Physician-Patient Communication in Ghana: Multilingualism, Interpreters, and Self-Disclosure

A dissertation presented to

the faculty of

the Scripps College of Communication of Ohio University

In partial fulfillment

of the requirements for the degree

Doctor of Philosophy

Shirley A. Acquah
June 2011

© 2011 Shirley A. Acquah. All Rights Reserved.
This dissertation titled
Physician-Patient Communication in Ghana: Multilingualism, Interpreters, and Self-Disclosure

by

SHIRLEY A. ACQUAH

has been approved for
the School of Communication Studies
and the Scripps College of Communication by

________________________________________

Christina S. Beck
Professor of Communication Studies

________________________________________

Gregory J. Shepherd
Dean, Scripps College of Communication
Abstract

ACQUAH, SHIRLEY A., Ph.D., June 2011, Communication Studies

Physician-Patient Communication in Ghana: Multilingualism, Interpreters, and Self-Disclosure

Director of Dissertation: Christina S. Beck

In this dissertation, I explored the communicative relationship between illiterate patients and physicians at a health care facility in Ghana. Drawing on constructivist grounded theory methods, I provide a substantive explanation of issues pertaining to multilingualism, use of interpreters, and patient self-disclosure. A total of 11 patients and 25 physicians participated in this study. I gathered data through observations, in-depth interviews, and focus group discussions.

Four major findings emerged from this study. First, results revealed that, although English is the lingua franca in Ghana, interactions in health care settings, especially with illiterate patients occur in indigenous dialects. Unfortunately, not all medical terminologies have indigenous dialect equivalents, and if they existed, participants did not know them, thus, creating comprehension difficulties during clinical interactions. Second, due to a huge linguistic diversity, language barriers are a common occurrence. Consequently, interpreters frequently help with clinical interactions. However, the non-existence of professional medical interpreting services, demand that patients and their physicians have to depend on relatives, friends, health workers, or ad hoc individuals whose inadequate translation skills are likely to compromise health outcomes. Third, patients are less likely to disclose pertinent health information due to the fear of reprimand from their physician, or lack of privacy in the consulting room.
Fourth, the needs of patients, such as relational aspect of care, were unmet because physicians experienced frustrations with heavy patient case loads, time constraints, and patients’ disengagement behaviors.

Implications from this study include the need to (1) review indigenous dialects, work to provide terminologies for health related topics, and make those available to patients and physicians, (2) identify indigenous dialects for which interpreters will be required, and establish a policy framework for the provision of professional medical interpreting services at health care facilities, (3) educate physicians on how to better dialogue and relate with their patients to ensure that patients feel comfortable disclosing various health information, (4) incorporate communication skills courses in medical school curricula, (5) encourage patients to ask questions or seek clarification during medical interactions, and (6) incorporate scheduled clinical appointments to ease physician work-load and enhance patient care.

Approved: _____________________________________________________________

Christina S. Beck

Professor of Communication Studies
My decision to focus on physician-patient interactions in Ghana for my dissertation research was partly influenced by some personal experiences. It all began on December 4, 2006 in Accra, Ghana. In the early hours of dawn, around 4:00 a.m., I realized that I was sitting on a wooden bench, which was a little confusing for me because not too long ago, I was sitting in the front passenger seat of my car. As I tried to determine how I had arrived at my present location, I began to adjust my eyes to the dimly lit surroundings. Meanwhile, I was experiencing excruciating pain all over my body. My neck and upper back hurt badly; I felt a cut on my upper lip, a chipped tooth, and multiple bruises on parts on my right knee.

I saw two ladies in white dresses. "Where am I"? I asked in a weak voice. “This is a hospital,” one of the ladies responded. “You and a gentleman were brought here by a Good Samaritan; you have been involved in a car accident,” she added. “I was brought with a gentleman?” I queried, “That’s my husband; where is he?” “Over here,” the lady replied. I managed to glance at the direction and saw my husband on a hospital stretcher. I asked the lady when we'd be receiving medical treatment, and she said it wouldn't be until 8:00 a.m. That's about four hours, I made a mental calculation. I asked if I could use a phone to make a call; the lady offered her cell phone. Slowly, I dialed the number of my uncle, a medical doctor, and informed him of our predicament. He quickly came over and arranged to have us transferred to another hospital where he worked.

This second hospital would be our new home for eight weeks. During my stay, I made friends with medical students, nurses, ward attendants, cleaners, and fully-fledge medical doctors. I observed various doctors who accomplished their responsibilities with
a sense of pride, while patients seem to be in awe of the healing miracles of scientific technology and medical expertise. Since I was a patient myself, I interacted with patients for the most part. These socializations gave me deeper insight to some patients’ background, their illnesses, their financial situations, and the uncertainties with which they struggled. Most of these patients had little or no formal education. Stated differently, they lacked functional literacy skills, not that it directly affected their health, but for me it generated many questions.

At the time of being a patient at this hospital, I was also in the first year of my doctoral program at a university in the United States of America, with a major in health communication. I had started to read about patient-provider communication, and I developed an interest in the topic. Consequently, my time at the hospital and interactions with various individuals ignited my desire to undertake an exploratory study about the concept of physician-patient interactions in Ghana. The results from my exploratory studies convinced me that the topic was worth investigating for a dissertation project.
Acknowledgments

I would like to express my thanks to the almighty Lord who has brought me this far. In those moments, when I felt overwhelmed balancing a full-time job and graduate studies, the good Lord gave me strength to move on. I extend my deepest love and gratitude to my advisor Dr. Christina Beck, for her immense love, support, and constructive feedback. “Dr. Beck, what could I have done without you? Although, I was your advisee, you embraced me as family, you listened while I shared my personal stories, and you showed so much concern.” Dr. Beck’s encouragement, understanding, and insightful feedback were valuable in helping me complete this dissertation. I am also grateful to my committee members Dr. Benjamin Bates, Dr. Devika Chawla, and Dr. Marina Peterson, who voluntarily offered to work with me and guide this dissertation with their constructive feedback.

On a more personal note, I thank my lovely husband, Gamel Acquah, for taking such good care of me and offering love, understanding, and support while I pursued my doctoral program. “Gamel, I know our long distance relationship hasn’t been easy, and I love you for being so thoughtful.” I extend my gratitude to my dear mother, Claribelle Quist, for the confidence she had in me, the encouragement she offered, and her constant prayers on my behalf. “Mom, when we talked on the phone and I always complained about graduate school workload, you would say, ‘the height by great men, reached and kept, were not attained by their sudden flight’ thanks Mom, for all the success and birthday cards that you always sent to me, God bless you.”

To my late father Emmanuel Osew, and my late uncle Peregrine Quist, I say “thanks to both of you for supporting my education and advising me to reach greater
heights.” Although you both did not live long enough to witness my Ph.D. milestone, I know you’d be proud of me.

I am deeply grateful to the Department of Residential Housing for the support that they offered throughout my graduate program. I thank my colleague Herbert Blankson for his academic advice at the onset and duration of my doctoral program. Finally, I am grateful to the patients and physicians whose participation and voices brought this project to fruition.
Table of Contents

Abstract .............................................................................................................................. iii
Preface ................................................................................................................................. v
Acknowledgments ............................................................................................................. vii
Chapter One: Multilingualism, Interpreters, and Disclosure .............................................. 1
  Socio-Cultural Context of Health Care ........................................................................... 4
  Health Care Systems in Ghana ................................................................................... 5
  The Role of Language ..................................................................................................... 7
  Multilingualism in Ghana ........................................................................................... 9
  Problem Statement ........................................................................................................ 11
  Rationale for Research .............................................................................................. 12
Chapter Summary ............................................................................................................. 13
  Overview of Dissertation Outline ................................................................................. 14
Chapter Two: Review of Literature .................................................................................. 15
  Language, Communication, and Reality ....................................................................... 16
  Language and Health Care ........................................................................................ 17
  Dialogic and Relational Aspects of Care ..................................................................... 18
  Language Barriers ...................................................................................................... 20
  Use of Interpreters ..................................................................................................... 25
  Role Expectations ..................................................................................................... 25
  Interpreter Assessment and Performance .................................................................. 27
  Information Disclosure ................................................................................................. 31
Research Questions ........................................................................................................... 35
Chapter Summary ............................................................................................................. 36
Chapter Three: Method ..................................................................................................... 38
  Overview ....................................................................................................................... 38
  Setting ........................................................................................................................... 43
  Research Participants ................................................................................................. 44
  Data Collection Approach .......................................................................................... 47
  Observation .................................................................................................................. 47
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interviews</td>
<td>48</td>
</tr>
<tr>
<td>Focus Groups</td>
<td>51</td>
</tr>
<tr>
<td>Data Analysis</td>
<td>52</td>
</tr>
<tr>
<td>Evaluating Grounded Theory Research</td>
<td>56</td>
</tr>
<tr>
<td>Reflections on the Process</td>
<td>56</td>
</tr>
<tr>
<td>Chapter Summary</td>
<td>60</td>
</tr>
<tr>
<td>Chapter Four: Results</td>
<td>61</td>
</tr>
<tr>
<td>Category System</td>
<td>61</td>
</tr>
<tr>
<td>Limited Vocabulary</td>
<td>65</td>
</tr>
<tr>
<td>Assumed Meaning</td>
<td>71</td>
</tr>
<tr>
<td>Interpreters</td>
<td>75</td>
</tr>
<tr>
<td>Physicians’ Perception of Interpreters</td>
<td>79</td>
</tr>
<tr>
<td>Type of Interpreters</td>
<td>83</td>
</tr>
<tr>
<td>Disclosure Patterns</td>
<td>86</td>
</tr>
<tr>
<td>Presence of Interpreter</td>
<td>87</td>
</tr>
<tr>
<td>Set-up of Consulting Room</td>
<td>90</td>
</tr>
<tr>
<td>Sensitive Topics</td>
<td>93</td>
</tr>
<tr>
<td>Fear of Reprimand</td>
<td>96</td>
</tr>
<tr>
<td>Relinquishing Agency</td>
<td>100</td>
</tr>
<tr>
<td>Disengagement</td>
<td>101</td>
</tr>
<tr>
<td>Disavowal</td>
<td>107</td>
</tr>
<tr>
<td>Patients’ Involvement Level</td>
<td>110</td>
</tr>
<tr>
<td>Controlling Agency</td>
<td>112</td>
</tr>
<tr>
<td>Hope versus Breaking Bad News</td>
<td>115</td>
</tr>
<tr>
<td>Hope</td>
<td>115</td>
</tr>
<tr>
<td>Breaking Bad News</td>
<td>117</td>
</tr>
<tr>
<td>Physician Frustrations</td>
<td>119</td>
</tr>
<tr>
<td>Patient Load and Time Constraints</td>
<td>119</td>
</tr>
<tr>
<td>Patient Behavior</td>
<td>123</td>
</tr>
<tr>
<td>Physicians’ Self-Assessment</td>
<td>126</td>
</tr>
<tr>
<td>Patient Education</td>
<td>128</td>
</tr>
<tr>
<td>Conclusion</td>
<td>130</td>
</tr>
</tbody>
</table>
Chapter One: Multilingualism, Interpreters, and Disclosure

Doctors and patients even if they come from the same social and cultural background view ill health in very different ways. Their perspectives are based on very different premises, employ a different system of proof, and assess the efficacy of treatment in a different way. Each has its strengths, as well as its weakness. The problem is how to ensure some communication between them in the clinical encounter, between doctor and patient. (Helman, 2007, p. 121)

The relational aspect of physician-patient communication has long been recognized as an important aspect within health care, and studies continue to emphasize how a medical experience might be compromise due to miscommunication (e.g., Beck, 2001; Ellis, 2004; Kreps & O’Hair, 1995; Mishler, 1984; Ray, 2005; Roter & Hall, 1992; Stewart & Roter, 1989; Thompson, Dorsey, Miller, & Parrot, 2003). Although good communication skills might be necessary for a good clinical experience, language proficiency is equally important.

Foucault (1973) argued that language plays a crucial role in all stages of the medical process (e.g., taking the patient’s history, finding out the symptoms, writing a prescription, etc). Even so, language barriers constitute one of the most common impediments to efficient communication. In health care settings, language barriers have been recognized to have adverse effects on patient-provider satisfaction and quality of care (e.g., Abbe, Simon, Angiolillo, Ruccione, & Kodish, 2006; Betancourt, Carrillo, & Green, 1999; Garrett, Dickson, & Whelan, 2008; Goldsmith, Slack-Smith, & Davies, 2005; Jacobs, Chen, Karliner, Agger-Gupta, & Mutha, 2006; Mutchler, Bacigalupi, Coppin, & Gottlieb, 2007). Even in situations where interpreters have been used, triad
(physician, interpreter, patient) communication is still fraught with problems, such as omission of phrases and words, false fluency, editorialization of information (Flores et al., 2003; Laws, Heckerscher, Mayo, & Wilson, 2004; Valero Garcés, 2005), co-diagnosing (Hsieh, 2006a, 2007), and compromising informed consent (Goldsmith et al., 2005).

Compelling literature exists regarding the outcome of language barriers within health care settings, but this assumption cannot be generalized to every geographical location. Apart from the cultural and linguistic diversity of each country, various studies suggest that, even in situations where the physician and patient speak the same language, the meaning of a message can still be compromised (Brown, Stewart, & Ryan, 2003; Cegala & Broz, 2003; Cegala, McNeilis, & McGee, 1995; Geist-Martin, Ray, & Sharf, 2003). Although research on communication within the clinical encounter gained momentum in the 1990’s, (e.g., Ballard-Reisch, 1990; Beck, Ragan, & du Pré, 1997; Cecil, 1998; Cegala, 1997; Clark & Mishler, 1992; Sharf, 1990; Thompson & Pledger, 1993; Waitzkin, 1991; Wyatt, 1991), issues regarding language barriers, interpreter use, and patient self-disclosure deserves further empirical research (Hsieh, 2009; Jacobs et al., 2006; Petronio, 2007; Waters, Sullivan, & Finney Rutten, 2009).

In terms of research on language barriers and interpreter services, scholars have focused on Western countries such as the United States, Canada, Australia, United Kingdom, and certain parts of Europe (e.g., Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003; Bischoff, 2006; Bowen, 2001; Flores, 2005, 2006; Hsieh, 2006a, 2006b, 2007; Jacobs, Agger-Gupta, Chen, Piotrowski, & Hardt, 2003; Karliner, Jacobs,
Chen, & Mutha, 2007; Pöchhacker & Shlesinger, 2007). However, a couple of studies have been undertaken in South Africa (e.g. Crawford, 1999; Herselman, 1996; Levin, 2006a, 2006b; Saohatse, 1998), but these studies do not necessarily capture experiences in other geographical areas.

To my knowledge, health communication is yet to evolve as an academic field in Ghanaian higher education (De Beer, 2009). Thus, minimal empirical research literature exists on specific aspects of physician-patient communication in Ghana. Related studies have narrowly focused on patient compliance with regard to malaria and HIV/AIDS (e.g., Adjei et al., 2008; Agyepong et al., 2002; Buabeng, Duwiejua, Dodoo, Matowe, & Enlund, 2007; Owusu-Daaku & Buanya-Mensah, 2010; Yeboah-Antwi et al., 2001). Hitherto, the link between language barriers, use of interpreters, and patient self-disclosure is under studied. Moreover, Ghana, similar to many Sub-Saharan African countries, is a multilingual culture with a huge disease burden. As a communication scholar, I believe the need to study issues related to multilingualism in clinical encounters not only fulfills an ethical obligation but it is also a step toward bridging the research gap as studies have focused on Western nations to the neglect of less advantaged countries such as Ghana. Moreover, the case of Ghana can provide an insight or exemplar to other developing health care systems in Africa.

As a result of the issues detailed above, my dissertation highlighted (a) which Ghanaian languages patients and physicians use during clinical interactions, and how these languages shape the communication process (b) how (if at all) interpreters are utilized if a language barrier exists, (c) how a triad (patient, interpreter, and physician)
interaction process influences patient self-disclosure, and (d) how patients and physicians interpret the dialogic and relational aspect of care. In order to understand how these elements shape the clinical experience, I adopted a grounded theory approach (Charmaz, 2006, 2008; Glaser & Strauss, 1967; Strauss & Corbin, 1990) which not only served as suitable method of inquiry for a topic which is under researched in Ghana but allowed for “emergent multiple realities” (Chamaz, 2006, p. 126) of participants’ experiences.

**Socio-Cultural Context of Health Care**

In many countries, the challenges which health care facilities face in relation to patients who lack proficiency in an official language might appear the same. However, significant variability in health care systems exists across various countries. While research and assessment in other countries might have implications for Ghanaians, we should note that every health care system reflects its country’s socio-cultural norms. Helman (2007) contended:

> Both the presentation of illness and others’ response to it are largely determined by socio-cultural factors. Each culture (and to some extent each gender, social class, region and even family) has its own *language of distress*, which bridges the gap between subjective experiences of impaired wellbeing and social acknowledgement of them. (p.128)

Helman further argued that, even in what may seem like homogenous cultures, preferred styles of communication may vary across different ethnic groups, and these determine how the clinical experience is constructed. In order to frame this study, I provide an overview of the health care system in Ghana.
Health Care Systems in Ghana

Formerly known as the Gold Coast, Ghana emerged as the first country south of the Sahara to secure its independence on March 6, 1957 from British colonial rule (Gocking, 2005). Ghana is located in West Africa along the Gulf of Guinea, and it shares borders with Burkina Faso on the North, Togo on the East, and Cote d’Ivoire on the West. The country naturally divides into southern coastal plains and northern savannah grasslands (Buah, 1998). Ghana’s population is estimated at 24 million, and the official language is English (Ghana Demographic and Health Survey, 2008). Administratively, the country is divided into 10 regions, each with a regional hospital (funded by the government).

Access to health care is a huge challenge, partly due to fewer health facilities and lack of human resource (Ghana Health Service, 2007). The Ghana Health Service indicates that the health care system is an integration of traditional and biomedicine. Traditional medicine, as described by the World Health Organization (WHO, 2009a), consists of health practices, knowledge and beliefs which incorporates animal or mineral-based medicines, and spiritual therapies, either used singularly or in combination to maintain well-being, treat, diagnose, or prevent illness.

Traditional medicine has been part of the Ghanaian culture for a long time, and approximately 70% of Ghanaians depend on traditional medicine for primary health care needs (Able & Busia, 2005; Oppong-Boachie, 2005; WHO, 2009a). Health care may typically be obtained from practitioners, including spiritual healers who use divination, rituals, prayers, fasting, incantations, occultism, etc. for the healing process (Tabi,
Another group of traditional health care providers are herbalists (Ariës, Joosten, Wegdam, & van der Geest, 2007). Herbalists use various parts and species of plants to prepare medicine (Tabi et al., 2006). In Ghana, herbal medicine is considered to be an over-the-counter medication, and it can be purchased from the pharmacy, chemical store, bus stops, vehicles, and the open market (Ghana Food & Drugs Board, 2009; Tabi et al., 2006).

