be associated with better emotional and physical health, higher symptom resolution, and better control of chronic diseases. Martin and Nakayama, (2005) noted that good communication is crucial to quality health care. Health care providers ask questions to diagnose problems, to help patients understand the treatment, and so on. Patients on the other hand, come to health professionals to ask questions and seek treatment. They assert that common complaint by patients had

to do with doctors' use of complex terminology or medical language or what Nelson, (2008) called medical "jargon", while Martin and Nakayama, (2005) refer to medical jargon as language which lack simple words that patient easily comprehend. They further argued that even native English speakers complain about the use of medical jargon, and that some patients are confused or find it difficult-to understand medical terminology used by doctors. In trying to understand more about a patient's family history, for example, doctors commonly ask a number of questions about the health of family members. The use of medical jargon results in miscommunication. English, by nature, is a complex language with set of rules and exceptions to rules. Even the native speakers of the English language have difficulty trying to make sense out of medical "jargon." If English speakers have trouble with common medical terms, doctors need to be especially careful using these terms. These authors used their society as a yard stick in their argument and ignore other countries which are indigenous societies. In Nigerian society and other African counties where indigenous languages are used more, doctors may not use medical terminology but rather would want to use local terms to explain in a way the patient will understand. The absence of this could be particularly confusing and this could lead to dissatisfaction. Doctors are supposed to be bilingual, who speak their native everyday languages (EL), and also fluent in medical language (ML), because some patients are typically unfamiliar with medical language and are only conversant in their everyday language. However, Bourhis *et al.* (1989) believe communicative norms should favour strategies that maximize communicative effectiveness between health professionals and their patients, Thus it can be expected that when doctors communicating with their patients, they switch from medical language to everyday languages. On the other hand, patients may have some basic understanding of medical language, and might attempt to use it for the sake of communicative effectiveness. Although, Martin and Nakayama, (2005)believed that doctors resorted switching to everyday languages when communicating with their patients, they argued that the use of medical language by doctors was regarded as a source of problems for patients, while everyday languages were seen to promote better understanding. They however added that when doctors are discussing medical issues with their patients, it may be difficult for them to clearly differentiate between the two vocabularies. Hadlow and Pitts, (1991) examined the understanding of common health terms by doctors, and patients. The results of the survey showed that clear

differences of understanding of common medical and psychological terms exist between doctors, and patients. The level of correct understanding was higher for doctors (70%) and lower for patients (36%). This survey has shown that medical language used by doctors can be of a problem to the patient who does not understand medical language and which leads to patient's dissatisfaction. Practitioners should always double-check if patients understand the language and medical terms that are used and always try to explain information to patients in simple and straight forward terms

Doctor's Communication Skill

Training doctors to improve their communication skills could potentially be cost-effective as it increases compliance, which in turn improves the overall health of patients. Studies on doctor-patient communication have demonstrated patient discontent even when many doctors considered the communication adequate or even excellent (Stewart *et al.,* 1995).

Having good communication skills is essential for doctors to establish good doctor-patient rapport. The content, structure, and function of the communication between doctors and patients have received little attention and has been excluded from the realm of scientific inquiry. As a result, most doctors have had little formal training in communication skills. Good doctor-patient communication has been shown to have a positive impact on a number of health outcomes in previous studies. In a study that explored the effects of communication skills training on the process and outcome of care associated with patient's emotional distress, improvement in doctors' communication skills was shown to be associated with a reduction in emotional distress in patients (Roter*et al.,* 1998).

A study in the United Kingdom between 2010 and 2013 has shown that special communication skills can improve health-care outcomes in people with intellectual disability, (Wullink*et al.,* 2009). Different aspects of the doctor-patient communication like patient's perceptions, communication skills of the treating doctor, and doctor empathy according to Kim,*et al.,* (2004) are also getting more importance both from doctors as well as research scholars. Good doctor-patient communication is important and has multiple impacts on various aspects of health outcomes. The impacts included better health outcomes, higher compliance to therapeutic regimens in patients, higher patient and doctor satisfaction, and a

decrease in malpractice risk. Although medical education has only recently started to emphasize the importance of communication between doctor and patient, and started to include the teaching of communication skills in many undergraduate and postgraduate learning programmers, it is still in its infancy in India (Kim,*et al.,* 2004). With the increase in malpractice claims for doctors, together with the increase in the volume of complaints and enquiries received by the regulatory bodies, and a rise in consumerism in medicine, good doctor-patient communication is becoming even more important. Conducting research in this area may help doctors, educators, and health service administrators to better understand the doctor-patient communication that is unique in social settings.

Doctors are trained to deal with various clinical situations but receive little or no training in communication skills and therefore their communication skills are predominantly instinctive. Patients and their relatives are understandably anxious and vulnerable and it is not surprising that things can go wrong if effective communication is not practiced. Although most doctors communicate effectively, there is increasing evidence that a large number of patients remain unsatisfied with the amount of information given and the manner of its delivery, (Audit Commission 1993). With regards to this, Dranove *et al.*(1999) believed that patient satisfaction offers insight into patients' perceptions of interpersonal relations. In addition, Stewart, (1984) and Kurtz *et al.*, (2002) also noted that good doctor-patient communication is essential for positive health care outcomes. These studies have shown that when doctors optimize their communication skills, it is beneficial for both the patient and doctor alike. For instance; improved patient health outcomes, improved patient satisfaction and increased patient compliance with recommended medical treatment are just some of the advantages documented when doctors optimize their communication skills. Several studies have indicated that patients who felt they had adequate communication with their doctor about their illness and also felt that their doctor listened intently with genuine interest were more satisfied and had higher rates of compliance, (Renchko 2005). The goals of communication are therefore, to: exchange information; reach mutually satisfying decisions; develop a common understanding; and build trust. Above all, education and training will therefore be the tool to improve both the doctor and patient communication skills. There is the need for practicing doctors to be

effectively trained to utilize a more patient-cantered approach and once trained; these skills become integrated into their routine practice.