In terms of biomedicine, health care facilities in Ghana are officially supervised by the Ministry of Health and the Ghana Health Service. Institutions which provide medical care include government operated hospitals, quasi-government institutions such as the military and police hospitals, and private hospitals owned by corporate organizations, religious missions, and individuals.

Some of the imminent challenges facing the health care system include shortage of medical staff. The Ghana Health Service (2007) reported the physician to population ratio as one caregiver for every 13,683 patients, and nurse to population as one nurse for every 1,415 patients. According to the Ghana Health Service, the total number of physicians as of 2004 was 3,240, and pharmaceutical personnel were 1,388 for the same year. A more recent report revealed the physician to population ratio as one caregiver for every 17,700 patients, and estimated that 60% of trained health providers practice outside Ghana (Dogbevi & Uddenfe 2009).

A further concern with the health care system is an absence of modern equipment and infrastructure. A study by Adjei and Ayernor (2005) revealed many challenges within government hospitals including the absence of automated medical record tracking
systems and unregulated policies to manage patient record movements. Adjei and Ayernor further noted that care facilities do not have any mechanism to monitor which patient folders are in transit. Only when an attempt to retrieve a folder fails do staff members consult the folder movement book for information about the location of the folder. Thus, a patient’s folder can be missing without health personnel’s knowledge.

Apart from the above issues, care facilities struggle with the huge disease burden (Ghana Demographic and Health Survey, 2008). Some of the most common illnesses include malaria, tuberculosis, cholera, meningitis, trachoma, vaccine preventable diseases, and HIV/AIDS. For example, statistics from the World Health Organization (2009b) reveal that, for every 100,000 people, mortality rate for non-communicable diseases is 786; incidence of tuberculosis is 206; mortality rate for cardiovascular diseases is 404; mortality rate for cancer is 138; HIV/AIDS is 131, and life expectancy is 50 years. These statistics not only illustrate the dire nature of health care delivery, but they also quest for a research agenda that will help understand the core relational and linguistic components which engulfs the clinical interaction. Knowing that language plays a vital role in health care, this research agenda is long overdue in a multilingual culture such as Ghana.

The Role of Language

According to the Swiss linguist, Ferdinand de Saussure (1959) language constitutes a system of signs for encoding meaning and the realities of the world. Importantly, language is culture-specific. In other words, each language systematically differs from others in the sense that it has a particular way of arranging the signs that
encode meaning, and of communicating the world to its speaker. In essence, every language serves as an efficient tool for comprehending the idiosyncrasies of the particular environment in which a people live. A particularly strong view of this aspect of language has also been articulated by Sapir (1949) who indicated that:

Human beings do not live in the objective world alone, nor alone in the world of social activity as ordinarily understood, but are very much at the mercy of the particular language which has become the medium of expression for their society. It is quite an illusion to imagine that one adjusts to reality essentially without the use of language and that language is merely an incidental means of solving specific problems of communication or reflection. The fact of the matter is that the 'real world' is to a large extent built up on the language habits of the group.

No two languages are ever sufficiently similar to be considered as representing the same social reality. The worlds in which different societies live are distinct worlds, not merely the same world with different labels attached... We see and experience very largely as we do because the language habits of our community predispose certain choices of interpretation. (p. 69)

From the above statement, we can say that language represents culture, meaning, and identity. Further, language has a symbolic function which includes religious and socio-cultural beliefs of a society (Giles & Johnson, 1981; Sapir, 1949). Giles and Soliz (2010) also maintained that, although language is reflected in personal interactions, much of the research assumes monolingualism although multilingualism is prevalent in many countries. Earlier studies by Giles and Coupland (1991) noted that:
Issues regarding language choice exist in many multilingual communities where a large number of ethnic groups coexist in the same social space, having their own (often mutually intelligible) language codes but with one or more languages in common. A prime concern with such situations has been which languages each group chooses, and whether speakers maintain or switch during social interactions. (pp. 101-102)

The issue of different language choices becomes more compelling within the context of health care delivery, and in situations where patients and providers do not share a common language. To further understand why multilingualism in health care settings should be examined, I will review the language culture in Ghana.

**Multilingualism in Ghana**

Ghana has a diverse language environment with over 44 indigenous languages as well as cross border languages with Togo, Benin and Nigeria (Opoku-Amankwa, 2009). Nine (Akan, Dagaare-Wali, Dagbani, Dangme, Ewe, Ga, Gonja, Kasem and Nzema) of the 44 languages have been officially approved for use in education and the media (Bodomo, 1996; Kropp, 1988; LaVerle, 1995; Opoku-Amankwa, 2009). Aside from the many language groups, controversy persists among policy makers and the citizenry concerning which of the above language(s) should double as a national language and be used as a medium of instruction in primary schools (Owu-Ewie, 2006). While some argue for an English only language policy to the exclusion of any indigenous language, others hold that students have to learn, read, and understand their indigenous languages, hence, the need for an indigenous language to be used as the medium of instruction
(Bodomo, 1996; Kropp, 1988; LaVerle, 1995; Opoku-Amankwa, 2009; Owu-Ewie, 2006). Some also contend that “there is in Ghana, an urgent need for coherent, meaningful and practical language policies” (Dei, Asgharzadeh, Bahador, and Shahjahan (2006, p. 251).

Apart from the debate about which language(s) to be used in schools, it is worth mentioning that the Ghana Institute of Linguistics, Literacy, and Bible Translation (GILLBT, 2009) estimates adult literacy rate for 2007 at 58%. According to GILLBT, even though majority of the population speak their indigenous language(s) fluently, they do not possess the formal literacy skills to enable them read information which might be written in English or the indigenous languages.

From my experience (Acquah, 2008), these language concerns affect health care delivery in multiple ways. For example, whereas the majority of health professionals in Ghana are bilingual (they speak English and an indigenous language), patients are either monolingual (speak one indigenous language), bilingual (speak English and an indigenous language or a combination of two indigenous languages), or multilingual (speak English and/or multiple indigenous languages). Although these language dynamics might pose challenges in everyday interactions, we must also understand how the indigenous languages shape communication patterns between health professionals and their patients. In this dissertation, I seek to provide insights about multilingualism and how the process of linguistic code switching influences clinical interactions.
Problem Statement

Research literature on patient-provider communication though extant is more focused on Western nations (e.g., Beck, 2001; Cole & Bird, 2000; Harter, Japp, & Beck, 2005; Ray, 2005; Sparks & Villagran, 2010; Thompson et al., 2003). As such, research and evaluations undertaken in other countries might have different implications for the Ghanaian health care system. In terms of physician-patient communication in Ghana, we lack empirical research on how socio-cultural factors shape health care delivery. Thus, we do not know whether or not medical communication in Ghanaian health care settings resemble, or differ from other parts of the world. In addition to these unanswered questions, other issues also prevail. For instance, during my search for literature and other relevant documentation to guide this study, I realized that the Ministry of Health in Ghana has no policy framework regarding language issues during a clinical interaction. In the absence of a language policy, hospitals do not have any guidelines as to who qualifies to be an interpreter if patients required one, and health providers are not necessarily responsible for providing interpreters either.

Prior to this research, I conducted an exploratory study on communication between patients and physicians at a health care facility in Ghana (Acquah, 2007). Findings suggested that the interactions which occurred in the consulting room seemed more of a “strictly business” atmosphere, than two individuals working together to find a holistic solution to a health problem. Notably, physicians focused on asking questions, and provided merger opportunities for patients to express themselves. When asked why such an imbalance, physicians contended that patients deviated from the subject matter
during the consulting process, thus, asking direct questions made the diagnosis easier and saved time. Another exploratory study at the same health facility (Acquah, 2008), revealed that patients hardly ask questions about their illness, and were often reluctant to share health information with their physicians. The findings from my exploratory studies depicted a health care process characterized by a relational imbalance. This prompted the need to further understand how patients and physicians interpret their communicative experience.

**Rationale for Research**

I have a patient who is a farmer and runs a business weaving rugs on a village farm. This patient speaks no English but is fluent in Xhoza and a few other local languages. His world has a wholeness which does not divide his mind from his body. He expresses himself in stories, metaphors and symbols which are mostly embodied and expressed in his traditional culture. I am fluent in English yet speak very little Xhosa. I ask myself: “Can I negotiate my patient from his world of meaning and natural rhythms into my world of medical technology? How do I explain immune system, hypertension, and anorexia in a language that will be meaningful to my patient?” (Ellis, 2004, pp. 2-3)

The above was a statement made by a South African physician who attended to a patient whose language and cultural expressions were unfamiliar to the physician. Challenging as certain situations might seem, one of the goals of a medical consultation is to find a common ground where a patient feels satisfied with the care they receive, and physician content with the care they have provided (Sparks & Villagran, 2010). Primarily, “such a
focus can clearly identify how physicians and patients both negotiate issues that they find problematic and may suggest alternative communication patterns that allow for health care decisions that minimize discomfort for both parties” (Verwey & Crystal, 2002, p. 99).

In Ghana, because neither ethnicity nor language proficiency is routinely added to medical history taking, we lack secondary data of records that pertain to the language differences of patients. As I have already detailed, no organized interpretation service exists, and the health care system does not take responsibility for ensuring communication between the patient and provider. Thus, the patient must find an interpreter, if necessary. Moreover, we do not know how socio-cultural factors might affect health interactions, nor how various aspects of physician-patient communication in Ghana mirror (or not) other parts of the world. Notably, our knowledge about physician-patient interaction is gleaned from studies undertaken in more advantaged Western countries. As communication scholars, we need to interrogate the potential challenges that a developing health system and multilingual country such as Ghana struggles with. Thus, this research will not only expand our understanding of medical communication in other geographical locations other than what the current literature offers, but the case of Ghana can provide insights to health care systems in other multilingual countries in Africa.

**Chapter Summary**

In this chapter, I previewed the socio-cultural context of the Ghanaian health care system in relation to multilingualism and medical communication. I noted that existing
research on physician-patient communication is prevalent in Western countries such as Europe and North America, with few studies in South Africa. I also indicated that though research in other parts of the world might have similar implications for Ghana, we still need to understand health care interactions and multilingual medical communication within the Ghanaian context.

**Overview of Dissertation Outline**

This dissertation has been structured into five chapters. In this chapter, I previewed the health care system as it pertains to physician-patient interactions and offered a rationale for this study. The second chapter is a review, evaluation, and synthesis of relevant literature as well as research questions. The review covers topics such as communication and language use in medical interactions, language barriers, use of interpreters, and patient self-disclosure. In chapter three, I detail my data collection and analysis procedures. Responses from participants and findings from this research are elaborated in chapter four. The final chapter includes a discussion and synthesis of the findings, implications generated from this research, limitations, and suggestions for future research.
Chapter Two: Review of Literature

Before I proceed with a review of the relevant literature, I must acknowledge the arguments about whether a “literature review” should be conducted when a researcher utilizes grounded theory approach. Consequently, the place of literature review in grounded theory is somewhat controversial (McGhee, Marland, & Atkinson, 2007). Some authors have asserted the importance of an initial review because it helps readers to identify the researcher’s viewpoint for the project, increase awareness of existing knowledge base, avoid methodological or conceptual pitfalls, and provides justification for a grounded theory approach (Antle May, 1986; Backman & Kyngäs, 1999; Hallberg, 2010; Hutchison, 1993; Walls, Parahoo, & Fleming, 2010). In contrast, others argued that avoiding an initial literature review prevents the researcher from being constrained, contaminated, or inhibited by previous studies, allowing theory to emerge from the data (Cutcliffe, 2000; Glaser, 1992; Hickey, 1997). In the mist of these contentions, Strauss and Corbin (1998) have provided a balanced view. They suggested both advantages and disadvantages of an initial review. From their perspective, “familiarity with the literature can enhance sensitivity to subtle nuances in data, just as it can block creativity” (p. 49).

These viewpoints notwithstanding, I decided to undertake an initial review, mainly due to the paucity of literature on physician-patient interaction in Ghana. Moreover, initial exploratory studies (Acquah, 2007, 2008) suggested that an initial review will allow for familiarity with existing literature, a better understanding of the central concepts and arguments related to my topic, and justification for engaging in the research (Hallberg, 2010; Walls et al., 2010). Additionally, results from this study
confirmed that an initial review of substantive literature at the research proposal stage did not restrict the discovery of new concepts during analysis of data.

Before I examine the literature, I must acknowledge that many of the studies discussed in this review have been conducted in countries other than Ghana. Therefore, I recommend caution in generalizing any results to the Ghanaian context.

**Language, Communication, and Reality**

In the book *language and reality*, Postman (1966) noted that “language, like other symbol systems, is often taken for granted…yet, there is no symbol system-conventional or otherwise that is more characteristic of a community or that more effectively distinguishes a community from others” (p. 40). Postman further indicated that the vocabulary of a language and its related metaphors “reflects the society’s way of reality, of representing it, of describing it, of picturing it” (p. 59). An interpretation of these statements is an illustration that not only does language categorize reality, but our social context also influences our choice of language (e.g., Fishman, 1972; Giles & Coupland, 1991; Giles & Johnson, 1981; Giles & Soliz, 2010). Related studies on language have been presented by Giles and Weimann (1987) who maintained that “the function of language in individual, relational, and multiple group identities…feature the interface between the ways language reflects, builds upon, and determines social reality as well as highlight the dynamic, skeptical, crafty communication qualities we all share” (p. 368).

Language can further be understood within the pragmatic framework which emphasizes the function of speech acts, intersubjectivity, dialogic perspectives, and coordinated negotiation of meaning during interaction (e.g., Baxter & Montgomery,
1996; Burgoon, Floyd, & Guerrero, 2010; Poter & Edwards, 2001; Rommetveit & Blakar, 1979). Broadly speaking, language is not only an attribute of group membership or ethnic identity, but is it reflected in the types of discourses we engage in, and the meanings or interpretations which develop from such discursive interactions (Giles & Soliz, 2010; Gumperz, 1982; Mass, Salvi, Arcuri, & Semin, 1989).

**Language and Health Care**

In terms of how language shapes health care interactions, concerns exist over the sociolinguistic imbalance in medical interactions (Giles & Coupland, 1991; Wiemann & Giles, 1988). Notably, health care professionals have been schooled to use medical language (ML) as opposed to everyday language (EL) which patients are familiar with. Moreover, some studies have established real differences in vocabularies used by physicians compared to that of patients (Bourhis, Roth, & MacQueen, 1989; Herget & Alegre, 2009; Samora, Saunders, & Larson, 1961; Scott & Weiner, 1984). Thus, physicians are familiar with ML as well as EL. On the contrary, a patient might possess limited knowledge of ML, and she/he might also have to translate from one language to another. Hence, the language dynamics gives more leverage to physicians during interactions with patients.

Moreover, contrasting languages during interpersonal and cross-cultural communication have been attributed to various motivational processes at work when speakers fluent in various dialects communicate with each other. These motivational processes are speech convergence, maintenance, and divergence (Giles, Mulac, Bradac, & Johnson, 1986). Convergence occurs when both speakers try to adapt the each other’s
speech pattern. Speech maintenance occurs when speakers fail or decide not to adapt to each other’s speech pattern, and speech divergence occurs when both speakers are cognizant of the differences in their speech patterns (Giles et al., 1986). In a more recent study, Dougherty, Mobley, and Smith (2010) noted that, due to the use of same language, it is usually assumed that “mutual meaning has been created. However, because of that linguistic convergence, divergent meanings may be camouflaged” (p.171).

As we review physician-patient communication in terms of language and reality, we must acknowledge the differences that exist in how physicians and patients negotiate and create meaning (e.g, Mishler, 1981, 1984; Waitzkin, 1991; Whaley, 2000).

**Dialogic and Relational Aspects of Care**

The field of health communication can be described as an interdisciplinary field. Consequently, various disciplines (e.g., interpersonal communication, medical sociology and anthropology, nursing, cross cultural studies, and applied communication) have investigated patient-provider interactions. Each of the above fields adopted different approaches to theorizing and conceptualizing patient-provider issues. In this sections that follow, I review and synthesize various literature relevant to my research topic (dialogic and relational aspect of care, language barriers, interpreters, and patient self-disclosure). Street (2003) explained the relational aspect of physician-patient interaction and indicated that:

Like other types of social interaction, the medical consultation is a dynamic, creative, and socially constructed event. Although certain technical activities may take place (e.g., a physical examination, a hypodermic injection), the primary
activity is talk as the provider and patient exchange information about health-related concerns; make decisions about medical care; and in the best of cases, establish or maintain a relationship characterized by rapport, trust, and respect. How the interaction unfolds depends on how the participants select, adapt, and coordinate their responses to accomplish their individual and mutual goals. (pp. 64-66)

Establishing good rapport between a physician and patient has been of concern for communication scholars (e.g., Beck, 2001; Ellingson, 2005; Gywn, 2002; Roter & Hall, 1993; Roter, Hall, & Katz, 1988; Sharf, 1993; Smith-Dupre & Beck, 1996; Street, 2001; Thompson, 1994; Thompson et al., 2003; Vanderford, Jenks, & Sharf, 1997). Generally, health communication scholars have paid attention to specific attributes related to the communication encounter, including patient satisfaction (Haskard, Williams, DiMatteo, Heritage, & Rosenthal, 2008; Quick, 2009; Wanzer, Booth-Butterfield, & Gruber, 2004; Wright & Frey, 2008), patient perceptions of physician communication (Cadello, Ray, & Pettey, 1995; Street, 1992), patient and physician explanatory model of illness (Helman, 1985, 2007; Kaplan, Greenfield, & Ware, 1989; Mishler, 1981, 1984; Zoller & Kline, 2008), health and culture (Dutta & Basu, 2008; Zoller & Dutta, 2008), and treatment adherence (DiMatteo, Reiter, & Gambone, 1994; Eggly et al., 2009; Mazor, Fischer, & Billings-Gagliardi, 2008).

Despite laudable achievements with physician-patient interactions, on-going research explicates the role of cultural and language barriers on physician-patient interactions (Brach & Fraserirector, 2000; David & Rhee, 1998; Derose & Baker, 2000;
Lee, 2009; Schouten & Meeuwesen, 2006). Specifically, Zoller and Kline (2008) noted that “significant room remains for development of dialogic perspectives that help to focus on the role of language and the co-construction of meaning in health care contexts” (p. 121). Although studies on physician-patient interaction provides rich descriptions of medical encounters from a variety of perspectives, the statement by Zoller and Kline (2008) is an indication that the much remains to be learned. The quest for additional research should not only focus on Western nations but capture experiences from developing countries such as Ghana.

**Language Barriers**

Masha Regenstein, a professor at the George Washington School of Public Health and a nationally recognized expert on language barriers in health care, observed:

> Communication between health care providers and patients is difficult, even when everyone speaks the same language. Add language barriers to the mix and it’s almost inconceivable that you have a really effective health care encounter. When patients and health care providers are not able to communicate clearly and thoroughly with each other, the quality of care suffers. (As cited in “addressing language barriers in health care,” 2007, p. 1)

A succinct look at the literature suggests that various studies differ on how “language proficiency” is defined or measured. For example, some studies (Goldsmith et al., 2005; Wearn, Goodyear-Smith, Everts, & Huggard, 2007) categorize a person’s ability to speak an official language (e.g., English) as either “English speaking” or “non-English speaking.” Other synonymous terms include “limited English proficiency” (LEP) or
“non-English speakers” (NES), (Divi, Koss, Schmaltz, & Loeb, 2007; Karliner et al., 2007; Schenker, Lo, Ettinger, & Fernandez, 2008; Wilson, Chen, Grumbach, Wang, & Fernandez, 2005).

In spite of these labels, measuring language fluency can be a huge challenge because words do not have stable meanings, and utterances can lead to different interpretations, depending on which context it is being used, given that medical language is distinctively different from everyday language (Herget & Alegre, 2009). For instance, Ellis (2004), narrating an experience in a South African hospital, posed the following question: “can I negotiate my patient from his world of meaning and natural rhythms to my world of medical terminology? How do I explain immune system, hypertension and anorexia in a language that will be meaningful to my patient?” (pp. 2-3). This statement is not necessarily about a shared language, but a need to establish meaning and mutual understanding.

In terms of language and communication, Wearn et al. (2007) found that general practitioners in Auckland, New Zealand experienced difficulty sharing informing with immigrant patients due to language barriers, and cultural issues. In a different study undertaken in Switzerland, Bischoff, Tonnerre, Loutan, and Stadler (1999) used quantitative methods to determine the languages spoken in an outpatient clinic and how health professionals communicated with patients in languages other than French. Bischoff et al. (1999) noted that junior physicians were asked to fill out a self-administered questionnaire after each patient encounter. They were then asked to report the following: whether or not the patient was a French-speaker and if not, to indicate the
patient’s mother tongue, the language abilities of both patient and physician. Findings revealed that, out of 1,091 consultations during the study period, the majority of the patients spoke one of four languages (i.e., Albanian, Somali, Tamil, and South Slavic) but had difficulty communicating in French.

Language barriers between physicians and patients have been studied as possible sources of frustrations, misunderstanding, and miscommunication (Bischoff et al., 1999; Garrett et al., 2008). For example, when dealing with non-English speakers, issues of language accuracy, fluency, structuring of explanations and presentation of symptoms emerge (Ali, 2003). Language difficulties can lead to judgments and stereotyping by both patients and health care providers (Bowler, 1993; Wright, 1983). Moreover, when language barriers pervade the clinical interaction, misdiagnosis, or poor medical care can occur (Abbe et al., 2006; Garrett et al., 2008) which sometimes leads to litigation (Levison, 1994; Levison, Roter, Mullooly, Dull, & Frankel, 1997). Further concerns with language barriers include patients’ inability to understand health care provider’s instructions (Dohan & Levintova, 2007; Gerrish, 2001), dissatisfaction with the quality of care (Flores et al., 2003; Garcia, Roy, Okada, Perkins, & Wiebe, 2004), and reluctance to disclose information (Julliard et al., 2008; Penn, 2007; Sankar & Jones, 2005).

Other challenges associated with language barriers include lengthy interview times due to the use of interpreters (Hampers, Cha, Gutglass, Binns, & Krug, 1999; Hampers & McNulty, 2002), lack of patient satisfaction (David & Rhee, 1998; Flores et al., 2003; Hornberger, Itakura, & Wilson, 1997), and concerns related to patient non-compliance (Sarver & Baker, 2000; Stotland, 2003). Apart from these issues, providing
informed consent has proven challenging for patients. For instance, a *New York Times* report indicated that a newly pregnant woman from Mexico was compelled to sign a consent form for an emergency surgery without actually understanding what the procedure entailed since no one could explain the document to her (Bernstein, 2005). This situation is not an isolated one; cases exist where patients did not understand the implications associated with a procedure and yet gave consent (Barnes, Davis, Moran, Portillo, & Koenig, 1998; Bottrell, Alpert, Fischbach, & Emanuel, 2000; Kirsch, 2000).

Available literature also suggests that language barriers have been linked with the utilization of, or access to, facilities and quality of care. In terms of accessing health facilities, Fox and Stein (1991) examined whether women of racial/ethnic (Hispanic) groups in the United States undertook a mammography. Fox and Stein noted that the possibility of women undergoing screening depended on whether their doctor discussed it with them. Unfortunately, differences in language discouraged any such discussions. Kelly and Groff (2000) also discovered that Spanish speaking mothers had not heard of a poison control center and did not know what services it provided. These mothers repeatedly cited their inability to speak English and the unavailability of bilingual staff at the poison center as the reason for not using the services. Other concerns with regard to access include the lack of written educational materials in Spanish (Lasater, Davidson, Steiner, & Mehler, 2001).

In addition to previous concerns, language barriers have also created communication difficulties in pediatric care. Studies have noted that parents with no English speaking skill who sent their children to a clinic cited the difference in language
as a cause for misdiagnosis, poor medical care, inappropriate follow-up, incomprehensible prescriptions, and hospitalization (Abbe et al., 2006; Flores, Abreu, Olivar, & Kastner, 1998; Levin, 2006b; Sarver & Baker, 2000). For example, a survey administered to parents who visited a pediatric Latino clinic at Boston Medical Center revealed that language problems were the single greatest barrier to accessing health care services (Flores et al., 1998). Similarly, Crane (1997) whose research took place at a hospital in Bakersfield, California, found that Spanish speaking patients did not fully understand diagnosis, treatment instructions, prescribed medicine, or plans of follow-up care which were all in English language. In another example, a research undertaken in a pediatric hospital in Cape Town, South Africa, determined that parents who spoke Xhosa as their first language had difficulty communicating with health providers who spoke English and Afrikaans. As a result, parents expressed difficulty with understanding doctors and making themselves understood (Levin, 2006b).

Though available literature has emphasized the effect of language barriers on health care (Garret et al., 2008; Jacobs, Agger-Gupta, Chen, Piotrowski, & Hardt, 2003; Jacobs et al., 2006; Pöchhacker, 2000), some studies generate unanswered questions. For instance, in a survey administered to medical doctors in Vienna, Austria, Pöchhacker (2000) sought to identify non-German speaking patients, the language communities to which they belonged, and the most suitable arrangements that health providers used to overcome language barriers. Findings revealed that, while 95% of respondents confirmed that they interacted directly with non-German-speaking patients, 91% of doctors were not sure how much patients really understood. According to Pöchhacker,
medical doctors reported that communication was largely assisted by ad hoc interpreters usually children. From my perspective, this study generates questions such as, (a) Are patients receiving the best of treatments or are they being misdiagnosed? (b) What are the implications of using children as interpreters? Even if this article comprises an isolated case, Jacobs et al. (2006) maintained that previous studies have not adequately explained how language barrier contributed to situations such as frequent admissions and longer hospital stays for non-English-speaking patients.

To further make the argument about the need for research on language barriers, especially in Ghana, we must note the high levels of illiteracy in both English (which is the lingua franca) and native languages (GILLBT, 2009). Given this situation, how do health providers ensure that patients understand their health conditions and prescription indications? What are the challenges providers face in trying to explain diagnosis in the indigenous languages, especially with words/phrases which do not have a corresponding linguistic equivalent? What are patients and providers perspectives about language barriers? This study attempted to provide further insight in regard to these questions.

**Use of Interpreters**

**Role Expectations**

Interpreting in a medical setting constitutes a common occurrence, if a language barrier exists between the health care provider and patient (Angelelli, 2004; Beltran Avery, 2001; Hsieh, 2006a, 2006b, 2009). The role of an interpreter has been conceptualized as a person who provides appropriate linguistic conversion from one language to another, and where necessary, assists to overcome communication barriers
embedded in cultural norms (Beltran Avery, 2001; Downing, 1995; Pöchhacker & Shlesinger, 2007). Normally, the interpreter works to (a) keep the focus of communication between the provider and the patient, (b) consciously strive to maintain a neutral position, and (3) maintain accuracy and completeness by ensuring that the meaning of messages are not distorted (Beltran Avery, 2001; Downing, 1995). Although such constructs provides a succinct view of what an interpreter does or is expected to do, studies reveal that the actual role of interpreters is somewhat ill-defined (Angelelli, 2004; Beltran Avery, 2001; Downing, 1997; Hsieh, 2006a, 2006b, 2007). For example, an interpreter can potentially assume a conduit role (transmit messages), a cultural broker (provide necessary cultural framework for understanding the message), or a patient advocate (act outside the bounds of an interpreted interview on behalf of the patient) (Beltran Avery, 2001; Hsieh, 2010).

In view of these somewhat fluid role designations, debates continue regarding whether the interpreter role should be restricted to an “objective role” or combine “cultural broker,” “educator,” “mediator,” and “advocate” (Angelelli, 2004; Beltran Avery, 2001; Downing, 1995, 1997; Hsieh, 2006a, 2006b, 2007, 2008, 2009). In some instances, interpreters have offered advice which was not given by the physician (Hsieh, 2006a, 2006b, 2007). In other cases, interpreters have assumed the physician’s role by obtaining medical history and giving medically related instructions (Angelelli, 2004; Bolden, 2000; Davidson, 2000). The inconsistency of the interpreter role is also compounded by unclear guidelines regarding the specific responsibility of an interpreter,
a situation which often generates ethical conflicts for interpreters (Dysart-Gale, 2005; Karliner et al., 2007).

Apart from the role definition issues, interpreters have been categorized into two distinctive groups; professional/trained/formal (those with specific education on medical interpreting), or ad hoc/informal (consisting of friends, family, hospital staff, physicians, nurses and volunteers). Usually, informal interpreters do not possess any special training but can interpret because of their proficiency in multiple languages (Angelelli, 2004). Regardless of the role definitions and interpreter training skills, available literature has documented specific outcomes of how the interpretation process shapes the medical interaction.

**Interpreter Assessment and Performance**

Although language barriers pose many challenges in the clinical encounter, language concordant does not necessarily generate common meaning for both patient and physician. For example, Ellis (2004) conducted a study in a South African clinic and discovered that one of the most common causes of misinterpretation resulted from African languages which utilized metaphors, allusions, and euphemisms when explaining illness. As a result, references and connotations required more than literal translations. Ellis also noted that such subtle shifts in meanings and translations lead to confusion and wrong information exchange between provider and patient, similar to what happens when interpretations are not done properly.

The discourse in medical interpreting has been analyzed both quantitatively and qualitatively foregrounding a number of different issues. In one of the earliest studies in
health care interpreting, Price (1975) conducted quantitative analysis with Hindu speaking patients in which two orderlies and a patient in remission served as interpreters. Assessing both translational accuracy and linguistic proficiency, Price found mistranslations, omissions, and distorted questions. Another early study conducted by Lang (1975) investigated the performance of orderlies serving as interpreters in Papua New Guinea. Adopting a qualitative, discourse-based approach, Lang illustrated various types of mistranslations which corresponded to what Price discovered in his study. Launer (1978) also analyzed tape-recorded consultations between 30 Hausa-speaking patients and four English-speaking doctors mediated by seven medical orderlies in a Nigerian Hospital. Findings revealed a number of deviations from the intended message, and a tendency for orderlies to assume the consulting process. In all these early studies, the interpreters had not received any training.

As mentioned earlier, health care facilities utilize the services of formal/professional and informal interpreters. Consequently, studies have revealed patients and health care providers’ orientation toward interpreters. For example, in a study to determine physicians’ perceptions of professional versus family interpreters, Rosenberg, Leanza, and Seller (2007) concluded that physicians preferred professional interpreters over family members, as family members were perceived to be less skilled with their translation. In a different study conducted in an Australian dental clinic, doctors expressed concern about informal interpreter’s accuracy of translation and grasp of dental terminology (Goldsmith et al., 2005). Other studies have also reported that family/ad hoc interpreters played caregiver roles instead of interpreting (Rosenberg et al.,
2007; Rosenberg, Seller, & Leanza, 2008), used overlapping words (Roberts, Moss, Wass, Sarangi, & Jones, 2005), omitted phrases and words, engaged in false fluency, and editorialized messages (Flores, 2005, 2006; Flores et al., 2003; Laws et al., 2004), co-diagnosed (Hsieh, 2006a, 2006b, 2007), and compromised informed consents (Goldsmith et al., 2005). Similar concerns emerged surrounding the use of children as interpreters, including the vulnerability of the child, children having to miss school, and compromising patient privacy (Giordano, 2007).

Even though ad hoc or informal interpreters pose a lot of concerns, their role cannot be totally ignored in the medical encounter. A national survey in the United States on the use of professional versus non-professional interpreters revealed that, while ad hoc interpreters more likely commit errors, they provide readily available interpreting and emotional support for patients (Lee et al., 2006). In addition, Rosenberg et al. (2008) also noted that family interpreters facilitated understanding, ensured patient inclusion, negotiated treatment, and supported patient recovery.

Apart from family members, other medical personnel, such as bilingual nurses and medical students, serve as interpreters. In a study that sought to examine how nurses performed as interpreters, Elderkin-Thompson, Silver, and Waitzkin (2001) noted that nurses omitted or added information which led to inaccuracies, thereby reflecting unfavorably on the patient and undermining patients’ credibility. The authors further indicated that nurses exhibited unfamiliarity with cultural metaphors which resulted in misunderstanding for both physicians and patients. In terms of using medical students as interpreters, Yang and Gray (2008) found that, although some clinicians opposed the idea
of using medical students, they also confessed that unavailability of trained interpreters warranted using medical students.

During my reading of various literature, I noted that while studies reference bilingual and multilingual health providers (physicians and nurses) as informal interpreters, these studies do not clearly distinguished health providers level of accuracy compared with family, friends, and volunteer interpreters. Moreover, studies fail to enumerate whether or not medical staff require additional training in translation services.

The use of professional or formal interpreters has also been documented. In situations where trained medical interpreters have been used, physicians have reported less errors and miscommunication of patients symptoms, (Angelelli, 2004; Flores, 2005; Flores et al., 2003; Hampers & McNulty, 2002; Karliner et al., 2007; Leanza, 2005) increased clinic visits, and utilization of hospital facilities (Bernstein et al., 2002; Flores, 2005). Additionally, patients have also reported better comprehension of diagnosis as well as satisfaction with treatment and care (Garcia et al., 2004; Karliner et al., 2007; Rosenberg et al., 2008).

Reliance on interpreters constitutes an important concept in physician-patient interaction (Angelelli, 2004; Elderkin-Thompson et al., 2001; Flores, 2005; Garcia et al., 2004; Hsieh, 2008, 2009; Karliner, Perez-Stable, & Gildengorin, 2004). However, the literature leaves many unanswered questions and inconsistencies surrounding the functions of an interpreter during the triad (patient, interpreter, and physician) communication. First, at what point does an interpreter draw the boundary; should an interpreter speak for the patient or provider when required by the situation? Further, the
literature does not clearly address the concept of accuracy. Should the interpreter mimic
an emotional tone of a patient’s message? How accurate must a translation be in order
for a physician to know they have made an informed diagnosis and for a patient to
determine that she/he has received proper care?

Last but not least, available literature fails to clearly address issues which pertain
to the use of medical staff (nurses or physicians) as interpreters. Some studies have
alluded to the time and cost constraints of such a process (Drennan, 1996; Gany et al.,
2007; Gerrish, 2001; Kravitz, Helms, Azari, Antonius, & Melnikow, 2000). However, it
is unclear (a) whether or not medical personnel abandon their work to serve as
interpreters, (b) if they receive additional income as interpreters, (c) and which
institutional measures or policies are in place to ensure that bilingual staff who serve as
interpreters assume an objective approach to their role.

Answers to the above questions might differ depending on which country as well
as the regulations or laws pertaining to interpreting within health care settings. The
availability of interpreting services depends to a large extent on the languages for which
interpretation is needed as well as health belief systems of a particular culture. This
dissertation attempted to answer the above inconsistencies by examining the nature of
health care interpreting in Ghana.

Information Disclosure

In the previous sections, I discussed how language barriers and use of interpreters
shape medical encounters. In this section, I interrogate these concepts and how they
influence patient self-disclosure. Stated differently, what types of health information will
a patient share (or not) with their health provider, and under what circumstances? Self-disclosure, or the intention to make known to others personal information about one’s self (Farber, 2006), operates differently within various cultures (Altman, 1977). In the health care context, where a patient might utilize the services of an interpreter, the presentation of a patient’s story can easily change, depending on who the audience is as well as the comfort or discomfort level of the patient (Farber, 2006). Moreover, a patient’s decision to disclose will also depend on the nature of a person’s illness, cultural values, gender, and the potential risks or benefits which might be associated with disclosing (Petronio, 2007).

Studies on disclosure have examined how the presence of friends and family members in the consulting room influences patient disclosure behaviors (Petronio, Sargent, Andea, Reganis, & Cichocki, 2004). Examples include family and friends, who double as informal health care advocates, offer emotional support, take on the role of language interpreters, serve as care takers, and provide assistance for patients to navigate the health care system (Biegel & Schultz, 1999; Echlin & Osthoff, 2000; Petronio et al., 2004; Piercy & Chapman, 2001).

Information disclosure is relevant to clinical decision-making, yet patients do not always disclose (Greene, Derlega, Yep, & Petronio, 2003). In some cases, patients may think that information is irrelevant, or they may experience anxiety, stigma, and embarrassment (Greene et al., 2003; Julliard et al., 2008; Prior, Wood, Lewis, & Pill, 2003; Rodriguez, Sheldon, Bauer, & Perez-Stable, 2001; Sankar & Jones, 2005). Research on primary care reveal that various factors determine whether or not patients
will choose to disclose information to their physician (e.g., Jenkins, Merz, & Sankar, 2005; Marwit & Datson, 2002; Rodriguez et al., 2001; Sankar & Jones, 2005).

Factors that most likely hinder disclosure include sexual conditions (Baldwin, Ginsberg, & Harkway, 2003; Gott & Hinchliff, 2003), domestic violence (Glowa, Frazier, Wang, Eaker, & Osterling, 2003; Zink, Regan, Goldenhar, Pabst, & Rinto, 2004), and mental health issues (Drennan & Swartz, 2002; Prior et al., 2003). In the case of mental health, a study conducted in New Zealand revealed that, although patients reported trusting their physicians, “fear” of psychological treatment inhibited disclosure (Dew et al., 2007). While sensitive topics might seem embarrassing for some patients, other factors, such as language barriers and the presence of an interpreter, also hinders patient disclosure (Dohan & Levintova, 2007; Julliard et al., 2008; Neville Miller & Rubin, 2007; Rodriguez et al., 2001; Sankar & Jones, 2005).