Importance of Communication in Health Care Service

Communication constitutes an important part of the quality of doctor care and predominantly influences patient satisfaction; it is a core element of doctor care, a fundamentally required doctor skill. Patient-doctor communication is the building block upon which the doctor's relationship with the patient is made (Nelson, 2008; Mauksch, 2008; Haftel, 2007; Barret, and 2006). The medical interview, during which doctor-patient communication occurs, is a tool by which the doctor gets to know the patient so that he/she feels like a person, not just a medical problem. In other words, communication should be seen as a dynamic, complex, and context-related ongoing multivariate process in which the experiences of the participants are shared (Sheldon *et al.*, 2006). Shattel, (2004) found that mutuality and simultaneity are central aspects in communication. O'Brien *et al.,* (2008) believed that the process of reciprocal contact between doctor and patient during their face-to-face assessment interview is aimed at (verbal and non-verbal) continuous, dynamic, two-directional information exchange. Information exchange is used here as a broad term to describe exchange and transmission of facts, opinions, feelings, etc. (conscious as well as subconscious), including the development of mutual trust within the communication process. Therefore, the exchange of information with the aim of understanding is the central characteristic of communication.

The above review is relevant to this study because doctors' communication has a direct effect on patient satisfaction because their association may be confounded in several ways and good communication leads to satisfaction hence, patients who are more satisfied with their care are likely to be satisfied with their doctors' communication. In addition, patients who have heard good news, or who have had a good health outcome, may give high ratings for the doctor's good communication and would report greater satisfaction. However, the most common complaints about doctors by patients is that doctors do not listen enough, will not give information, and show a lack of concern or lack of respect for the patient. As a result, large number of patients leave the consultation without asking questions about things that are troubling them or do not receive what they regard as a satisfactory response. A qualitative study based on 35 patients aged 18 years and above, found that only four of the

35 patients voiced all their concerns during the consultation (Barry, 2000). He went on to say that most common voiced concerns related to symptoms, requests for diagnoses and prescriptions. The most common unvoiced concerns were worries about possible diagnosis and what the future holds.
In a related study by Smith and Hoppe, (1991) in their study, also found that higher levels of information-giving by the doctor, time spent in discussion of preventive care by the doctor, and greater interview length were positively associated with patient satisfaction and increased time spent in patient chart review led to decrease in satisfaction.

From the review above, it can be seen that some significant progress has been made on the importance of communication, how it can result to patient's satisfaction if properly managed and how it can also cause dissatisfaction if patients are shown lack of respect and attention. When there is a kind of communication gap between the doctors and the patients, it can lead to patients' dissatisfaction.

The Study Area

The city of Maiduguri, capital of Borno State is an ancient city located in North-Eastern Nigeria and inhabited mainly by Kanuri, Shuwa and Hausa. Present day Maiduguri is a cosmopolitan city which is inhabited by various ethnic groups from the entire country and from neighbouring countries of Cameroon, Chad and Niger. It is endowed with agricultural resources with supply of professionally skilled, semi-skilled and unskilled manpower from other states in Nigeria and from neighbouring countries of Chad, Cameroon and Niger. Relative to other industrialized cities such as Kano and Kaduna in the north, Lagos and Port Harcourt in the south, Maiduguri is of lower economic and social activities, but still has its own share of both. The city is known for its fish trade (*Banda* trade) with fish being brought from Baga on the shores of Lake Chad. It also has a Federal University, the University of Maiduguri, and a Federal Secretariat both of which attract personnel from other parts of the country and from outside of the country. There has been increasing number of banks, hotels, schools and Federal Government Ministries, departments and agencies within the metropolis, (Koroma, 2004).

The University of Maiduguri Teaching Hospital, (UMTH) is located in Jere Local Government in the metropolitan city of Maiduguri. It is a

tertiary hospital established to render services such as service delivery, training, and research and as a referral center for primary and secondary public health institutions as well as for neighbouring states (Koroma, 2004).

It is a third generation Teaching Hospital established by the Federal Government, and was commissioned by former President Shehu Shagari on July 23, 1983, (UMTH Annual Report, 1997). Since then UMTH has been offering a combined service of teaching, research and provision of medical care to the North-Eastern states and beyond. The UMTH was designated as "Centre of Excellence in immunology and infectious diseases" and as a National Referral centre for HIV/AIDS research, diagnosis and management by the Federal Government in 1986. It has a World Health Organization (WHO) Polio laboratory for diagnosis and management of polio with the ultimate goal of polio eradication. The hospital presently has over thirty departments and many bed facilities, and several wards. The Department of Obstetrics and Gynaecology under study was established to provide obstetrics and gynaecology services, conduct relevant research and train undergraduate and post-graduate students. It has 25 staff capacity that made up of 5 professors, 10 consultants, and 10 resident doctors. Obstetrics and gynaecological services are provided at the Antenatal Clinic (ANC), Post-Natal Clinic (PNC), Gynaecological Clinic (GNC), Family planning Clinic (FPC) and Labour Ward (LW). The department was classified as `Centre of Excellent' in reproductive health (UMTH Annual Report, 1997).

Sources of Data

Primary and secondary data were used for this study. The primary source of data was generated through the use of questionnaires and in-depth interview. The questionnaires were in six (6) sections which comprised of twenty one (21) questions. The questionnaires were designed in structured and open-ended format, so as to identify how satisfaction could be achieved through effective communication, to understand patients' point of view and identify the challenges faced by them. The questionnaires were carefully guided by the research objectives. The first section was made up of the demographic data of the Respondents (patients), who came to the clinic for Obstetrics and Gynaecology purposes while the second section was on the condition prompting the visit of the respondents to the Obstetrics and Gynaecology department.

The remaining four sections were questions constructed to answer the four research questions of this study.

The secondary data were from textbooks, journals, patients' records from the Obstetrics and Gynaecology department and other relevant materials on the subject matter were used in this study.

Population of the Study

According to the Record in the Department of Obstetrics and Gynaecology, there were 850 outpatients seeking care and treatment of conditions related to Obstetrics and Gynaecology such as, Ante-natal, Post-natal, Gynaecological, Family planning and Delivery at the time of this research. There were also 25 doctors who render these services in the Department of Obstetrics and Gynaecology, University of Maiduguri Teaching Hospital. The Nurses were excluded in this study because they were not relevant in this study due to the fact that this study was based on doctor-patient communication during consultation.

Sampling and Sampling Technique

The sample was made of (20%) of the population of this study which consisted of 170 outpatients of the Obstetrics and Gynaecology Department. The 20% of any population is large enough to generalise in a given research. Stratified random sampling technique was used to draw the sample from the population which consisted of patients who came to the clinic for medical attention. Out of which, there were 106 pregnant women, 23 nursing mothers, 16 gynaecological problems, 10 family planning and 15 deliveries. Questionnaires were administered to 170 respondents but only 164 were returned. Only patients who came as outpatient bases to the clinic were sampled. In-depth interview was conducted with five (5) consultants and five (5) mothers using the simple random sampling.

Method of Data Collection

Questionnaires and in-depth interview method were used as a primary source of data in this study. The questionnaires were designed to provide quantitative data, while the in-depth interview provided qualitative data. They were also designed to identify outpatients' who came for ante-natal, post-natal, delivery, gynaecological or family planning in the out-patient section of the Obstetrics and Gynaecology department. Questionnaires were administered to one hundred and seventy (170) respondents.

This study utilized both qualitative and quantitative methods. According to Gazali (2004), qualitative study seeks to minimize mistaken conclusions and therefore increase the level of validity ad reliability of the survey.
The qualitative data is used to triangulate with quantitative data so as to get a clear picture of issues at hand. The findings of the qualitative data are discussed along with the findings.
Data were collected by selecting every third patient that was waiting to consult the doctor. There were twenty one (21) questions formulated to answer the research questions, and open-ended questions formed the bulk of the questions.

The in-depth interview method was used to elicit the patients' experiences regarding the situation under study. There were five doctors and five mothers selected for the in-depth interview respectively, using the simple random technique method of selection.

The questionnaire has six (6) sections that is, section A-F. Section A is the demographic data of the respondents such as age, marital status, and educational background. Section B was on the conditions that prompt the visit to the clinic. Sections C-F were constructed to answer the four research objectives of the study. The samples were collected for four (4) clinic days from the respondents (patients) on the average of four (40) questionnaires per clinic day. Only outpatients who came for Obstetrics and Gynaecology clinic were sampled. Patients who could read and write filled the questionnaires themselves, while those who could not read or write were assisted by the researcher and a research assistant who had been trained in the administration of the questionnaires for this study. The right of each patient to participate or opt out of the study was respected. The in-patients were excluded in this study because they might be too ill or weak to give valuable data for this study. Two (2) clinic days were used for the in-depth interview with the doctors in the Obstetrics and Gynaecology department to share their views regarding the research objectives of this study, and one (1) day was used to interview the mothers who had many years of experience in attending the clinic under study.

Method of Data Analysis

The data generated from the questionnaires, interview and records (from the Obstetrics and Gynaecology department) were analysed using descriptive (frequency distribution, percentages) and inferential statistics (Chi square -X^2).Chi square statistics at the 0.05 level of significance was

used to show whether there was any relationship between communication and patients' satisfaction. The computation was performed using the methods described by Ott,*et al.*, (1983); and Ifah, (1996). This method of analysis was selected because it is used for both descriptive and inferential statistics especially in the social sciences.
The Chi Square formula is giving as follow:

RESULTS

Demographic Characteristics of Respondents

This section presents data on demographic characteristics of the patients. The variables considered in the discussion are age, marital status and educational qualification of the respondents.