In a study to determine what patients tell or not tell their physicians, Julliard et al. (2008) found that respondents expressed difficulty in disclosing information due to language barriers. Moreover, interviewees believed that their confidentiality was not protected when a translator was present. Similarly, Gold-Smith et al. (2005) also reported that use of informal interpreters led to concern for patient privacy, embarrassment in discussing personal details, and reluctance of patients to reveal complete or accurate information. Moreover, cultural norms and taboos have also hindered disclosure from patients (Dohan & Levintova, 2007; Grant, 2006).

On the contrary, Kuo and Fagan (1999) found that patients’ level of comfort and willingness to disclose was largely determined by who is interpreting. In their study, Kuo
and Fagan noted that patients reported greater levels of comfort in disclosing embarrassing or sensitive topics with interpreters who were bilingual physicians or family members/friends, as opposed to telephone interpreters or professional interpreters. In other situations, a male interpreter with a female patient and vice versa could be a deterrent for some patients to discuss sexuality or domestic violence issues (Grant, 2006; Rosenberg et al., 2007).

Literature on patient disclosure has focused heavily on HIV/AIDS (e.g., Agne, Thompson, & Cusella, 2000; Andrewin & Li-Yin, 2008; Caughlin et al., 2009; De Baets, Sifóvo, Parsons, & Pazvakavambwa, 2008; Hawk, 2007; Mitchell & Knowlton, 2009), potentially because of the global nature and stigma associated with the epidemic. Even so, the decision to disclose one’s HIV status is not the same in all cultures. Though not a universal phenomenon, disclosure patterns among individualistic and collectivistic cultures differ. For example, some studies conducted with persons living with HIV or AIDS have confirmed the differences in disclosure patterns between patients residing in sub-Saharan Africa (Antelman et al., 2001; Neville Miller & Rubin, 2007) and those in North America (Derlega, Lovejoy, & Winstead, 1998; Greene, 2000; Greene et al., 2003; Greene & Serovich, 1996). These studies posit that the possibility for patients in Western cultures to disclose exceeds those in Sub-Saharan Africa. However, these findings are very specific to HIV/AIDS, not necessarily other illnesses.

As detailed in this section, the literature on disclosure focuses more on stigmatizing illnesses. In this study, I interrogate the concept of disclosure from Ghanaian health care perspective. For example, I review the kinds of information that
patients’ likely share with their physicians, the circumstances under which such disclosures occur, and whether or not the presence of an interpreter influences a patient’s decision to disclose.

**Research Questions**

Research on communicative practices and policies in various health care environments has yielded multiple results. However, health care institutions differ in their policies regarding the monolingual and multilingual needs of their patients and providers. Despite major initiatives to ensure “culturally sensitive and patient-centered care” (Kanter & Horowitz, 2009) such arrangements might differ within specific national contexts (Helman, 2007).

As discussed earlier, great linguistic diversity exists in the Ghana. However, ways in which this situation shapes the communicative experiences between physicians and patients remains unknown. Moreover, the non-existence of interpreter service legislation creates inconsistencies as to what needs to be done when a language discordant becomes apparent during a clinical interaction. Based on the contributions and limitations of existing literature, my dissertation sought to understand the nature of physician-patient interaction as well as language barriers, use of interpreters, and disclosure. As a result, I posed the following questions to guide my research:

*RQ1:* Which Ghanaian languages do patients and physicians use during clinical interactions, and how do these languages shape the communication process?

*RQ2:* How (if at all) are interpreters utilized if a language barrier exists?
**RQ3**: How does a triad (patient, interpreter, and physician) interaction process influence patient self-disclosure?

**RQ4**: How do patients and physicians interpret the dialogic and relational aspect of care?

These questions were informed by the researcher’s previous exploratory studies (Acquah, 2007, 2008) as well as various questions which have not been adequately addressed by previous research. Overall, this study has several strengths: (a) understanding how multilingualism shapes the physician-patient interaction, (b) gaining an insider perspective on how the use or non-use of interpreters influences patient self-disclosure, and (c) developing a data-driven perspective about the nature of physician-patient interactions in Ghana. The long term objectives include a proposal to (a) develop a training module for health care providers on communicative skills, (b) introduce a communication skills course in medical school curricular, (c) design education programs for patients to engage with their health care treatment plans, and (c) develop a policy framework to streamline interpreter services within health care facilities.

**Chapter Summary**

In this chapter, I reviewed and evaluated available literature relevant to my research interests. Based on my assessment, I concluded that various studies have been able to accomplish the existence of language barriers in the clinical encounter and the benefits of interpreters in communication process. Unfortunately, these studies have been conducted in places other than Ghana. Also studies have failed to establish whether or not indigenous populations who speak multiple native languages encounter similar language issues during clinical interactions. Further, the literature on disclosure focuses
on HIV/AIDS and other stigmatizing diseases and only offer fragments of other health conditions for which patients might chose to disclose or not. Having evaluated and synthesized existing literature, I proposed four research questions which my dissertation attempted to explicate. In the next chapter, I discuss my data collection methods, the study site, selection of participants, and data analysis procedures.
Chapter Three: Method

Overview

My current work is an extension of two exploratory studies which I conducted on physician-patient interaction at a government teaching hospital in Ghana (Acquah, 2007, 2008). These previous studies generated a dozen questions about health care interaction between physicians and their patients. Unfortunately, a dearth of research literature exists specific to medical communication in Ghanaian health care systems. Thus, in order to understand how health care is negotiated and experienced, I adopted an interpretive approach to gathering and analyzing data.

Interpretivists hold the view that participants construct their social reality (Berger & Luckmann, 1966; Garfinkel, 1967; Husserl, 1965). For example, Zoller and Kline (2008) noted that, interpretive approaches focus on the basic assumption that perception or reality is constituted as individuals engage in interactions and attach meaning to phenomena. Cegala and Street (2010) contended that, “rather than adopting a theoretical framework a priori, interpretive approaches derive conceptual themes from careful analysis of discourse garnered from ethnographic, observational, and interview data collection methods” (p. 402). Martin and Nakayama (1999) also maintained that, interpretive research is concerned with “describing the subjective, creative communication of individuals, usually using qualitative research methods” (p. 5). Notably, the interpretive perspective offers in-depth understanding of lived experiences and various construal of discourse which provides insights into the multiple ways in
which communication fosters particular meanings (Martin & Nakayama, 1999; Zoller & Kline, 2008).

In terms of health, “interpretive scholarship demonstrates the ways that individuals define and make sense of health and illness through factors such as personal experiences, interpersonal negotiations, cultural backgrounds, and class frameworks” (Zoller & Kline, 2008, p. 98). With regards to this study, interpretive approach proved useful in understanding the “local context within which health meanings are constituted, health-care relationships are negotiated, and health practices enacted” (Zoller & Dutta, 2008, p. 12). Further, interpretive approach allowed me to gain a better insight to participants’ experience with health, the complexities of discourse or meaning, and the ways in which social context shape medical interaction (Helman, 2007; Waitzkin, 1991).

As part of the interpretive framework, I utilized constructivist grounded theory (Bryant, 2002; Bryant & Charmaz, 2007; Charmaz, 2000, 2005, 2006, 2007, 2008; Charmaz & Mitchell, 2007, Clarke, 2005) as my mode for gathering and analyzing data. Generally, grounded theory has been widely used to investigate various topics involving communication between patients and health care providers. Examples include patients’ needs and experiences (Meldrum, Tsao, & Zeltzer, 2009; Nguyen, Barg, Armstrong, Holmes, & Hornik, 2008; Rottmann, Helmes, & Vogel, 2010; Sparks, Villagran, Parker-Raley, & Cunningham, 2007), as well as health providers perspectives (Aita & Kai, 2010; Enguidanos et al., 2009; Shachak & Reis, 2009).

Grounded theory as a method of inquiry was developed in 1967 by two sociology researchers, Barney Glaser and Anselm Strauss. According to Glaser and Strauss,
engaging in grounded theory allows researchers to duly represent the actions, interactions, and social processes of participants. Although Glaser and Strauss prompted varied opinions on “how to do” grounded theory, this method of gathering and analyzing data has evolved over time. Consequently, various schools of thought exist about how to approach grounded theory. However, the two major schools include the objectivist (e.g., Glaser, 1978, 1992, 1998, 2001, 2003, 2005; Glaser & Strauss, 1967; Strauss, 1987; Strauss & Corbin, 1990, 1994, 1998) and the constructivist (e.g., Bryant, 2002; Bryant & Charmaz, 2007; Charmaz, 2000, 2002a, 2005, 2006, 2007, 2008; Charmaz & Mitchell, 2007; Clarke, 2005).

Objectivists (e.g., Glaser, 2001, 2003, 2005; Strauss & Corbin, 1990, 1994, 1998) hold the view that grounded theory generation involves various stages of evaluating research data. First of all, the researcher conducts interviews based on multiple visits to the field. The researcher then begins with open coding to determine the major categories of the data. The next step is axial coding, which helps in the identification of a “core” phenomenon. The researcher then goes back to the data and creates categories around the core phenomenon. These categories could be grouped as casual conditions (what factors caused the core phenomenon), strategies (actions taken in response to the core phenomenon), intervening conditions (broad and specific situational factors that influence the strategies), and consequences (outcomes from using the strategies). The final step of the process involves selective coding, in which the researcher develops propositions that relate to the categories. Through this process, the researcher develops a substantive or low-level theory at the completion of the study.
Alternatively, constructivist grounded theorists (e.g., Bryant, 2002; Bryant & Charmaz, 2007; Charmaz, 2000, 2005, 2006, 2007; Charmaz & Mitchell, 2007; Clarke, 2005) assert that the original approach to grounded theory is somewhat infused with “positivist ideology.” As a result, they advocate for a more constructive grounded theory which emphasizes divergent world views and multiple realities. Charmaz (2006) argued that “constructivist grounded theory lies squarely in the interpretive tradition” (p. 130). Charmaz further indicated that constructive grounded theory places more emphasis on values, beliefs, views, assumptions, and ideologies of individuals, than on the methods of research. Other proponents of constructive grounded theory (Bryant, 2002; Hall & Callery, 2001) also maintain that both data and analyses constitute social constructions that reflect various cultural orientations. Further, constructivist grounded theory propose a reflexive position (Charmaz, 2008; Cutcliffe, 2000; Mruck & Mey, 2007) toward the research process, allowing for consciousness on the part of the researcher as well as research participants.

In spite of the different schools of thought, certain overlaps (e.g., coding, memo-writing, theoretical sampling, saturation, and sorting) exist in terms of how data is collected and analyzed. In terms the research questions for this study, a constructivist approach proved useful because it calls for “an obdurate, yet ever-changing world but recognizes diverse local worlds and multiple realities, and addresses how people’s actions affect their local and larger social worlds” (Charmaz, 2006, p.132). Additionally, because explanatory models about physician-patient interaction have been developed in places other than Ghana, a constructivist grounded theory, which also subscribes to
interpretive ways of experiencing phenomenon, proved valuable in understanding how language barriers, use of interpreters, and patient self-disclosure is negotiated and experience in the Ghanaian health care system. For instance, the grounded theory method requires data to be streamlined through constant comparative approaches and also incorporates systematic procedures to ensure that the researcher’s ideas are grounded in data (Charmaz, 2008).

Another element which guided my choice of constructivist grounded theory as the most suitable approach is based on the notion that interpretive research does not seek to provide “definitive conclusions” but to discover alternative perspectives based on participants’ stories (Charmaz, 2006, 2008; Elliott & Jordan, 2010). Thus, while grounded theory helps to generate data in a systematic manner, it also recognizes that the interaction between researcher and participants leads to the co-construction of knowledge; hence, the method is “emergent” (Charmaz, 2008). As such, the researcher becomes part of the data. Subsequently, as I engaged in dialogue with physicians and patients, I acknowledged my personal ideas or biases, and I worked to ensure that those had little interference with the research findings.

As suggested by Charmaz (2006), “the tenets of grounded theory methods resides in offering a guide to interpretive theoretical practice, not in providing a blueprint for theoretical products” (pp. 128-129). Therefore, the data generation and interrogation led to the formulation of various analytical concepts. I used these concepts to generate a substantial explanation of how language barriers shape clinical interactions, and patient
self-disclosure. Consequently, I gathered data using three techniques: participant observations, in-depth interviews, and focus group discussions.

**Setting**

My research occurred at one of the leading and largest public hospitals in Ghana. This facility, which also serves as a teaching hospital, is located in Accra, the capital city of Ghana. I selected this site because it also offers a range of specialized and comprehensive health care services in the country. As a result, it attracts a huge and diverse group of patients. Apart from its services being reasonable for the low to average income earner, the facility accommodates referrals from all over the country (Ghana Health Service, 2007). Although the attributes mentioned influenced my decision to select this facility, I had previously conducted two exploratory studies at this site (Acquah, 2007, 2008), and this dissertation constitutes a follow-up investigation. Hence, I was familiar with the study site, and I had also developed a cordial working relationship with some administrators and physicians. Consequently, I did not encounter any difficulties with gaining access, and I was offered immense assistance.

Prior to the onset of the project, I submitted a research proposal to Ohio University Institutional Review Board (IRB), and I was issued an approval (see Appendix A) before I began data collection. Similarly, the management of the health facility also reviewed my proposal before granting me access to their facility. Throughout the research process, I made sure the study remained in complete compliance with ethical and IRB guidelines.
Research Participants

The nature of my research questions warranted specific respondents. Therefore, two groups of participants engaged in this project. These included physicians who speak English and a Ghanaian language, and patients who identify as illiterate or semi-literate (cannot read or understand English, and cannot read a Ghanaian language) but speak and understand a Ghanaian language. In other words, my selection of participants was based on a purposeful sampling process. Therefore, I included individuals who could provide specific information regarding my research questions (Creswell, 2007; Lindlof & Taylor, 2011; Patton, 2002). With this approach, I could explore the similarities and differences in opinion among these two groups which added scope and breadth to the study.

I employed various methods to solicit volunteers to engage in this study. For physicians, I created an advertisement (see Appendix B) describing the nature of the study, and I posted copies on various bulletin boards around the facility. I also engaged in the snowball sampling process (Lindlof & Taylor, 2011) by contacting physicians that I know and asking them to refer me to other colleagues. Physicians who participated in this study were dentists, diabetes specialists, urologist, oncologists, orthopedic surgeons, an epidemiologist and a dermatologist. I interviewed five dentists; four females and one male. The male dentist had been practicing for 8 years; two of the females each had 3 years of experience; the third had 11 years of practice, and the fourth, a specialist in maxillofacial surgery, had 18 years of experience. In the diabetic unit, I interacted with eight physicians; four of them were females who had been practicing for 27, 20, 13, and 9 years respectively. The other four were males with 15, 12, 10 and 9 years of experience.
I also interviewed two female urologists with 19 and 11 years of experience, as well as a male urologist with 4 years of practice. In the oncology unit, I spoke with two female participants who had 7 and 8 years of practice, as well as four male participants with 15, 13, 10 and 8 years of experience respectively. Other participants included a female and male orthopedic surgeon. The former had 15 years and the latter 6 years of experience. The last two participants were a male epidemiologist with 9 years of practice and a male dermatologist who had been practicing for 4 years. In all, a total of 25 physicians participated in this study, and their ages ranged from 32 through 65 years. At the onset of an interview, I assigned each physician a pseudonym.

In terms of recruiting patients, I sought permission from the management of the health facility to visit various units in the wards to speak with patients and ask their participation. At the wards, I was assisted by the Senior Nursing Officers (SNOs) who allowed me to interact with patients and invite their voluntary participation (see Appendix C for recruitment information). My interaction was limited to patients who were in the recovering stage but had to be kept in the ward for observation. Stated differently, these individuals could chat with me for about 30 minutes or more without putting undue pressure on their health. Basically, I ensured that individuals who got invited to participate in this study were comfortable with their health condition and willing to reflect on, and share their experiences.

Patients who participated in this study were from the surgical, diabetes, and medical wards. Overall, 11 patients engaged in this study, and their ages ranged from 36 through 68 years. All patients took part in focus group discussions as well as one-on-one
interviews. Prior to our interactions, I assigned each participant a pseudonym. Patients from the surgical ward included two women recovering from fibroid surgery; Yaa, a 58 year old woman who sells tomatoes, onion, plantains and yams in a local market, and Ama, a 38 year old seamstress. Others included Adjoa, a 43 year old hair dresser, recovering from appendicitis surgery, Kwame, a 45 year old taxi cab driver recuperating from hernia surgery, and Yaw, a 52 year old carpenter recovering from an orthopedic surgery in the right femur. Participants from the diabetic ward included Abena, a 55 year old woman who sells cooked rice and beans in the local market. Abena had a diabetic sore on her right leg and had a 50% chance of an amputation. Others were Kojo, a 65 year old tailor with an amputated left limb, Afia, a 48 year old hair dresser, and Akua, a 36 year vegetable seller, both under observation for high blood sugar. Participants from the medical ward included Serwaa, a 68 year old housewife diagnosed with breast cancer, and Kofi, a 62 year old mechanic diagnosed with prostate cancer.

I collected initial data from June through August 2009. After reviewing my initial data, I realized that certain concepts needed refinement, and I went back to the study site again from November through December 2009, for additional information. My research questions focused on participants’ experiences as they pertain to language barriers in communication, reliance on interpreters, disclosing health information, and relational aspects of care. Although I focused on my research questions during the data collection process, I kept an open mind about related topics on physician-patient interactions.
Data Collection Approach

Observation

As part of my data gathering approach, I engaged in participant observation at the out-patient-department (OPD) of the surgical and diabetic clinics. In their discussions on participant observation, Atkinson, Delamont, and Housley (2008) noted that:

There is, therefore, no alternative to the close observation (by whatever means) of everyday social performance. This observational work is, moreover, intensely focused on the visual aspects of such performative action. A thorough understanding of the ceremonials of the everyday, the exchanges of gestures (including spoken gesture), the construction of normal appearances, the unspoken dialogue of mutual perception—these all call for close and detailed observation.

(p.187)

This process allowed me to observe interactions among patients, their relatives, and health care providers. In order to gain a better perspective for my research questions, I divided my observations into three categories: place, people, and events. In my little book, I noted the daily routine of the OPDs and observed the social interaction that permeated this environment. Sometimes, I asked physicians if I could observe their daily routine, and a few allowed me to visit with them during ward rounds. Others, in consultation with their patients, permitted me to “sit in” during the clinical interaction on the condition that their conversations not be audio-recorded. During my consulting room observations, I jotted down points on a piece of paper. Immediately after I got out of the consulting room, I transferred the information into my field notebook and elaborated on
them. As part of the observations, I also documented significant events or activities, jotted my reflections, and listed things that I needed to follow-up on.