Table 1: Distribution of Demographic Data of Respondents (n=164)

	Responses	
Options	**Frequencies**	**Percentage (%)**
Age of the Respondent		
18-22yrs	14	8.54
23-27yrs	64	39.02
28-32yrs	24	14.63
33-37yrs	52	31.71
38yrs and above	10	6.10
	164	**100**
Marital status of the Respondents		
Married	144	87.80
Single	14	18.5
Widowed	6	3.66
	164	**100**
Educational of the Qualification		
Islamic Education	28	17.07
Secondary	24	14.63
Tertiary	112	68.30
Total	**164**	**100**

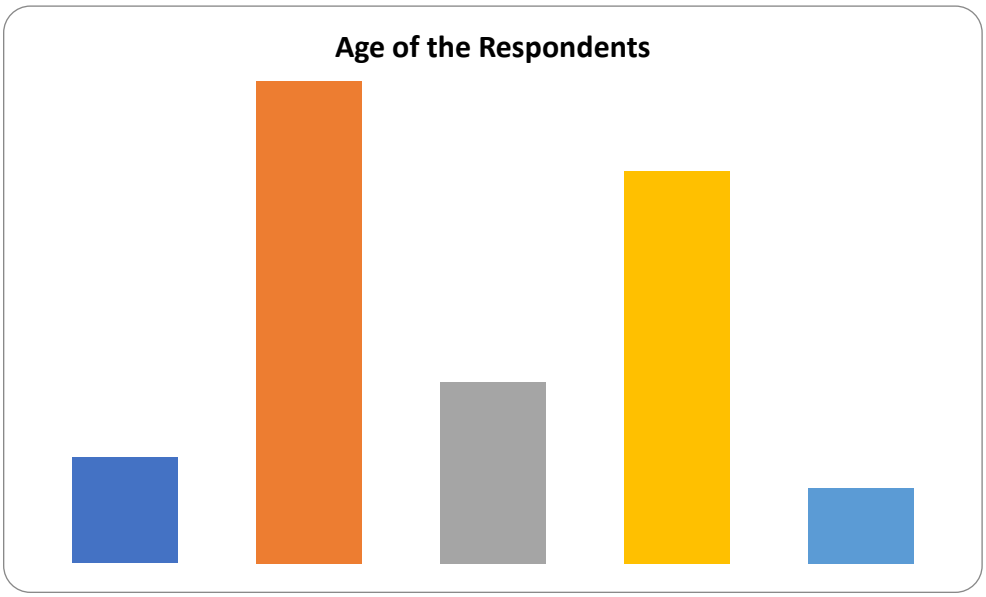

Figure 1: Age of the Respondents

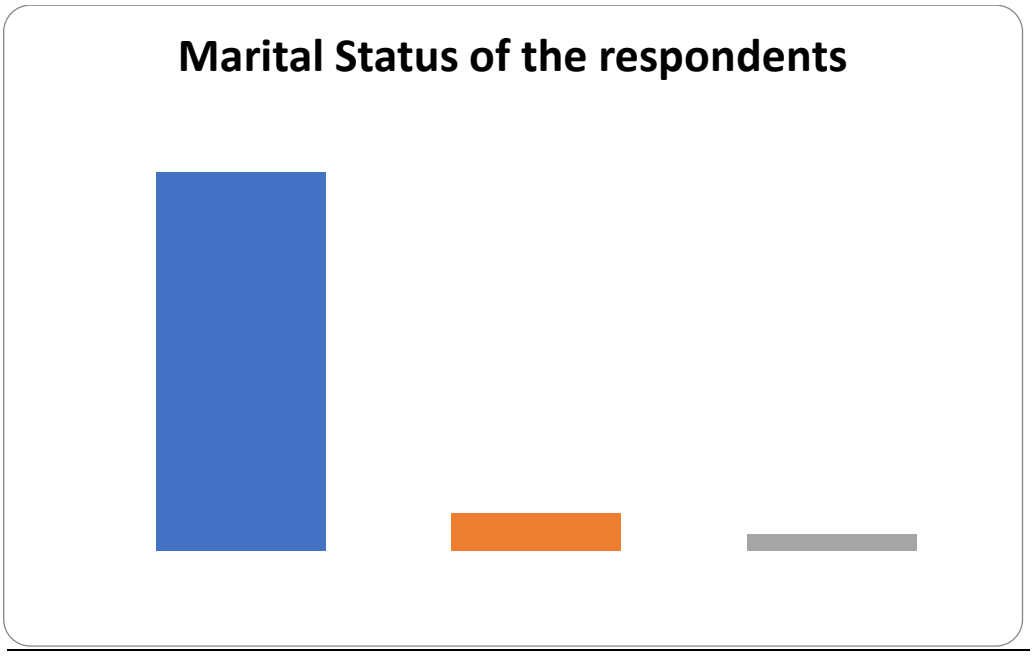

Figure 2: Marital status of the Respondents

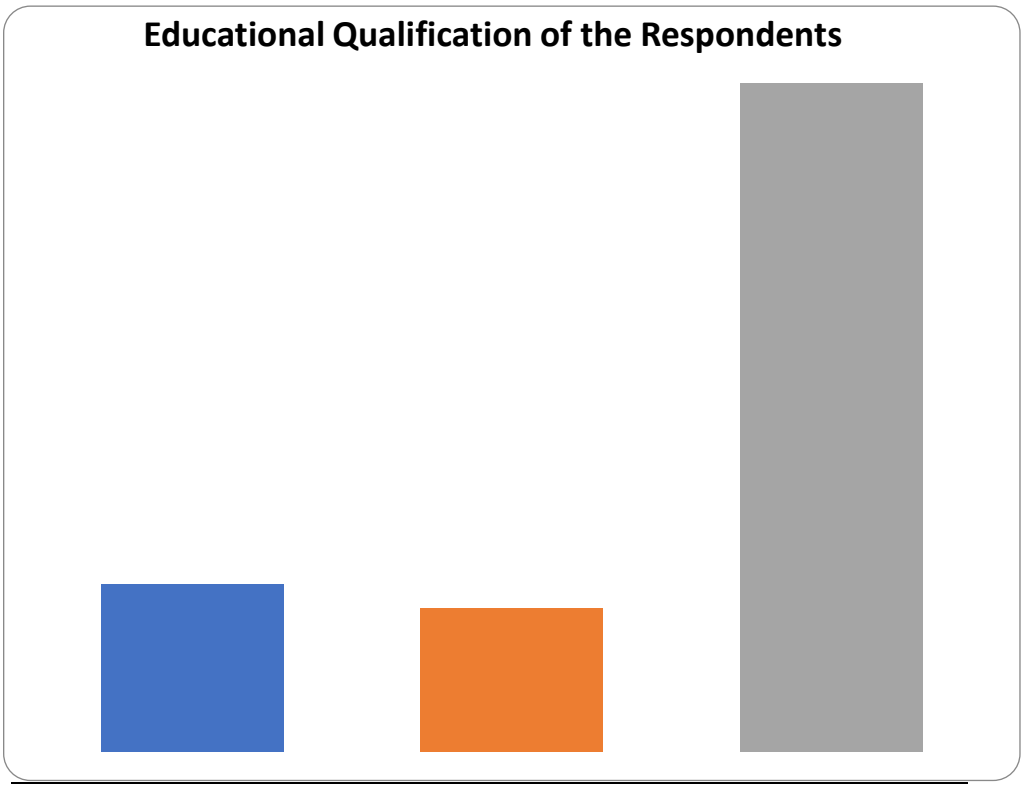

Figure 3: Educational Qualification of the Respondents.

Table 1 shows that respondents (85.36%) patronizing the Obstetrics and Gynaecology section in UMTH are in their reproductive age bracket of 23-37 years and so tend to visit the facility most. The two extremes of reproductive age (18-22) and (≥38) years were the least in patronizing the facility with 9.10 percent and 6.49 percent respectively. In this part of the country, Borno state, girls are married out early but from the response, it was observed that many of the girls may be schooling or due to socio-economic constrains they may be patronising other facilities they can afford. The least on the table may be due to the fact that many women at that age may be approaching menopause or have decided to stop having children. Most of the respondents 87.80 percent patronizing the facility were married women. This may be so because it is generally believed that married women are responsible and respected in Africa societies. Few, 18.5percent were unmarried, while 3.66percent were widows. Most of the respondents 68.30percent had tertiary education. This high numbers of literates may be due to the fact that not everybody can afford the hospital bills in the UMTH and so the low income earners who are likely to be

illiterates do not patronise the facility much. About 14.63percent and 11.07percent had secondary and Islamic education respectively. It could be seen that majority patronizing the facility were in their reproductive age of bracket of 23-37 years, married, and had tertiary education.

Condition Prompting the Visit to the Clinic

This section discusses the condition prompting the visit to the clinic for the determination of their ailments. Variables considered include: Ante-natal, Post-natal, Gynaecological, Family planning and Delivery.

Table 2: Distribution of Responses on Condition Prompting the Visit (n=164)

Nature of visit to the Obstetrics and Gynecology section		
Options	**Frequency**	**Percentage (%)**
Ante-Natal	104	63.41
Post-Natal	22	13.41
Gynecological	15	9.15
Family Planning	9	5.49
Delivery	14	8.54
Total	**164**	**100**

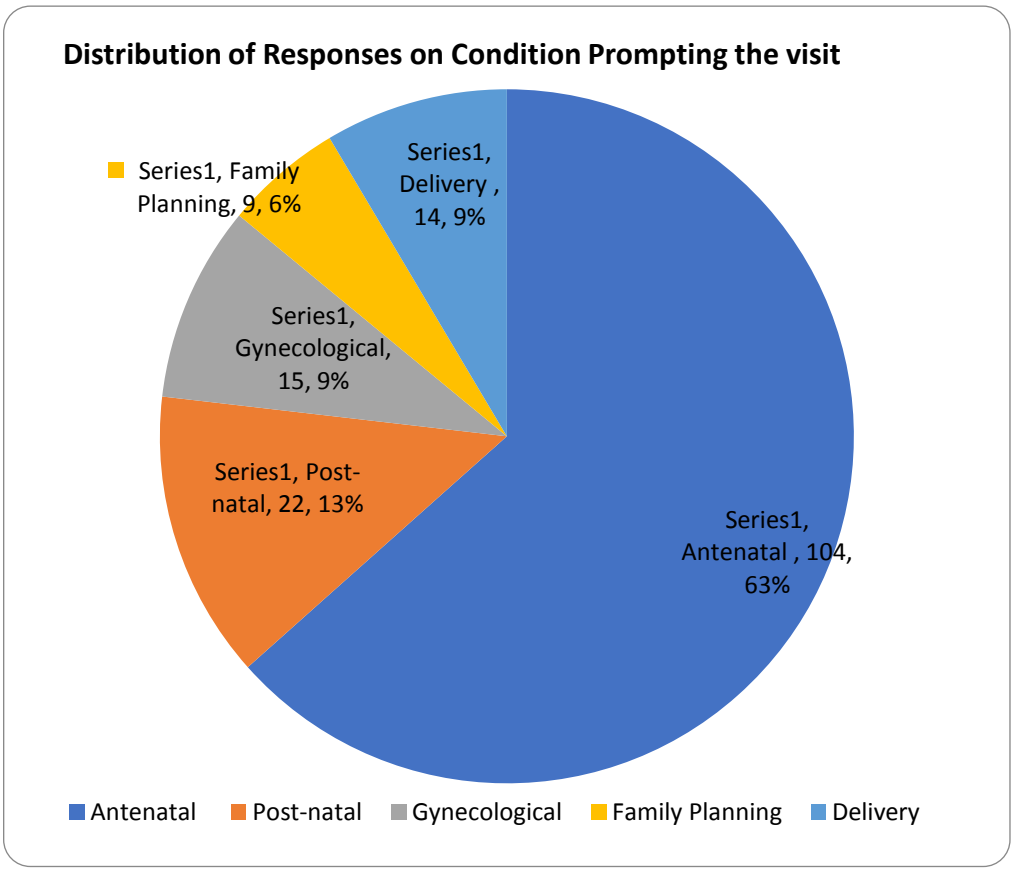

Figure 4. 4: Responses on Condition Prompting the Visit

As contained in Table 4.2, it is shown that Ante-natal care formed the bulk 63.41%percent of the reason for attending the Obstetrics and Gynaecology clinic. This may be due to the awareness on the importance responding of safe delivery. The data also indicated that only 13.41percent were observed to be patronizing the clinic for post-natal consultation probably it is because they feel their babies did not have problems after delivery hence there is no reason to visit the facility. Only 9.15percent attended the clinic for gynaecological, while only 8.54percent attended the clinic for delivery purposes. This indicated that the patients go to other delivery centers or deliver their babies at home. It was observed that family planning is not seriously preferred as only 5.49percent attended the clinic for family planning. This attitude may not be unconnected with the religious and traditional mindset of the indigenous ethnic groups – Kanuri, Shuwa and Hausa – who believe that family planning is more of less not acceptable.

Assessment of Doctor-Patient Communication

This section discusses the Doctor – Patient Communication. Variables considered during communication with the Doctors include: communication as a challenge, doctors' communication skill, effective communication with doctors, doctors use of medical language and way to improve communication to enhance patients' satisfaction.

Table 4. 3: Distribution of Responses on Doctor-Patients Communication

n-164			
Variables	**Options**	**Frequency**	**Percentage (%)**
Communication as a challenge to patients' satisfaction	Yes No Don't know	15 138 11	9.15 84.15 6.70
Doctors' communication skills determine patients' satisfaction	Agree Disagree	120 44	73.17 26.83
Effective communication with doctors determine patients' satisfaction	Agree Disagree	102 62	62.20 37.80
Doctors use of medical language to describe medical conditions affect patients satisfaction	Agree Disagree	71 93	43.29 56.71
Ways to improve communication to enhance patients satisfaction	Improve on communication skill Doctors should make sure their patients understand them. Doctors should show more concern to patients.	103 14 48	62.80 8.54 28. 66
Total		**164**	**100**

Table 4. 3 show that majority 84.15percent of the respondents believe that communication was not a problem between them and their doctors. This means that doctors communicated well with them. A small 6.70percent proportion does not have any opinion in regard to this. Majority 73.17percent of the respondents agreed that their doctors' had communication skills. Most of the doctors and patients were indigenous people who speak same language. This could be the reason why majority of the patients believed that doctors communicate well with them, while 26.83percentdisagreed. This also may be as a result of the few non-indigenes attending the facility who felt that their doctors do not give

enough attention to them due to indigenous affiliation. Majority of the respondent's 62.20percent agreed that good communication with their doctors lead to their satisfaction and also improve their health outcome. This may be so because large numbers of the respondents were literates and so can interact very well with their doctors. Only 37.80percent of the respondents did not consider communication as a factor that determines their satisfaction. On the issue on medical language (ML), (56.71%) of them, were of the view that doctors did not use medical language (ML) during medical consultation as also pointed out by the doctors and mothers. This may be due to the fact that majority of the respondents were educated and may not even notice if doctors occasionally use (ML), while 43.29percent of the respondents believed that doctors use medical language during consultation. This means that some of the respondents leave the clinic dissatisfied. On measures needed to improve communication between doctors and patients, more than two thirds 62.80percent of respondents are of the opinion that there is no problem between doctors and patients communication. A small 8.54percent proportion recommended that doctors should make conscious efforts to improve their communication skills in order for patients to understand them. A few 28.66percent of respondents advocated more show of concern by doctors towards them.