In the process of being an observer at the study site, I also engaged in “ethnographic interviews,” otherwise known as “informal conversation interview” (Patton, 2002, p. 342). Consequently, I interacted with other health workers and patients waiting at the OPD. These spontaneous interviews allowed me interrogate my memos and at the same time refine my interview protocol. In the course of the observations, I was able to explore the hospital culture and make meaning of various interactions patterns among patients, their relatives, and health providers (Atkinson et al., 2008; Lindlof & Taylor, 2011).

**Interviews**

The interview protocol that I used in this study was guided by Charmaz’s (2006, 2008) model for developing grounded theory interview questions, as well as recommendations from my dissertation advisor and committee members (see Appendix D for physician interview protocol, and Appendix E for patient interview protocol). I conducted one-on-one interviews separately with patients and physicians. The initial questions were open-ended, with the intent of exploring physician-patient interactions. As the discussions progressed, I began to focus more on the core research questions, such as language barriers, use of interpreters, patient disclosure patterns, and physician-patient interpretation of the dialogic and relational aspect of care. All interviews occurred on the premises of the facility.
Interviews with physicians were conducted in English. Prior to our interaction, I thoroughly explained the details of my research to each physician by reviewing (a) the purpose of my study, (b) voluntary nature of participation and the ability to redraw at any time without consequences, (c) description of the research process and how results might be used, (d) request to audio-record our conversation, (e) explanation of how participant confidentiality and anonymity will be protected, (f) description of risks and benefits to participants, and (e) explanation of when and how audio data will be disposed of. After reviewing the consent form (see Appendix F), I answered any questions. Each physician then signed a consent form, and I provided a copy for each participant. My interviews with physicians occurred either in a conference room or the doctor’s lounge. I began by asking participants to describe their relationship with their patients. I then narrowed it to my interview protocol and used probes to elicit additional responses about their perceptions and experiences.

With regard to patients, because they could not read and provide written consent, I translated the original consent form into the Twi language which happened to be a common indigenous dialect spoken within the health care facility (Acquah, 2007, 2008). A copy of the translated consent form was also submitted to Ohio University IRB. Patients who participated in this study spoke Twi, Ga, and Ewe. Because I fluently read, write, and speak each of the languages mentioned, I did not encounter any difficulty explaining and translating the consent form to patients. In order to verify that each participant understood the process, I verbally reviewed each item on the consent form as I did with physicians. I clearly stated that all identifying information would be edited
during the transcription process. Furthermore, I assured patients that their decision to participate in this study would not in any way interfere with their health information or the relationship with their physicians. I also made it explicit that our conversation would be audio recorded. After explaining the process, I asked clarifying questions from patients to confirm that they had indeed understood. I also answered questions that they posed. Before each interview began, a patient provided oral consent in the presence of a witness (physician or nurse).

In order to ensure that patients felt comfortable during our interaction, I specifically asked each patient whether she/he had a particular location in mind where we could talk. Some patients said they did not mind being interviewed at their bedside in the wards. Others preferred to be interviewed privately. In such cases, the SNO’s were kind enough to allow us to use one of their quiet lounge areas. To make patients feel at ease with the interview process, I started with questions such as “describe the relationship between you and your physician.” I then followed up with specific questions about language barriers, use of interpreters and patient disclosure. In cases where I needed to seek clarification or follow-up on a particular response, I asked questions such as “can you tell me a little bit about that?” With permission from participants, all interviews were recorded, transcribed in full, and annotated with field notes.

After each interview, I turned off the audio recorder and spent 10-15 minutes talking informally with the participant. I took brief notes during these conversations to use as additional data if needed. Interestingly, the post-interview process served as a forum where physicians shared their frustrations about various issues, and patients
expressed concerns about their illness and hospitalization. During our interactions, I also informed participants that, if I needed clarification on a subject that we had discussed, I might return to ask further questions. All of my participants understood, and they said they would be happy to speak with me again. In all, I obtained 108 hours of interview data.

**Focus Groups**

In addition to observations and interviews, I also engaged in focus group discussions to generate additional information about my research phenomenon. According to Kreuger and Casey (2009), focus groups allow for candid discussions that elicit a range of feelings, opinions, and ideas. Due to physicians’ busy schedules and the inability to find a suitable time for each person, only patients participated in the focus group discussions. Fortunately, patients who agreed to participate in this study were on admission at the hospital. As a result, I did not encounter much difficulty in bringing everyone together for the focus group. I conducted two focus groups made up of five and six participants respectively. All participants in the focus groups were also interviewed individually (see section on research participants for patient demographics). I scheduled a convenient time with each group separately. Once again, I reviewed the nature of the study as well as the consent process (see Appendix G). Prior to the discussion, each participant provided verbal consent, and also permitted me to audio record our conversations.

During the focus group discussions, I posed open-ended questions (see Appendix H) about aspects of my research which needed more elaboration or clarification. For
example, I asked patients whether or not they would be comfortable disclosing certain types of health issues in the presence of an interpreter. I also asked patients to share their perceptions about clinical interactions especially in cases where they have to depend on an interpreter. During the focus group discussions, I listened while participants engaged in dialogue with each other about their perceptions and/or experiences. If the discussions seemed to be veering off topic, I politely interrupted and re-focused it. Each focus group lasted for approximately 2 hours. Overall, the focus groups proved useful because they did not just supplement the observation and interview data, but also allowed for additional concepts to emerge and existing ones to be more refined.

**Data Analysis**

After each interview, I transcribed the audio recording and deleted all identifying information. All participants’ names were replaced with pseudonyms. I also noted information about participants tone in the transcriptions especially in cases where the participant made an emphatic point. Although the process of manual transcription proved tedious, it allowed me to immerse myself and become familiar with the data.

Realizing that data collected from this study was voluminous (participant observation notes, memos, interviews and focus group discussions), and the fact that data collection and analysis were happening simultaneously; I devised an organizational strategy to keep track of all the information. First of all, I set up folders with information specific to my core research questions as well as folders which contained major concepts that I had identified as being important for analysis and discussion. I also had a third file titled the researcher’s file where I kept memos of personal observations, as well as my
reflections of the research process. In line with constructivist grounded theory, I began initial coding while I was still collecting data. In other words, I engaged in close reading and interrogation of the data and tried to make meaning of action and processes (Charmaz, 2008; Gubrium & Holstein, 2008; Lindlof & Taylor, 2011; Silverman, 2006).

Second, I reviewed various phrases, sentences or paragraphs that struck me as significant, or of interest multiple times. For example, when participants describe events, I tried to make sense of those in connection with what occurred in the setting. Moreover, when reading the transcripts, I worked to explain participants’ statements and what analytic sense I could make of them. Through this process, I was able to identify which codes seemed most frequent and/or significant. For example, during the interviews, physicians mentioned that, although they interact with patients in the indigenous dialects, explanation of certain health conditions posed a challenge due to the non-existence of equivalent vocabularies in the indigenous dialects. An incident of this kind was of interest but needed further refining, so I reviewed additional data to properly contextualize such codes or concepts. Also, there were moments when certain codes seemed too abstract, such as when participants assumed that dialogue equals mutual understanding. Fortunately, because data gathering and analysis were happening simultaneously, I was able to contact some participants to ask additional questions and clarify specific codes. I engaged the same strategy for various codes in the emerging data.

The third step after the initial coding was focused coding. With this process, I sorted and synthesized my data to determine which ones explicated my research
questions, and which ones could become possible theoretical categories (Charmaz, 2006, 2008). Throughout the initial and focused coding, I also referred to memos and field notes. This process helped me to sort data in an organized manner and also to link various codes and categories. For example, responses from participants alluded to the notion that a link existed between patient illiteracy, physician authority, and patient vulnerability. Another example was patients’ reluctance to disclose information which could be linked to the set-up of a consulting room, presence of an interpreter, or physician behavior. After merging newer codes and categories with existing ones, I became convinced that majority of the codes had become repetitive. This phenomenon clearly indicated that I need not collect additional data, as it would not likely generate any new concept.

The fourth step in the analysis process entailed the synthesis of codes into categories. Charmaz (2006, 2008) maintained that although a researcher may be able to describe a phenomenon, the easiest way of relating with the data is to conceptualize a pattern. As the analysis progressed, I scrutinized the categories for their “power, purpose, and pattern” (Charmaz, 2006, p. 158). In this regard, I engaged in conceptual analysis in order to make comparisons and note differences in the responses between patients and physicians. For example, during the interviews, physicians mentioned that they needed patients to be more involved in management and treatment decisions. Some patients referenced physicians’ expertise and maintained that they did not need to participate as much. In some cases, patients expressed an eagerness to learn more about their condition, but physicians failed to provide any explanations. I construed these
codes into categories such as “relinquishing agency” and “controlling agency.” I utilize the term “agency” to denote “personal empowerment over the management of health and illness” (Zoller & Kline, 2008, p. 117). Specifically, “relinquishing agency” implied patients’ surrendering all health care decisions to their physicians. And “controlling agency” represented physicians underestimating the amount of information that patients are willing to learn about their condition.

During the final stages of the analysis, I worked through the categories in order to comprehend how patients make meaning of their illness experience. I also interrogated physicians’ interpretation of their relationship and interaction with patients. For example, responses suggested that during consultations, physicians assumed that they had provided thorough explanations regarding a health condition to their patients, only to realize that a misunderstanding had occurred. I coded such responses into a category called “assumed meaning.”

As I worked on my analysis, I generated additional categories such as “patient disengagement and disavowal,” “physician frustration,” and many others (see chapter four). Throughout the examination of the codes and categories, if I observed any patterns between patients and physicians responses, I asked questions such as; under what conditions (social context) do these distinctions and similarities arise and how are they contested or maintained? I continued with this process of analysis for all of the data. Eventually, I used participants’ responses to produce a framework about how patients and physicians in Ghana construct their experiences of the clinical interactions (for related argument, see Charmaz, 2008; Sparks & Villagran, 2010).
Evaluating Grounded Theory Research

Some of the elements of grounded theory research include credibility, originality, resonance, and usefulness (Bryant, 2002; Bryant & Charmaz, 2007; Charmaz, 2006, 2008; Clarke, 2005). For this research, I established credibility by using multiple data collection approaches, such as observations, interviews, and focus groups. Moreover, I also engaged in systematic comparisons between various codes and categories, and established relevant patterns. Further, I gathered ample data as evidence to support claims, and to provide the reader with enough information about the studied phenomenon.

In terms of originality, this research occurred in Ghana, which at the time of this study, lacked substantial empirical research on various aspects of patient-provider interactions. Moreover, the health care context within which the study occurred provides a new conceptual framework for challenging, refining, and extending current ideas about medical communication.

Assessing the resonance and usefulness of this study, I can say that certain taken-for-granted assumptions between patients and physicians interactions have been highlighted. The study also offers deeper insights about the experiences of illiterate patients. Last but not least, findings illuminate further research into areas such as patient education, interpretation services, and communication training in medical schools.

Reflections on the Process

As I engaged in various observations at the study site and interactions with participants, I constantly reminded myself that I am part of the culture which I was
studying. Thus, my ability to reflect inward as a researcher and outward towards the linguistic and social factors shaped the research process. As such, as events unfolded, I would reflect on and scrutinized how I interpret each incident (McCabe & Holmes, 2009; Neill, 2006). Often, I had to challenge myself, and interrogate my personal ideologies in relation to responses from participants (Finlay & Gough, 2003). Personally, these moments of introspection became a tool that I used to improve my interactions and understand how best to tap into the experiences of my participants especially patients.

Occasionally, I experienced this tension of reflection and being reflexive and I acknowledge any bias by recording them in a memo form (Jootun, McGhee, & Marland, 2009). Engaging in reflexivity during a qualitative research process has been explained by Guba and Lincoln (2008) who maintained that:

Reflexivity-as well as the post structural and postmodern sensibilities concerning quality in qualitative research-demands that we interrogate each of ourselves regarding the ways in which research efforts are shaped and staged around the binaries, contradictions, and paradoxes that form our own lives. We must question ourselves, too, regarding how those binaries and paradoxes shape not only the identities called forth in the field and later in the discovery process of writing, but also our interactions with respondents, in who we become to them in the process of becoming ourselves. (pp. 278-279)

In undertaking this study, I realized that my previous role as a patient at the facility and the experiences that I encountered could result in potential biases and assumptions. Moreover, I questioned how my educational background informed the manner in which I
framed participants’ experiences. As a result of the potential subjectivity and inability to completely detach myself from this research, I have included in this section, a few of the challenges that I experienced.

The first example pertained to the responses from physicians which alluded to the notion that majority of patients did not engage in treatment decisions or show particular interest in their health condition. I tried to understand why a patient would not express interest in their own health. At a time when I became a patient, I would ask questions and speak with physicians about my health, and I felt that all patients should be able to do that. However, I constantly had to remind myself that, as a researcher, I was in a privilege position and well educated. Moreover, my academic knowledge about health communication pushed me to seek answers if I was unsure of something. Unfortunately, patients in this study had little or no formal education which in a way inhibited how much information they possessed about their health condition, and how it translated into what types of discussions they might have with physicians. Moreover, findings suggested that some patients preferred to be passive participants in their own health decisions.

The second personal contention I experienced related to my observation of the behaviors by some nurses and physicians at the OPD and wards. For instance, nurses yelled at patients, and physicians hardly provided any explanations when patients asked questions about their condition. I began to question these health providers’ interpersonal adaptations and the relational aspect of care. Thus, whenever I recorded my personal feelings and tensions, I made a conscious effort to minimize their influence in my interpretation and analysis. Finally (2002) suggested that reflexivity can help us examine
our position, perspective and the context. Likewise, King and Horrocks (2010) noted that, reflexivity allows the researcher to assess and acknowledge unconscious motivations, and implicit biases that she/he brings to the study.

As I engaged in analysis and discussion of my findings, I ensured that participants’ voices were duly represented and if I made any claims, I supported those with relevant data. Yet, majority of the responses for each research question captured more of physicians’ experiences than they did patients. This imbalance was a result of the high number (25) of physicians compared 11 patients. While I acknowledge that physician autonomy pervaded clinical interactions, I would also recommend caution in terms of how we interpret patients’ “silences.” As a researcher, I worked to ensure that all interview and focus group questions were framed in a manner to elicit an equal amount of information from both participants. And to the best of my knowledge, patients elaborated on various research questions given how much those questions pertained to their experiences (see chapters four and five).

Broadly speaking, I believe that I engaged in reflexivity to the extent that it allowed me to critically examine my data until I was able to explicate concepts and categories in a meaningful way. Consequently, I came to appreciate the dynamic nature of physician-patient interactions as it pertains to my culture and the possible stress and pressure that engulf the hospital environment.

While the grounded theory procedure required a great investment on my part as a researcher, I thoroughly enjoyed the experience. From my perspective, the rigors of grounded theory method allowed me to acknowledge and account for the ways in which I
influence the research findings and what comes to be accepted as knowledge. For example, how does my interpretation of the data explicate the stories and experiences of my research participants? Even as I worked to represent participants voices as best as I could, I recognize that “it is impossible for anyone, no matter how reflexive, to completely escape his or her standpoint” (Ellingson, 2005, p.137).

**Chapter Summary**

In this chapter, I explained my data gathering approach and my choice of qualitative inquiry. I further stated that, due to the dearth of literature on physician-patient interaction in Ghana, I utilized constructivist grounded theory (Charmaz, 2006, 2008) methods to collect and analyze data. This methodological structure allowed me to review language barriers, use of interpreters, patient disclosure behaviors, and the relational aspects of physician-patient interaction in a more holistic manner.

As part of the data gathering process, I undertook field observations, conducted interviews with physicians and patients, and engaged in focus group discussions with patients. I thoroughly transcribed my data and compared them for commonalities and differences. Finally, I coded my data and used those to generate specific categories for each research question. I evaluated the methodological rigor of a grounded theory approach and shared my reflections about the research process.

In the next chapter, I present my findings based on participant responses. I use selected fragments of data to establish similarities or differences within my research questions, generate relevant concepts, and advance explanations (Lindlof & Taylor, 2011).
Chapter Four: Results

In this dissertation, I worked to generate a substantive explanation about physician-patient communication in Ghana. In essence, I sought to answer the following research questions: (a) which Ghanaian languages are used during clinical interactions, and how do these shape the communication process? (b) How (if at all) are interpreters utilized if a language barrier exists? (c) How does a triad (patient, interpreter, and physician) interaction process influence patient self-disclosure? (d) How do patients and physicians interpret the dialogic and relational aspect of care? Even though these research questions guided the study, I also kept an open mind about the data in order to uncover important insights which might not have been captured by the research questions. Overall, my analysis revealed a picture of a complex health care structure in which multiple issues came into play.

In this chapter, I present my conceptualization of responses from participants and how I used those responses to generate various categories. Before I proceed with the details of this analysis, I must indicate that these findings are based on my analysis of a particular group of physicians and patients, and they might not necessarily be characteristic of all patients and physicians. However, the information generated provides valuable insight into some aspects of physician-patient communication in Ghana.

Category System

In my analysis, I kept asking questions such as, “what are the most striking issues about the phenomenon, and how can I genuinely represent participants’ voices?” In
grounded theory research, one major task is to merge the conceptual findings into a core category which will reflect the storyline for the research (Charmaz, 2008). In this section, I provide a brief synopsis of how I used the data from each research question to develop various categories.

For my first research question, I learned that patients and physicians struggled with vocabulary limitations when communicating in an indigenous language. Stated differently, certain health terminologies in English either did not have indigenous language equivalents and even if terminologies existed, participants did not know them. Typically, vocabulary inadequacies meant that patients and physicians maintained different levels of understanding regarding a diagnosis. For instance, physicians would assume that they had provided a thorough explanation to their patients only to realize that a gross misunderstanding had occurred on the part of the patient. I coded these responses and categorized them as limited vocabulary and assumed meaning.

Responses from the second research question revealed that in situations where language barriers existed, physicians or patients sought the services of an interpreter. In the health care facility, an interpreter is someone who is fluent in the language for which translating is required, and not necessarily someone who has expert knowledge of interpreting. Thus, individuals who have been known to offer interpretation services included patient relatives/friends, nurses, medical doctors, auxiliary health workers, and total strangers.

Even though the services of interpreters are urgently required, an aspect that continued to be overlooked was patient privacy. As will be revealed later in this chapter,
patients experienced some level of discomfort in sharing their health information with
interpreters. Yet, patients did not share their discomfort with their physician. Moreover,
because interpreters offered services on a voluntary basis, they did not adhere to any
ethical guidelines. The implications of such an arrangement meant that patients’
confidential information could not be guarantee as it was unclear whether or not
interpreters shared such information with other persons. Based on these findings, I
developed categories such as perception of interpreters and type of interpreters.