Data Analysis

To determine doctor-patient communication and its effect on patients' satisfaction, the data were analyzed using the Chi-square (X^2) statistic. Chi-square,

Table 4. 7: Analysis of Doctor-Patient Communication

Variables	Agreed		Disagreed		Total	
	O	E	O	E		
Doctors' Communication Skill	120*A	5.09	44	*D	7.50	164
Effective communication	102*B	18.49	62	*E	0.28	164
Use of medical language in communication	71*C	7.30	93	*F	10.75	164
Total	293		199		492	

*Indicates the different cells in the table.

Calculation of the X^2 statistics on "Doctor-Patient Communication and patient satisfaction", yielded a X^2 value of 31.11 which is higher than the

critical value of 13.82, at the 0.001 level of significance. At the level of significance (α) of 0.001, the calculated value of X^2,31.11, is higher than the critical value of 13.82. Thus, there is a highly significant difference between patient satisfaction and the independent variables: doctor's communication skill, effectiveness of communication, and use of medical language in communication. If the Null Hypothesis, H_o,of no difference were true, then the probability, *P*, of obtaining these differences, would be less than 0.001 (one in one thousand). Stated mathematically, (X^2 =31.11; $P < 0.001 = \alpha$). Thus the Null Hypothesis, H_o, is rejected in favour of the alternate hypothesis, H_A. This indicates that communication skill displayed by the doctors; effective doctor-patient communication style, and use of medical language to explain health issues are determinants of patients' satisfaction.

Table 4. 8: Analysis of Patients' Level of Satisfaction with their Doctors.

Variables	Satisfied		Dissatisfied		Don't know		Total
	O	E	O	E	O	E	164
Satisfaction on Doctors' Communication Style	123 A	126	18 C	21.5	23 E	16.5	
Satisfaction on medical information	129 B	126	25 D	21.5	10 F	16.5	164
Total	252		43		33		328

Analysis of responses to research question 2which is on "Patients' Level of Satisfaction with Doctors", indicated that there is a significant difference between doctor's communication style with patients' satisfaction and satisfaction with medical information provided by doctors. The calculated X^2 value of 6.4 is higher than the critical value of 5.99 at the 0.05 level of significance. Thus the Null Hypothesis (H_o) of no difference is rejected because if the Null Hypothesis were true, then the probability, *P*, of observing such differences is less than 0.05. (X^2= 6.4; $P < .05 = \alpha$). This indicates that there is significant level of patient satisfaction in relation to the way doctors listen to patients' complaints and also with how they provide medical information to the patients. This means that patients' satisfaction depends on doctors' communication style during consultation and therefore, provision of medical information to patients cannot be over emphasized.

Table 4.9: Analysis of Communicative Behaviour and Patients' Satisfaction

Variables	Yes	No	Total		
	O	E	O	E	
Counselling and reassuring during consultation	102*A	12.84	62 D	2.47	164
Affective behaviours as important factors to patients' satisfaction	64 *B	0.82	100 E	7.82	164
Understanding of doctors' diagnosis of ailment	49*C	7.17	115 F	5.57	164
Total	**215**	**277**	**492**		

Responses to research question 3 indicated that there is a significant (X^2 = 36.69) difference in doctors' communicative behaviour, counselling and reassuring patients during consultation and doctors' affective behaviours on patients' satisfaction. The calculated X^2 value of 36.69 is seen to be higher than the critical value of 13.82 at the 0.001 level of significance. Thus the probability *P* of obtaining such differences in the responses if the Null Hypothesis of no difference, H_o, were true is 0.001 (α) (i.e. 1 in 1000). This means that patients derive satisfaction from counselling and reassurance by their doctors during consultation; affective behaviour of doctors is very important to patients' satisfaction, as well as getting patients to understand doctors' explanations of the diagnosis of their ailments.

DISCUSSION OF FINDINGS

To achieve the objectives, questions were framed and asked to seek patients' opinions on Doctor-Patient Communication and Patients' Satisfaction.

The first research question sought to find out "if communication with doctors was a challenge?" The results indicated that majority of the respondents believed that communication was not a challenge between them and their doctors. This is also confirmed by the doctors and the mothers in the clinic because majority of the doctors and the patients were indigenous people who speak same languages that is, (Hausa and Kanuri). It indicates that communication is an important tool that drives patients' satisfaction. This finding is in line with that of Judith and Thomas (2005), who reported that communication is relevant in the health care services and it is crucial to quality health care and as a result, brings about patients' satisfaction. The use of everyday language (EL) or indigenous language instead of medical language is a better way to convey

the message without provoking stress in a patient. If doctors use medical language (ML) to describe scientific medical conditions in a clinic where the majority of patients speak indigenous language even though majority of the respondents were educated, it could be particularly confusing and could lead to inadequate treatment and dissatisfaction. The result indicates that communication skill displayed by the doctors; effective doctor-patient communication, and use of medical language to explain health issues are determinants of patients' satisfaction even though doctors did not use medical language in explaining patients' conditions as indicated in Chi-square calculation. In other words, good communication between doctors and patients make important contributions to recovery and satisfaction. Although, the Symbolic Interactionist theory has not moved far beyond the original concepts of Mead and Blumer, it persists as an important theoretical approach to the study and explanation of social interaction among small groups of people interacting in ways that are relevant to health. The theory suggests that "Humans act toward people, things, and events on the basis of the meaning they assign to them. Once people define a situation as real, it has very real consequences. Without language there would be no thought, no sense of self, and no socializing presence of society within the individual.