The third research question revealed particular lapses regarding patient disclosure
during medical consultation. For instance, the set-up of consulting rooms in various
clinics (e.g., surgical, urology) compromised patient privacy. Typically, one consulting
room consisted of four physicians, four nurses, four patients and accompanying relatives
where applicable. In essence, unintentional eavesdropping occurred. And because some
patients were conscious about their surroundings, they felt uncomfortable disclosing
information which they considered private.

Another important dimension in disclosure patterns focused on the relationship
between patients and their physicians. As will be revealed in the data, physicians
admitted to reprimanding patients who visited the hospital with a degenerated condition.
Physicians argued that some patients choose to engage in alternative or complementary
treatment such as divinations and herbal medicines before visiting the hospital. Knowing
that they risk being reprimanded for engaging in alternative treatments patients usually
concealed pertinent health information from physicians. Thus, categories for research
question three, included set-up of consulting room, sensitive information and fear of reprimand.

The fourth research question generated contradictory categories. For example, physicians complained that majority of patients chose to disengage in treatment discussions even though physicians invited patient participation. At the same time, patients noted that physicians did not make the effort to provide explanations about their conditions. And even if patients made attempts to inquire, those were often ignored. Moreover, patients trusted their physicians and did not find it necessary to engage in discussions or ask questions. Also, patients in this study indicated that they lack enough knowledge to engage in health discussions, which in their opinion is a technical area of expertise. Hence, the choice by some patients to relinquish all treatment decisions to their physicians. An underlying tension which emerged was that while physicians asked for patient participation, they failed to consider those groups of patients who would need guidance in order to engage in health care discussions. Analyzing the fourth research question proved challenging as patients responses failed to capture the dialogic and relational aspect of their clinical experience. These tensions will be further explicated later in this chapter, and the discussion segment in chapter five.

As I interrogated the various categories for each research question, I discovered the lack of collaboration that permeated the clinical interaction and how pertinent issues were overlooked or taken-for-granted. Consequently, the storyline for this study reveals the subtle differences in how patients and physicians interpret the clinical experience. As a result, developing a core category proved challenging as the research questions varied
distinctively. Nonetheless, a common pattern seemed evident across each finding.

Notably, physician’s responses reflected their knowledge of the constraints and challenges they experienced with their patients, yet they lacked initiative to rectify these exigencies. For instance, physicians mentioned the potential implication of reprimanding patients but argued that it was in the patients’ own interest. Likewise, patients admitted that concealing relevant health information from their physicians proved detrimental to providing them with proper care. I managed to work with findings in order to delineate patterns and categories, not necessarily to define a core category since the research questions varied significantly. In the sections that follow, I provide detailed findings for each research question.

**Limited Vocabulary**

As noted earlier, Ghana has a diverse language environment with over 44 indigenous languages (Opoku-Amankwa, 2009). Nine (Akan, Dagaare-Wali, Dagbani, Dangme, Ewe, Ga, Gonja, Kasem and Nzema) of the 44 languages have been officially approved for use in education and the media (Bodomo, 1996; LaVerle, 1995; Opoku-Amankwa, 2009). Since language plays an important role in medical interaction (Eckler, Worsowicz & Downey, 2009; Jacobs et al., 2006; Karliner et al, 2007) and real differences exist in vocabularies used by physicians compared to that of patients (Herget & Alegre, 2009; Whaley, 2000), I explored how multilingual processes shape physician-patient communication.

In response to questions on language barriers, physicians who participated in this study referenced the use of English language as a medium of instruction in school.
Hence, they enumerated the challenges they encountered when transferring medical vocabularies to the indigenous dialects. Dr. Ayivor, urologist with four years experience explained “as you aware [English] is the official language in Ghana, and students are instructed in English, so we have become used to English words. However, and we have to serve indigenes who don’t necessarily speak English, and it can be very challenging.”

In a similar version, Dr. Abdul, a male dermatologist with four years experience noted:

…sometimes it’s difficult; you have to understand that in our local dialect the vocabulary is very small compared to English, even when you are trying to break down your medical terms into English it is sometimes difficult for the patient to understand. I think those are some of the concerns I have.

Dr. Ayivor reported that, “since patients visit from all over the country, you never know what language problem you are likely to encounter.” Dr. Abdul also added that “typically, Twi or Akan is the popular dialect that patients and health workers use in this hospital. However, dialects such as Ga, Hausa and Ewe are also common.” All physicians in this study agreed with Dr. Abdul in terms of the language difficulties.

Although Twi emerged as a common language for interaction, I discovered that concerns existed about cross-language transfer of vocabulary related to health (i.e., from English to an indigenous language). Stated differently, not all English terminologies have the complete equivalents in the Ghanaian languages, partly due to different conceptualizations or unavailability of such culture aspects in Ghana. Dr. Ofori, a female surgical oncologist who has been practicing for seven years noted, “…cancer language can be very dense, we have terms such as radiotherapy, chemotherapy, biopsy and many
And to be honest with you, I do not know the Twi names for these procedures.”

Even if an equivalent existed, physicians did not know it. In his experience, Dr. Ntuklu, a surgical oncologist with 15 year of experience noted:

Sometimes too, I discover that if am using the Ghanaian language, I don’t know the name of a particular organ. For example, I was explaining to a patient that he had a tumor in the bladder, and I didn’t know the word bladder in Twi, so here is what I did. First, I explained that there is something which makes the urine and then it is transported into a sack… with this mental picture patients understand that they have a sack somewhere in the pelvis which is emptied from time to time and that’s where their health problem is coming from. A fair idea of what problem they have helps them understand a possible surgical procedure, and also reinforces medication compliance.

Indicating some of the challenges associated with explaining diagnosis using the indigenous language, Dr. Issaka, an orthopedic specialist who speaks fluent Twi and has been practicing for six years described the situation, “can you imagine having an x-ray for a patient and trying to let the patient understand in simple terms what osteoporosis means?”

The issue of non-equivalent health vocabulary in local Ghanaian languages was also shared by Dr. Offei, a female dentist who has been practicing for three years. According to Dr. Offei, “in the field of dentistry, it is very challenging, because the Ghanaian languages don’t have same English words to describe certain conditions related to the mouth or teeth… I use everyday examples and I hope that they get it.” In an effort
to ensure clarity, Dr. Ofori, shared how she used everyday analogies to convey a health situation to her patient:

I have had patients who had leukemia, but trying to explain it in [Twi] was practically impossible, so I tell them it’s like a factory…that is suppose to produce milk and milo, and suddenly someone decides let’s just produce milk, so then the other product like milo goes down. It’s the same thing that happens to the body, there are white and red cells, which the body needs. But if there are too many white cells and we’ve got red cells in fewer quantities, then there is a problem …and I will not use leukemia per se because chances are they will not understand.

Dr. Ofori also added that the process of explaining diagnosis in the Twi language can be laborious, and sometimes she is not sure if the patient fully understood the explanation. The issue of limited vocabulary, as explained by physicians, can be further compounded in situations where a patient is less educated. In his experience, Dr. Amartefio, a male diabetes specialist, noted:

Translating the medical terms even to people who speak English can be tough. With the less educated person it’s really difficult getting them to understand diagnosis, so sometimes I have to use pictures to be able to communicate. And there are instances where I get the feeling I did not communicate well but that is not my fault because the language is not just coming. As time goes on, I try to build my vocabulary in some of the local languages.

Using analogies appears to be the plausible means by which physicians help patients, especially those with low literacy levels to grasp the meaning of a diagnosis.
Still on the concept of limited vocabulary, Dr. Ntuklu, not only mentioned the potential limitations within the indigenous vocabulary but indicated that sometimes he was not sure if his patients really understood explanations about diagnosis:

For me, it is not difficult to understand my patients, but it is difficult for them to understand me. For instance, if I have to explain a medical terminology, or say cancer to an illiterate person, I have to give analogies and sometimes it may go the other way. Because what you are trying to communicate, the person takes it literally and it backfires. Then I have to give two or three different analogies in order for the patient to understand their condition.

Apart from physicians drawing analogies to explain a health condition to a patient (especially those with low literacy levels), concerns about how patients explain their condition during the consulting process were also discussed. Dr. Ayivor offered some instances:

It’s even difficult explaining to the patient, and even if they get it, it’s equally challenging giving back the information I need. The way they would go about it… for instance, a patient who says their back hurts, and then you ask the patient what is the pain like? And the patient goes like “it is going all through me, it would go this way and come that way” … I mean this doesn’t follow the rules in medicine, I mean … you can’t fathom what they are saying and it becomes very difficult making a diagnosis. I don’t know how many accurate diagnosis you can make from descriptions of this kind.
Dr. Ayivor’s comment that patients’ explanation of their health condition is sometimes incomprehensible is not peculiar to Ghana. Challenges that participants experienced with vocabulary limitations have also been noted elsewhere. For example, in a study conducted in Angola, Matheson (2009) found that many people in Angola do not speak Portuguese which is the official language. And in health care settings, medical words do not have translations in ethnic Angolan dialect. Matheson further noted that even with skilled translators, language barriers exist.

Comments related to limited vocabulary also emerged from patients during our focus group discussions. Patients in this study (all illiterate) expressed the challenges that they experienced either in trying to explain, or understand their health condition. Kwame, a 45 year old taxi cab driver recovering from hernia surgery, noted “although I understand and can speak Twi, sometimes I find it difficult expressing myself, especially when the doctor demands detailed explanation of my [illness], like how I am feeling …” Similarly, Serwaa, a 62 year old trader diagnosed with breast cancer, stated “sometimes when the doctors are explaining this whole cancer thing and the associated treatments that I have to go through, I find it difficult to keep up, as they keep going on and on.” Serwaa’s comments connects with physicians statements of using analogies or stories to ensure that patients have a better understanding of their condition. Serwaa openly admitted her low literacy level and commented that “I wish I could read, that way I could understand what the doctor writes in my folder, the types of medicine am taking and a better idea of my illness.”
Related to the experiences which patients in this study shared, Matheson (2009) again noted that many illiterate patients in Angola do not have a scientific comprehension of their body. As a result, they visit the hospital with complaints such as “I have a snake in my body biting me” (p. 1197). In trying to understand the difficulties that patients encounter and how they explain their symptoms, we realize that choice of language is dependent on the vocabularies that an individual is familiar with, and how best they can express themselves using the language that they speak. Unlike the patients in this study, I have not encountered difficulties with the indigenous dialects as I have always communicated in English whenever I visited a hospital in Ghana. However, as I reflected on the responses from participants, I realized that I would virtually be unable to provide an indigenous dialect equivalent of various terminologies as they pertain to health care.

As detailed in the literature review, language is vital to how individuals construct meaning. Therefore, the manner in which vocabulary limitations of indigenous dialects shape participants comprehension of the medical experience is discussed in the next section.

**Assumed Meaning**

As detailed earlier, participants in this study expressed concerns about the limited vocabulary in the indigenous dialects. Regardless of these challenges, participants explained that they managed to “get by” when communicating in the indigenous dialect. Yet, a concern that emerged from this data was whether or not patients clearly understood various explanations about a health condition. Physicians cited instances where they believed that they understood a patient’s explanations, and assumed that patients
interpreted questions and instructions clearly, only to realize that there had been serious misunderstanding on the part of the patient. Dr. Akwetey, a female diabetes specialist with nine years of practice, described her experience:

At times too patients are not able to assimilate what I tell them, and then they will come back a week or two later and ask the same questions again… I expect them to have picked certain things that I said. Unfortunately this is not the case. In situations where I am not available and a colleague has to treat my patients, there have been cases where patients have said I told them [nothing] about their condition. Then my colleague will look through their folder and ask “didn’t the doctor say this and that?” and the patient goes like, “I didn’t understand”… sometimes it can be very frustrating.

Other physicians mentioned that they provided the necessary information to their patients, yet, they experienced instances where the patient did not seem to understand explanations. Re-echoing Dr. Akwetey’s comment, Dr. Parkins, a female dentist with 18 years of experience, noted:

When patients’ come for review, you realize that there are things you said that really didn’t sink in, and I have to [repeat]. I find this not only in my field because other doctors complain about the same problem… hmm! It’s as if we have not said anything to the patient. But I am sure I said something, so what I actually do is to write down whatever I say to the patient that way if they come back and say I didn’t tell them something, I can refer to my notes in their folder.
Concurring with her colleagues, Dr. Ofori shared a few lessons she had learned over the years of interacting with patients and the steps that she takes to ensure better communication:

Hmm...! Let’s say I have learnt a lot from the patients; not to make an assumption, because I used to make assumptions. I feel I have explained things fully so I go like “any questions” and the patient says [no] then I continue “do you understand”? And they say [Yes]…am happy but the patient comes next time and I realize they are asking questions I thought I had covered in their previous visit.

So I have learnt to always try and review what we’ve discussed.

The realization that patients did not understand explanations about their condition not only served as a source of frustration for physicians, but also resulted in treatment delays.

Dr. Ofosuhene, a female urologist with 11 years of experience, lamented “I had a patient who needed to be referred to a tertiary center for management. After explaining his condition, he apparently didn’t understand and came back two weeks later without visiting the consultant…can you imagine?” In addition to possible treatment delays, Dr. Asare, a female diabetes specialist with 27 years experience, referenced the potential misdiagnosis that can occur if physicians do not make an extra effort to ensure a common understanding between themselves and their patients:

It is important to communicate well with your patient because they come with stories. For example, in this environment, patients especially the illiterate come and tell you they’ve got what is called “koko” and actually it is supposed to be hemorrhoids but they may be having another condition, so as a doctor, if you
don’t probe thoroughly, you will focus on the rectum and overlook that actual health problem.

Apart from comments from physicians, I also witnessed first-hand a miscommunication which had occurred between a physician and their patient. During my field work, I asked some physicians if I could “sit in” during the consulting process. To my great surprise, some of them agreed on condition that the patient also provided consent and that I did not audio tape the encounter. Fortunately, a handful of patients said “yes.” I observed the following scenario when I was invited into a consulting room in the surgical unit. After reviewing a patient’s folder, the physician said, “I treated you last week for a condition and asked you to purchase some medicine, have you done that?” The patient responded that he did not know he had to purchase any medicine. Moreover, the patient seemed to have misplaced the prescription, so the physician had to issue a new prescription and requested a nurse to accompany the patient to the pharmacy. After the patient had left, the physician informed me that such occurrences were common. During the interviews, it became evident that, occasionally, physicians’ grasp of patients’ narration did not reflect what the patient meant. Recounting her experience, Dr. Sackey, an orthopedic surgeon with 15 years of practice, noted “sometimes it gets a little [confusing] when after a patient finishes his/her narration, I try to review what they said only for them to say that my understanding of their illness is not necessarily what is happening to them.” Dr. Sackey further stated that, “to avoid such occurrences and possible misdiagnosis, I ask multiple questions to get a better comprehension of patients’ illness.”
Patients in the focus group discussions also confirmed physicians’ assertions about comprehension issues. For majority of these patients, they only have a vague understanding of their condition. For example, comments such as “sometimes how the doctors explain the lab report can be very confusing,” “when you leave the doctor’s office, you are not sure whether or not they understood what you said because some of them don’t ask any questions, they just write a prescription.” Overall, these excerpts reveal how the process of information exchange might result in meaning shift. Further, the data suggests that meaning shift is possible even if interactions occur in the same language. Dougherty, Kramer, Klatzke, and Rogers (2009) also maintained that in situations where there is language convergence and meaning divergence intended meaning may not be conveyed and interpreted as expected.

In summary, responses from my first research question detailed the use of indigenous dialects for interactions as well as concerns about medical terminologies that were either non-existence or unknown to participants. Further, I elaborated on the possible misunderstandings and meaning shifts that occurred even when the same language was spoken. In the section that follows, participants provided feedback on how they facilitated communication in situations where clear language barriers existed.

**Interpreters**

Although interacting in the indigenous languages created one-on-one moments for patients and their physicians, often language barriers occurred and these required the services of an interpreter. Focus group discussions about how patients coped with language barriers revealed that, health care providers will usually ask if there is an
accompanying relative or friend who could provide translation. In cases where the patient could not find an interpreter, health care providers ultimately find someone to help. According to patients in the focus groups, “the rationale for visiting the hospital is to seek medical treatment, therefore if you cannot communicate directly with the doctor, and there’s someone who can facilitate the process, then you’d have to work with that.” Consequently, patients in this study provided limited perspectives about interpreters. Thus, responses on this topic captured more of physicians’ experiences.

Physicians who participated in this study stated clearly that, to the best of their knowledge, the health facility does not provide interpretation services. This assertion was also confirmed by nurses during my field observations. I also discovered that the provision of trained or professional medical interpretation services is not part of the Ghanaian health care system. Responses from participating physicians indicated that, they depend on nurses if a patient needs an interpreter. However, if a nurse does not speak the patient’s language, physicians seek the assistance of other health providers, the patient’s relatives, friends or ad hoc individuals to help with interpretation. Dr. Afram, a female oncologist surgeon practicing for 11 years described the situation:

Usually most of our patients come with their relations. If their relations speak English, I use them as interpreters. In the absence of that, I call on some of the nurses around who could give me that interpretation service, when that doesn’t work then I may have to find around the hospital whoever is available and understands that particular language to help me with the interpretation.
According to Dr. Ofori, relatives and nurses act as the foremost group for interpretation needs:

First thing I look out for is accompanying relative, chances are that the relative will be able to tell me what’s wrong with the patient. I also rely on other members of the team; either doctors or nurses. In our unit, one language barrier that keeps coming up is Ewe dialect. Fortunately, we have two or three Ewe speaking nurses so we tend depend on them a lot. Being part of our team, the nurses understand the diagnosis, and are able to elicit or provide information to patients.

Dr. Awuku, a male oncologist with 10 years experience, agreed with his colleagues on the ever present language barriers and reliance on interpreters:

I worked in a district hospital which I mentioned earlier on. In that region more than half of the people speak Dagomba…more often than not; patients cannot speak a language that I understand. In such cases, I just call in somebody to do the interpretation. Of course! Interpretation has its own barriers, but since we are without eh…the proper form of communication that’s the best we can do. The same thing happens here in the teaching hospital… I don’t speak Ga, so there are some patients who come in and they can’t speak even a single Twi or English, in order to treat the patient, I will eventually have to call in somebody who speaks Ga to do the interpretation.

Commenting on the use of interpreters, Dr. Ayivor mentioned that, “there have been occasions where I have had to require the services of another patient… because the patient who needs to be treated speaks a language which none of the health workers can
understand.” While Dr. Ayivor recognized the potential concerns related to using another patient as an interpreter, it was clear that, sometimes, that was the only option available.