In research question two, with regards to "how satisfied are patients with their doctors", there is indication that there is a high level of satisfaction because majority of the respondents were satisfied with their doctors. The high level that is, 75.00 percent of satisfaction was influenced probably by high percentage 68.30 percent of literate respondents who patronised the clinic. The findings in this study are similar to the findings by Eze*et al.*(2006), but are lower than the findings of Iliyasu *et al.*(2010), although, Olusina *et. al.* (2004) recorded lower patients' satisfaction. The relatively high level of literacy in the population of this study could be the reason for the high level of satisfaction. The Chi-square calculation indicates that there is significant level of patient satisfaction in relation to the way doctors listen to patients' complaints and also with how they provide medical information to the patients. When doctors optimise their communication skills, it is beneficial for both the patient and the doctor. For instance, improved patient health outcomes, improved patient satisfaction and increased patient compliance with recommended medical treatment are just some of the advantages that can be seen when doctors optimise their communication skills. The Symbolic Interactionist theory suggests that "Humans act toward people, things, and events on the basis

of the meaning they assign to them. This means that patients' satisfaction depends on doctors' communication style during consultation and therefore, provision of medical information to patients cannot be over emphasized.

SUMMARY

The research work is on the analysis of Doctor-Patient Communication and how it affect Patient's Satisfaction in the Obstetrics and Gynaecology Department, University of Maiduguri Teaching Hospital, (UMTH) Maiduguri, Borno State, – Nigeria. This study was carried out using four research objectives and four research questions to assess and determine Doctor-Patient Communication as it affects Patient Satisfaction in the Out-Patient Section of the Obstetrics and Gynaecology Department, (UMTH). The research problem of the study was clearly stated, and some of the key terms used were defined accordingly in line with their use in the study. The literature review was based on the following: doctor-patient communication, patient's satisfaction, communicative behavior and what hinders doctor-patient communication. The theoretical framework for this study was based on symbolic interactionism. It is a theoretical approach in sociology developed by George Herbert Mead, and Blumer's idea was adopted. This model was adopted to explain the role of symbol in the language as core elements of all human interaction and how satisfaction could be influenced by the way of communication of the provider. This study basically focused on the Outpatient Section of the Obstetrics and Gynaecology Department of the UMTH with population of one hundred and sixty four (164) respondents. The study revealed that majority 39.02 percent of the patients were within the age bracket of 23-27 years, 87.80 percent were married, 68.30 percent had tertiary education and 63.41 percent have been attending the Obstetrics and Ggnaecology Outpatient Clinic for mostly ante–natal bases. The study also revealed that 75.00 percent of the patients were satisfied with their doctors' level of communication except on the issue of drug prescription. Although, the high percentage 68.30 percent of the patients had tertiary education, the result revealed that patients did not understand doctors' explanations on diagnosis due to the fact that doctors did not explain clearly; did not ask if patients understood them and, in addition, visitors usually interrupt while consultation was in progress and this resulted to divided attention during consultation. Education itself and the role of communication is an important context for health outcome. Even

though majority of the respondents were educated, it was found that more than half 57.32 percent of the respondents believe culture creates barrier with regards to doctor-patient communication. Culture is known to be the way of life of people and as such, the culturally bound beliefs, values, and preferences a person holds dear, influence how he/she interprets healthcare messages. These cultural preferences can also influence a patient's listening and speaking practices in clinical encounters and therefore, has the potential to hinder communication.

Shyness was found to be the major barriers of communication between doctors and patients as indicated by the doctors because patients found it difficult to disclose certain information with their doctors. The shyness may be attributed to cultural and even religious backgrounds of the patients. Even though the patients did not regard religion as a barrier, being shy during consultation is an indication that religion also plays a role in this regard because the patients thought some medical examinations were considered contrary to their religion. This can affect the patients' health outcome.

All the respondents 100 percent advocated for the use of interpreters. Interpreters as intermediaries are crucial when communication is impaired between the doctors and the patients.

CONCLUSION

Based on the findings from the study, the following conclusions were drawn:

Effective communication between doctor and patient is an important clinical function and is the first step in establishing good doctor-patient rapport. A large 75.00 percent of patients were satisfied with their doctors' level of communication displayed in the consultation room except on the issue of drug prescription. Though, this study found that most 68.30percent of the patients were literates, but they seemed not to have understood what the doctors told them about diagnosis of their ailments as indicated by 70.12percentof the patients. Communication between doctors and patients is the most important component of good medical practice, not just because it identifies problem, but it also defines expectation and help to establish trust between the two parties. Interruption by visitors who came in to either greet or discuss issues with their doctors distracts both the doctor and the patient during consultation. In other words, allowing visitors or any other person to

interrupt during consultation sometimes affect patients' health outcome.

The major barrier that was found to impede communication between doctors and the patients was shyness. Communication between the patients and the doctors had strong influence on the patient. Patients' shyness to explain some health issues with their doctors can result to complications. Patient-satisfaction in health service delivery is inherently tied to effective doctor-patient communication during clinical consultation therefore, when patients are shy about their illnesses the patients will not achieve their health desire. Although, there was no language barrier, the need for interpreters as intermediary to augment effective communication between doctors and patients was supported by both the doctors and the patients.

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