From the responses provided, physicians prefer to use nurses as interpreters although interpreting is not part of nurses’ job description. In situations where nurses experience a language barrier, physicians tend to rely on relatives, friends, other patients or whoever is able to help with interpretation - a situation which I experienced firsthand. As mentioned earlier, I obtained permission to “sit in” on some consultations. In one such occasion, a physician asked if I could offer interpretation for a patient. This patient happened to be a middle-aged lady with a huge lump beneath her chin. She could only speak Ga, and not Twi, which appeared to be the only indigenous dialect that both the attending nurse and physician could speak and understand. Since the physician was aware that I could speak Ga, he asked the patient if she would allow me to be their interpreter, and the patient agreed. On another occasion, I had to interpret for a 65 year old man who was suffering from hernia. In both instances, I noticed how the three-way interaction was restricted to a question-answer format. In addition, I realized that those patients who depended on an interpreter tended to ask few questions.

On the contrary, interactions seemed more relaxed and lasted longer if the patient and physician spoke the same language. For instance, during one of my observations, the patient was a 15 year old lady who spoke fluent English. I noticed how she kept asking one question after the other and how the physician responded as he could. As I reflected my short role as an interpreter, I began to imagine on how difficult it might be for a patient to have to confide in a total stranger, and knowing that such patients did not have
any alternative. While I do understand the urgency of providing an interpreter for a patient, it is also important to consider the privacy and disclosure issues that might surface when relatives, friends or ad hoc personnel are used as interpreters. For instance, how much information is a patient willing to divulge to a total stranger? What is the guarantee that the patient’s private information will be kept in confidence even by relatives or friends? Unfortunately, these questions cannot be answered holistically because the culture of medical interpreting is not formalized in Ghana, nor is literature available on health care interpreting. Therefore patients have little leverage over who should interpret for them.

Nonetheless, research on health care interpreting in other parts of the world suggest that interpreters play a valuable role in bridging language barriers and enhancing the physician-patient interactions (Angelelli, 2004; Dysart-Gale, 2005; Hsieh, 2007, 2008, 2009, 2010; Jacobs et al., 2006). Even so, concerns emerge about how interpreters without any formal training in medical translation adversely influence a communication encounter (Flores, 2005; Rosenberg et al., 2007, 2008). This concern becomes relevant in the Ghanaian context where the data from this study suggests that no formal interpreting services can be accessed by patients and physicians. In essence, no guidelines exist for clinical interpretation. Consequently, in the section that follows, physicians shared their opinions and experiences in relation to interpreters.

**Physicians’ Perception of Interpreters**

Overall, physicians acknowledged the importance of interpreters in bridging language barriers and facilitating the interaction process. Yet, physicians also shared
their experiences on how interpreters shape the communication process. According to Dr. Ofosuhene, “using an interpreter helps, it’s such a relief, but I wish I could communicate directly with all my patients.” Other physicians also enumerated particular concerns when using an interpreter. In his experience, Dr. Safo, a diabetes specialist who has been practicing for nine years, explained:

Most often, the interpreter is able to help me get a good history in order to make a diagnosis. However, I also realize that sometimes the interpreter does not understand the questions that I ask the patient; they either end up summarizing or do not appreciate why I need detailed response from the patient. In some cases too, I can sense that the patient is withholding vital information because of the presence of the interpreter.

Dr. Safo’s statement reveals the possible privacy issues that patients encounter when interpreters are used. Besides over summarization or withholding information, participants expressed concerns over message transformation. Dr. Afram noted:

Sometimes during the transformation of the question… from the doctor to the patient, the interpreters are sometimes not able to give the exact question or the exact probing question you the doctor are giving…[but] what else can I do than to work with whatever information I get. And sometimes when information is being given back through the interpreter, sometimes I don’t get the answer I expect.

Dr. Afram also added that, “in situations where the interpreter is unfamiliar with a highly technical term, I try to simplify things for the interpreter. However, I am able to tell that they have a difficult time explaining to the patient.” Sharing her experiences, Dr.
Akwetey asserted that using an interpreter is associated with limitations because “most of the time, they are not able to convey what I actually want to the patient and vice versa.”

In addition to possible miscommunication, Dr. Agyei, a female diabetes specialist with 20 years experience, maintained that using interpreters prolonged the consulting process:

…using interpreters amounted to spending too much time with a patient,

I feel that the use of interpreters prolong the interaction time, there is always some doubt about the quality of information received and passed on from and to the patient respectively…sometimes what I mean is not exactly what is communicated…at times the interpreter gives answers in way he/she understands and not the way they were said by the patient. Much as it may not give the best of interaction needed for doctor-patient, we also cannot provide proper care for patients without interpreters.

Elaborating on the various issues associate with using interpreters, Dr. Zak, a male epidemiologist for nine years, was more worried about the lack of trained medical interpreters:

We don’t have trained interpreters, and sometimes it affects the quality of care. Because even though I don’t understand a language I realize that there is over summary because the patient will say a lot of things and the interpreter says a sentence or two and I realize that some information in missing. Since I am trying to have a diagnosis I base my analysis on the information that I get, but sometimes I feel that a trained interpreter will do a better job.
Although Dr. Zak would prefer trained interpreters, it is unclear when a service of the kind will be provided within the Ghanaian health care system. To make the best of out of their situation, physicians in this study indicated that nurses are the most preferred option for providing interpretation services. They argued that nurses can be more trustworthy and are also knowledgeable about medical issues.

Unfortunately, physicians do not always have the luxury of using nurses as interpreters. Therefore, family members, friends, and ad hoc personnel are routinely invited to help with interpretation, and this poses challenges. As detailed in the responses from physicians, using untrained interpreters resulted in omission, addition, substitution or incomplete rendering of information.

Apart from lapses regarding information exchange, using untrained interpreters raises concerns about patient privacy. As mentioned earlier, medical interpreting services are unavailable in Ghana, thus, interpreters are unaware of any ethical guidelines about protecting the privacy of patients. Consequently, health care seekers and practitioners face the possibility of conflict of interest, personal judgments and biases which might influence objectivity on the part of the “untrained” interpreter.

Concerns expressed by physicians regarding the services that interpreters render are not peculiar to Ghana. For example, in terms of finding appropriate terminology, a study conducted on tensions and challenges of using trained interpreters revealed that, “providers expect interpreters to find equivalent medical terms and transfer the exact information across different languages” (Hsieh, Ju, & Kong, 2010, p.173). Overall,
comments by physicians in this study, suggest that fluency in a local language does not equal competency as an interpreter, especially in terms of health related matters.

**Type of Interpreters**

In addition to the issues raised in the previous section, the question of whether or not trained medical interpreters are needed became part of my conversation with physicians. It was obvious that, while information sharing is vital for diagnosis and treatment, the issue of cost and need has to be considered. Stated differently, the potential cost involved in setting-up and/or utilizing the services of trained medical interpreters. In this regard, opinions differed. Dr. Edem, a female diabetes specialist with 13 years experience, suggested that “we need medical interpreters trained in multiple languages. This is because we can get direct translation, so that the distortion can be minimized.” Similarly, Dr. Awuku contended that “it would be good to have professional interpreters because they will be trained, and also be educated medically to understand some of the terms, so that during interpretation, they can provide accurate information.” Even though Dr. Ofori, who is with the oncology department mentioned that their nurses have been helpful in providing interpretation services, she also stated the rationale for trained interpreters:

Em! When it comes to the specifics of oncology, our nurses have quite a fair amount of knowledge, when you stray from that into other medical conditions for instance hypertension, diabetes, etc. sometimes it’s a bit shaky there, so we definitely need people who at least understand the main concept which we like to stress. For instance, medication compliance etc, em… they should be familiar
with those concepts to be able to explain it. That’s the big problem we definitely need interpreters. If its oncology ward, we don’t have a problem, but every time the patient has something else it becomes a bit of a problem. It’s like you want to get someone else to ask the person “what did you hear, what did she say” to be sure that you have got the right information. So if we have trained interpreters definitely it would be good.

According to Dr. Afram, the services of trained interpreters are valuable for a teaching hospital which also doubles as a referral facility:

In Ghana about 60% of the population speaks Twi, so I think most doctors can “get by” but when it comes to other languages, it will be difficult trying to train doctors, but I think it might be easier to have trained interpreters, especially for a big hospital like the teaching hospital where you have people coming from all over the country it would just be nice for us to have interpreter services so that once you need an interpreter, one is readily available.

Much as some physicians will welcome the services of trained interpreters, Dr. Zak tries to put the situation in a larger perspective:

I think that currently what we are having now is not the best, using the nurses and patient relatives as interpreters. So it would be good that we train interpreters to assist the situation when there is a language barrier. But the challenges that we have are the multiplicity of the dialects in the country… all the same we have to start from somewhere, I think it would facilitate our work and enable us provide
better quality services and the privacy concerns will be avoided and patient care enhanced.

While making a valid argument for trained medical interpreters, Dr. Zak also addresses the reality of multiple dialects in Ghana, as well as the logistics involved with providing interpretation services; a dilemma which was also echoed by Dr. Ntuklu:

Though I think interpreter services are needed, the practicalities of it is a little bit difficult. Because if you seek interpreter services, we have a lot of languages in Ghana, how are we going to provide interpreters for all those languages? You may take out some major languages that you think people speak often, but for those major languages, you will find doctors who might speak these languages, so you usually wouldn’t need the services of a professional interpreter as such. But for those other minor languages that few people speak, those are the problems.

Contrary to comments from other physicians, Dr. Yussif explained that providing interpretation services:

…would add to the operational cost because you see in the hospital, there invariably will be someone who speaks that local language. I personally don’t think that we need medical interpreters. In my experience I would say that health workers “get by” regardless of language barriers.

Whereas the issue of cost and need have been well articulated by some physicians, concerns loom about the notion of “getting by,” as reported by Dr. Yussif. For instance, where does “getting by” leave the patient with regard to privacy? If some physicians prefer the “getting by” approach what measures will be taken to ensure that patients’ right
to confidentiality is protected? While it is beyond the scope of this dissertation, I think it is critical to probe further into interpretation services especially for a hospital which is not only the largest in the country, but also doubles as a referral facility.

The data from this study suggests that often bilingual or multilingual health professionals are used as interpreters. The question this generates is: how often does a health worker have to leave their normal work routine to provide interpretation services? Moreover, we do not know whether or not health professionals who double as interpreters are objective in transmitting information and ensuring that patients concerns are duly represented. Also is there a possibility of stream-lining the process by providing short training on ethics regarding medical interpreting? The pros and cons of providing medical interpreting services within the Ghanaian health care system will be further explicated in the discussion segment.

**Disclosure Patterns**

In addition to language and interpretation issues, information sharing by patients posed a major concern in this study. Findings suggested that the decision by patients to share or withhold information during the consulting process is influenced by multiple factors. For example, patients would usually withhold information either because they assume it is not relevant to their case or that the physician already knows. However, four main reasons accounted for lack of disclosure from patients. These include (a) presence of an interpreter, (b) set-up of consulting room, (c) sensitive topics, and (d) fear of reprimand.
Presence of Interpreter

Physicians in this study indicated that, due to the absence of interpreter services and lack of procedure on who qualifies to facilitate communication on behalf of a patient, serious concerns exist about privacy. As I will detail below, physicians shared their experiences and observations regarding patient disclosure behaviors. Physicians noted that sometimes patients are insecure about the confidentiality of information that they convey through the interpreter given that no clear guidelines pertain to the process. Consequently, patients may be reluctant to provide details about some aspects of their private life which might be useful for diagnosis and treatment. Dr. Ofori shared past experiences regarding patient disclosures:

Em… I recall working in the gynecology department; people come in with infertility issues, but when I ask questions, they seem very reluctant and go on all sort of things. It’s even [worse] when you can’t communicate directly with the patient and you have to do it through a family member. Also when I was working at GU (genitourinary) patients who have gonorrhea are unlikely to disclose in the presence of another person. Usually, if the story presented by the patient doesn’t make sense or correlate with lab tests, I send the relative away to go and get medication or pay for services or something. I then find someone else; either another doctor or nurse who speaks the language and ask direct questions. Even then, patients are uncomfortable.

Although findings from this study suggest that family members or friends serve as interpreters, Dr. Zak noted that their presence is not always convenient:
Especially if it should happen that the interpreter is known to the patient then the patient may obscure some of the information especially when it comes to sensitive issues. If I realize that I don’t have all the information and the presence of the interpreter being known to the patient has led them to obscure some of the information, then I will have to go ahead and look for someone maybe another doctor who can do the interpretation.

Sharing a similar perspective, Dr. Edem expressed concern about patients’ unwillingness to articulate their objection of persons who get invited as interpreters:

Patients’ don’t usually speak up, if they tell you forthright that they are not comfortable with somebody else translating then it becomes easier, then I can find out what they are comfortable with. But what I have observed is that when the doctor invites somebody else to translate, whether the patient is comfortable or not they will be [quiet]. But what I am not so sure of is whether they will give all the information. Do you understand what I am saying? In other words, the person who is translating will do their part, but as to whether patients will tell the doctor their real problem is another question.

In addition physicians’ comments on how the presence of an interpreter influences a patient’s decision to disclose certain information, focus group discussions by patients confirmed this occurrence.

Patients in this study mentioned that, they experience tensions between sharing information and remaining silent. Yaa, a hairdresser recovering from appendicitis surgery, noted “even when the interpreter happens to be my relative, I am not
comfortable revealing everything to them, because you never know who they will tell.” Kwame, who was recovering from hernia surgery, also stated that “sometimes it feels awkward to express your illness to a total stranger. If a nurse or doctor is the interpreter, that’s fine, but with someone that I don’t know, it becomes a little difficult…I hope you understand.”

The privacy concerns raised by participants can be examined using communication privacy management (CPM) theory (Petronio, 2002). The theory posits that when individuals are confronted with privacy issues, they experience tensions over whether or not to share such information and with others. Petronio further argued that, in health care situations, a patient’s decision to disclose will also depend on the nature of a person’s illness, cultural values, gender, and the potential risks or benefits which might be associated with disclosing (Petronio, 2007). Other studies have suggested that, issues such as language barriers, and the presence of an interpreter also hinders patient disclosure (Dohan & Levintova, 2007; Julliard et al., 2008; Neville Miller & Rubin, 2007; Petronio, Jones, & Morr, 2003; Rodriguez et al., 2001; Sankar & Jones, 2005).

In this study, the responses revealed that patients experienced discomfort when sharing information through an interpreter. Further, physicians do not provide any guidelines as to how a patient’s privacy should be protected by an interpreter. Might these circumstances explain why some patients are reluctant to tell a physician that they are uncomfortable with a particular interpreter, or is it because patients realize they lack an alternative?
**Set-up of Consulting Room**

An interesting aspect of patient disclosure behaviors pertained to the set-up of some consulting rooms. A brief account of my observations of the physical environment is contained here. This synopsis is specific to the surgical clinics. During these clinics, consultations are held in rooms which are partitioned by polished plywood. Each room has a ceiling fan, no carpet, a hand wash sink, a closet, and simple furniture (large wooden desk and chairs). The walls have been adorned with posters of various health conditions, adjourning the consulting room are two other rooms used for patient examination.

Unfortunately, the consulting room lacks an air of privacy; usually, two physicians share a desk, and a total of four physicians share a room, with two nurse assistants. Because patients can visit with their relatives, if four consultations happen simultaneously, then a consulting room holds a minimum of ten people, excluding family members. This atmosphere underscores patient load and inadequate infrastructure. Until things get better, physicians make the best of out the situation. However, physicians also noted pertinent concerns about how the consulting room atmosphere influences patient disclosure. Dr. Kaiko, a surgical oncologist with eight years experience, elaborated:

There is no privacy in the clinic because I may be seeing one patient and another doctor is also seeing a patient in the same room, and sometimes the two of us maybe sharing one table. So if a man comes and has a problem with their genital area, they are not able to say it...hmm! They just point to the area; I then realize that the patient is not comfortable so I tell the nurse to find a room for me to
examine the patient. The reality is, some of the questions have to be details about their sexual habits, and it’s not comfortable.

When asked whether or not patient confidentiality is breached due to the set-up of a consulting room, Dr. Ofori explained:

This happens a lot, there are more than two doctors in one room. But in this department, the conditions which come here are not really frowned on or stigmatized in the society so you get the feeling that the patients don’t really mind talking about their problems in the presence of other patients, as opposed to issues of fertility, genital infections, or other illnesses that are frowned on in society. For those situations, it’s even difficult for the patients to discuss that with a doctor, especially if a third person is present. And it’s a problem, even if you don’t have two doctors in one room, you are just separated by a thin partition and the person next door can hear whatever is going on in the other consulting room. So confidentiality is a real problem.

As stated by Dr. Ofori, in some cases, privacy may not be a problem due to the nature of a patient’s condition, but patients may still find themselves in a dilemma. For instance, the decision to disclose private information which might be audible to other patients in the consulting room, but aid in medical treatment, or the decision to remain silent. Dr. Yussif also reiterated concerns about sharing a consulting room:

Health worker patient communication in Ghana is difficult, if the patient comes and has a problem that she/he doesn’t want to share openly. The set-up is that even if she/he is sitting in front of the health worker, immediately she/he talks, if
you are a few yards away you will hear. It’s gotten worse, I took my cousin to see a urologist and there were two other doctors by his table talking to other patients. And I was like this is a consultant, how come there are two other doctors? I have never seen anything like what I saw at the urology dept, and situations like this leave the patient in a vulnerable state because they are not sure about who is listening and how to present their case.

Elaborating on the infrastructure situation, Dr. Nsiah, an oncologist with 13 years experience, lamented:

…you know some patients leave and they are not satisfied not because the doctor is not well trained but the environment did not allow them to say all the things they came to hospital for…sometimes when the patient is leaving the consulting room, he/she would return and say “there is one more thing” or sometimes they go away come back in a week’s time, and I am like, your medication is not finished, and they go like, “the last time I came to see you, I did not tell you everything” then they look around the room, and if there aren’t any other patients/doctors there, they begin to speak about other intimate issues.

Commenting on the set-up of consulting room, patients in the focus group expressed concern only when they must discuss a sensitive topic. Kojo noted:

…and sometime last year when I had submitted my lab report to the doctor, she asked how many sexual partners I had… such questions can be embarrassing but anyway, I said I had one partner but actually, I have two girlfriends. I didn’t mean
to lie but you see, there were these other patients, doctors and nurse in the room, and I didn’t want them to think I was promiscuous.

From what I gathered, patients hardly question any situation, let alone infrastructural issues. Often, patients indicated that they tried to cope with whatever form of privacy that they are accorded. In terms infrastructural problems, my field observations revealed that not all clinics within the health care facility experience problems with the set-up of a consulting room. In essence, physicians have to determine what can be done to provide privacy for patients who visit the surgical or other clinics where the consulting room is a shared space.

**Sensitive Topics**

Another sub-category about potential reasons why patients might not disclose information is linked to the nature of their illness. In order to put things into perspective, I will draw from CPM theory (Petronio, 2002; Petronio & Reierson, 2009). As detailed earlier, CPM theory posits that individuals develop privacy rules based on their cultural values, gender, assessment of potential risks-benefits, and the situational context. In this study, participants’ responses reflect such behaviors. For example, physicians reported that in their experience, patients seemed reluctant to share, or struggled with the presentation of conditions which bothered on sex, genitals, stigmatizing disease such as gonorrhea or HIV/AIDS. Dr. Issaka explained:

When a patient’s problem is a little bit on the private side, especially when it has to do with pelvic region, or with respect to sexual activity, it takes a long time to tease the information out of the patient. And that is because some people have
deemed it as culturally inappropriate to talk about these things…you can’t just come and talk about coitus in front of an unknown person.

Elaborating on issues of patient disclosure, Dr. Yussif noted that, if a history does not reveal much information and patients exhibit a lot of hesitation during the consulting process, a physician must probe further to avoid making a wrong diagnosis:

I will tell you my experience as a young doctor. I treated a patient based on the information he had provided. However when I wrote the prescription and told him he could leave, he was still sitting. So, I said “oh, I think I have finished with you” Then he says “you think I will be ok?” Coincidentally, I asked “what about your sexual relationship with your wife?” Then he says ah!ah! Madam “enonso ka ho” meaning it’s also part of the problem. Apparently…he had sexual dysfunction, but couldn’t tell the female nurse during the history-taking session.

Physicians asserted that patients deliberate disclosures on many levels. Dr. Safo, a diabetes specialist with nine years experience, noted that non-disclosure is prevalent with patients who have HIV/AIDS:

I remember once a patient asked me “so is AIDS that serious?” she was a patient at another hospital and she was supposed to go for Anti-Retroviral Drugs and because of that she switched to a new hospital. Actually, she had a reaction to some medication, and was rushed to this hospital and later on she confided in me that she didn’t want to go back to the previous hospital because she didn’t want her friends to know that she was at the fever’s unit which is where HIV/AIDS patients are admitted.
The comments suggest that patients experience some level of embarrassment when they have to share sensitive information directly with their physicians.

Apart from participants’ comments, my field experience regarding patients’ presentation of sensitive information is contained here. During one of my consulting room visits, a middle aged man in a wheelchair visited with his mother. According to the mother, the patient was suffering from tuberculosis. Upon reviewing his folder, the physician asked the patient whether he had told his mother about his condition, but the patient responded in the negative. Apparently, the patient was HIV positive, but he had concealed such information from his mother. This scenario is a manifestation of how difficult it might be for some patients to seek treatment or access counseling, especially when they do not want family or friends to know. In this particular instance, the physician went ahead to break the news to the patient’s mother. Later on, I asked the physician why the patient’s privacy was not protected. The physician responded that, since the patient was getting weaker, it was important to inform his mother. That way, the patient’s mother will be provided with the necessary support and resources on how to care for the patient.

During the interviews, I asked patients about the kind of information that they might be uncomfortable sharing with their physician. Three male participants responded that for topics such as sexually transmitted diseases, HIV/AIDS, psychiatric conditions or alcohol abuse, they would deliberate whether or not to fully disclose to their physician. When I probed further, Yaw, a 52 year old carpenter recovering from an orthopedic surgery in the right femur explained “let’s say I discover I have gonorrhea, and I tell the
doctors, they will think that am a womanizer and will ask that bring my partner to hospital so we can both be treated, it’s an embarrassment.” Asked how he might seek medical help, Yaw said he would rather talk with close friends who might suggest some over-the-counter medication for him to purchase. Kwame, another male participant seemed to agree with Yaw. Kwame stated that, “I would be more comfortable disclosing to a male physician than a female.” Although other patients agreed that certain health topics are difficult to discuss with a physician, they exhibited a more positive attitude toward disclosure. For example, Akua noted that, “discussing topics such as yeast infection can be somewhat embarrassing, but it’s important to tell the doctor in order to receive proper treatment?” As previewed earlier, an individual’s discussion to disclose information is dependent upon their assessment of potential risks or benefits (Petronio, 2002; Petronio & Reierson, 2009).

**Fear of Reprimand**

An intriguing sub-category which I discovered about disclosure, centered on the manner in which some physicians relate with patients. Physician participants in this study contended that some patients might be reluctant to share information because of the fear of being yelled at, or rebuked for reporting late. Although I was a little surprised by this revelation, I appreciated the honesty with which physicians shared this information. Dr. Boyema, female dentist with 11 years experience, explained:

Most of our patients don’t present early. In most cases, they may have visited other places, administered some herbal treatment, etc. As a result, they are always afraid that the doctor is going to scold them about why they didn’t visit the
hospital early enough. So during the consultation, they’d rather give you reasons they didn’t come to the hospital early instead of focusing on explaining their condition.

Dr. Konadu, another dentist, noted that illiterate patients usually hesitate in sharing information about their health condition:

I sometimes notice that illiterate patients are very quiet and would rarely speak unless you ask questions…sometimes that is basically because they delay in coming to the hospital. In our setting, when patients report late, are reprimanded either by the nurses or doctor. So in the patient’s mind, the fear is that if they divulge that they’ve problem for this number of weeks or months, the health worker is going to shout on them. And this sometimes makes them scared to the extent that they are untruthful about how long they have had the disease just so they avoid that kind of condemnation or reprimand.

Lamenting on the issue, Dr. Abdul noted that “apart from illiteracy, financial constraints seem to be the reason why patients present late.” Dr. Abdul further mentioned how complicated and deteriorated certain conditions get before they are brought to the hospital, which sometimes explains why health workers speak a little harshly to patients.

When asked why they reprimand patients, Dr. Parkins explained “in a unit like dentistry, where I perform maxillofacial surgery, patients usually say that they had either been using herbal medicine or engaging in spiritual prayers.” Dr. Parkins maintained that physicians should be honest with a patient about the potential consequences of late treatment. Agreeing to earlier comments, Drs. Ntuklu, Yussif, and Allotey acknowledged
the potential implications of reporting late. However, each expressed concerns about the manner in which some physicians reprimand patients. Dr. Ntuklu noted:

The main thing is not to get angry or annoyed when patients come late to the hospital. That has been a problem, even though it’s late and some doctors feel that they could have done better if the patient had reported earlier, it is not good to take it on them, because that is the main reason why patients withhold information.

Dr. Yussif also added:

In terms of the patients, there could be some form of public education for them to understand that the information they give the doctor is what we work with. For instance, if a patient goes to a traditional doctor or herbalist, this healer seems to know everything about their illness. As a result, some patients don’t realize that the hospital is different and that it is the information they give to the doctor that will help with a proper diagnosis. They think that if we do a laboratory test or x-ray we must know everything about their illness, but it is not so.

Dr. Allotey provided an episode of patients’ experiences during their medical visit and why rebuking the patient might not be the best approach:

Some health workers have no patience…imagine a doctor has prescribed red, white, yellow, different colors of tablets, lotion, and syrup for the patient. The pharmacists don’t take time to explain the dosage and the patient being illiterate cannot read the dosage on the package. More often than not, the patient ends up administering the medicine wrongly. Eventually, when the patient is back for
review, the health worker is angry and says “is that how I instructed you to use the medication?” but we health workers sometimes forget that the patient is ill and vulnerable.

It is clear from the responses provided that not all physicians reprimand their patients. However, it is important for physicians to realize how their behavior influences a patient’s decision to share relevant health information (Forbat, Cayless, Knighting, Cornwell & Kearney, 2009; Sparks & Villagran, 2010).

Still on the issue of reprimand, patients in this study described instances where they concealed important information because they were afraid the doctor or nurse would yell at them. During my interview with Akua, a 36 year old vegetable seller and a diabetic patient, I asked whether or not she had experienced any form of reprimand. In her response, Akua said:

The nurses and doctors on this ward are really nice but others are not very nice. I remember when I delivered my 2nd child - after the delivery, one nurse came to the ward to warn us that if we soiled the bed sheet with blood, we are in trouble. So, even though I was bleeding after delivery, I concealed it with a pad and did not tell the nurses or doctors. However, there was this other patient sleeping next to my bed, she complained about my bleeding and rushed to call a nurse. Apparently, my condition was worse than I envisioned, but because of the nurse’s earlier warning, I was scared to speak up.

Akua’s story is not only tragic but pathetic, and her fear of asking for help is disturbing. Unfortunately, Akua is not the only person who had such an experience.
In response to what he knows about diabetes, Kojo, a 65 year old tailor and a diabetic patient who was recovering from an amputation of his left limb, explained “I don’t want to be inquisitive, I know it’s my fault, I have a drinking problem. I take in a lot of alcohol after work, so I think that must have caused it.” When I asked if he had mentioned his drinking problem to his physician, Kojo responded in the negative. He added “I am sure the doctor is already upset with me. Because when I was admitted at the ward, the doctor mentioned that my leg could have been saved if I had reported early.” I gathered from our conversation that, although Kojo had already taken a personal decision to stop drinking, he was not prepared to discuss the issue with his physician. Linking Kojo’s interview to earlier explications from physicians about patients concealing relevant information, Kojo wanted to avoid a conversation with a physician which might result in a rebuke.

My interrogation of the excerpts in this section generates a few observations. First, do physicians consider the vulnerable state of their patients? How is a patient to react when he/she is greeted by an unfriendly health care provider because he/she reported late to the hospital? The fear that patients entertain over the reprimand that they might receive from their physicians’ is contained in how participants in this study interpret the relational aspect of health care.

Relinquishing Agency

In response to questions about dialogic and relational aspects of care, participants shared their experiences. For example, physicians in this study elaborated on patients’ lack of participation. They enumerated problems with patients not showing an interest in
knowing the details of their health problems, disengaging in the treatment plan, and relying on the physician to make all decisions. Further, physicians commented on the need for low literate patients to invest time in their health. As detailed in chapter three, I employed the term “relinquishing agency” to describe a patient’s choice to not engage in health care decisions (Shalowitz & Wolf, 2004). As such, categories in this section focus on patient disengagement and disavowal behaviors, as well as their level of participation in treatment decisions.

**Disengagement**

Focusing on the importance of patient involvement, Dr. Ofori describes an unspoken culture which suggests that patients are not to question their physicians:

> Well, in Ghana I think it’s…err…it’s something that patients have come to expect. A lot of patients will tell you that they are not allowed to ask questions in the consulting room and, if you ask them which doctor said don’t ask, they can’t really tell, but patients kind of expect that you don’t have to ask questions, and that’s a big problem now because increasingly we are dealing with conditions that require patient participation. The patient must be in full control of their treatment plan…diabetes, hypertension, chemotherapy, etc. the patient must be a partner. But unfortunately the prevailing thing is patients are afraid to ask questions. You see so it’s a big problem.

While Dr. Ofori has no doubt that her patients trust her medical expertise, Dr. Ofori also believes that, with the increasing nature of chronic illness, patients must play a vital role in managing and monitoring their own health. Unfortunately, that level of engagement is
still lacking among some patients. According to Dr. Nsiah, it bothers him when patients assume that physicians should just fix a problem without involving the patient on any level:

One concern I have had is when the patient just thinks that I should solve their problem and don’t want an explanation to what problem it is. And yet as a doctor, I know that this condition is not a cure business it’s a management process and it might take a long time.

Dr. Nsiah further noted that, at the oncology department where they deal a lot with cancer issues, health providers must educate patients on the various levels of treatment in relation to the nature of a cancerous organ. Dr. Nsiah elaborated on patients’ disinterest in gaining relevant information, and a focus on cure:

Another challenge I face more especially with respect to the cancer problems is when the patient can’t appreciate the reason for surgery and thinks that I should give drugs to solve the problem. A common occurrence is breast cancer, once I tell someone that the lab report says your breast is cancerous, drugs cannot solve the problem so we will have to take off your breast – then it means they are not coming back to the hospital… At times you cannot blame the patient. In our Ghanaian setting, native/herbal treatments have promised a cure… therefore the patient does not appreciate the importance of surgery. When they leave sometimes they don’t come back to the hospitals at other times they return when the condition is deteriorated… such situations are very disturbing. Even those we have assumed are very literate still don’t get it.
Confirming previous comments, Dr. Afram also noted that patients are less interested in knowing the cause of their condition and more eager to receive medication:

The main problem with some patients is that at the end of your diagnosis when you try to explain to them what the problem is, they find it very difficult to appreciate. Most of them are interested in getting medicine that will make them feel better. They are not concerned with explanation, that’s what I have noticed mainly about the illiterate patients.

Speaking about illiterate patients, Dr. Boyema emphasized that patient participation is lacking on many levels. She stated that, “about 60% of the patients I treat are illiterate; they are not interested about their illness, let alone taking part in the management process.” Elaborating on participation levels, Dr. Abdul wishes that interactions with patients will be more of a partnership:

I wish patients were more involved…I tell them about options for management and they tell me to do whatever is best for them. I think it’s because they can’t appreciate what is going on with their health due to their level of literacy…I am hoping that my interactions with patients would evolved into a partnership than me having to make decisions all the time.

In spite of the seemingly lack of engagement from patients, physicians make the extra effort to communicate with relatives of illiterate patients as I noticed during one of my “sit-in” sessions. On this occasion, a physician announced that a patient will have to start chemotherapy. Even though the physician tried to explain the process, the patient obviously did not understand. The physician asked to speak with the patient’s son, but he
was not present at the time. So the physician gave his cell phone number to the patient and asked that the patient’s son contact him.

On another occasion, I witnessed a consultation where an elderly woman (probably in her early 70s) was informed of a possible surgical procedure. However, the woman did not comprehend the physician’s proposition. At the time, the woman’s daughter was also in the consulting room, but realizing that the daughter did not also understand the rationale for surgery, the physician asked if they had been accompanied by other relatives. The elderly woman responded in the affirmative and invited her son to the consulting room. The physician explained the pros and cons of surgery, after which both parties agreed that the family should think about it, and then inform the physician about their decision.

From my observations and interactions, physicians routinely go the extra mile to support their illiterate patients by relying on relatives who are able to explain relevant information. Unfortunately, not all patients have literate relatives who would accompany them to the hospital.

According to physicians, other reasons why patients opt to not participate in treatment decisions bothers on the trust they have in their physicians. For example, in cases where multiple treatment options are available, physicians have shared such information with patients. Yet, patients routinely tell the physician to do what they (physician) deemed best. Physicians argued that although they appreciate the trust from patients, the lack of interest is more concerning. Dr. Ayivor believes that, the connection
between patients and their physicians should be more of a partnership, instead of a
“superior-subordinate” relationship:

Most of the time, patients believe that the doctor knows it all, even if you ask for
their point of view on a specific management, they would say ‘you are in-charge
and you know what best to do for them.’…this is not okay because management
depends on two parties; the doctor who is administering and the patient whom it
affects. If a patient is not so comfortable with a plan of treatment then the doctor
is wasting his or her time - because eventually, the patient will be back in the
hospital within a short period. Often, patients’ think the doctor is [boss], and they
[patient] don’t have a role in managing their own health.

Recounting the level of patient participation, Dr. Allotey, a male diabetic specialist with
15 years experience, explained:

Some patients are quick to discuss their problem and all that they know about it.
For example, the fact that it has affected someone they know, etc. [But] when it
comes to the treatment, a lot of them say I should do whatever is right. Then I
have to re-emphasize that ‘no I have told you everything about your situation, I
need you have to make some decision and these are the options.’ At times, some
of them eventually settle on a plan. However, majority would still want me to
decide for them.

Similar to previous comments, Dr. Akwetey, also from the diabetic unit, noted “more
often than not, if I provide patients with possible options, they usually say I am the expert
so I should do what is best for them.” Although Dr. Akwetey admitted that a patient’s
lack of knowledge about his/her condition influences their level of engagement, she was quick to add that she provides explanations before asking a patient to make a decision.

Referencing the level at which physicians expect patients to be engaged, physicians in this study clearly appreciate the concept of partnership or shared decision-making which is highly encouraged in medical communication (Gray & Spatz, 2009; Müller-Engelmann, Keller, Donner-Banzhoff, & Krones, 2011; Ray, 2005; Robertson, Moir, Skelton, Dowell, & Cowan, 2011; Wennberg, 2010). However, Shalowitz and Wolf (2004) have argued that, while it is ideal to promote and practice shared decision-making, the potential barriers which exists for low literate patients should not be ignored. Shalowitz and Wolf further noted that, during interactions with low literate patients, physicians should work to understand patients’ desires, and the level at which they want to be involved in the decision-making process.

Although physicians elaborated on patient disengagement in decision-making, physicians’ responses fail to reflect how they would support patients to be more engaged. Moreover, physician responses also depicted an imbalance of power during the interaction process. For example, Dr Ofori’s comment “a lot of patients will tell you they are not allowed to ask questions in the consulting room” connects with patients’ decision to disengage with treatment plans, which portray an unequal relationship during medical interactions. Damico, Simmons-Mackie and Hawley (2005) noted that manner in which individuals construct their communicative interactions “correlate with underlying social factors such as power” (p. 63). Clearly, physicians’ responses are indicative of the power differential which accounts for patients’ disengagement in health care decisions.
Disavowal

In addition to perceived lack of engagement from patients, physicians also commented on patients’ reaction to information about diagnosis, management plan, and potential risks. Dr. Opoku, a male dentist with eight years experience noted that patients who practice herbal or other forms of traditional treatment have a different conception of biomedicine. Dr. Opoku shared an experience:

Not too long ago, about two weeks I had a patient with a massive swelling of the jaw, which needed immediate surgery to avoid losing the patient. After I had explained to the patient the seriousness of his condition, I set an intravenous into his vein, only to come back and realize that the patient had removed it. In a follow-up conversation, the patient claimed that in their village, and it is believed that one does not have to attempt doing anything that will result in puncture of the skin or any part of the body.

Dr. Opoku further explained that due to over-reliance on herbal treatment or other spiritual beliefs, more than half of the patients who visit the dental department present degenerate conditions which require surgery. Yet, these patients decline to undergo a surgical procedure, and physicians have to convince patients to accept the seriousness of their condition.

Dr. Ayisi, a male diabetes specialist who has been practicing for 12 years indicated that majority of his patients struggle with the notion of a chronic condition. According to Dr. Ayisi, “some patients believe that diabetes and hypertension should disappear after a week of treatment, and they avoid long term medication.” Another
condition, for which patients assume a state of disavowal, is cancer. According to Dr. Ntuklu, “the majority of women who visit with breast cancer cannot fathom their predicament. Even with counseling, they don’t get it. Sometimes, I have to introduce patients to others who have recovered from cancer to prove that it can be treated.” Dr. Nkulu also explained that even with clear evidence from lab tests, some patients still do not believe they have cancer. The subject of disavowal is not confined to a particular group of patients. Dr. Asare observed it as a general occurrence:

What I find about Ghanaians is that most of them don’t want to actually know what is wrong with them, even the educated ones. When you tell them it becomes a whole psychological problem. I remember I had a patient once who had liver cancer and he had been told he had hepatitis. This was an educated person so I thought that well let me tell him what the disease is …the prognosis and whatever. It turned out that he was so upset with me. Even the educated ones can’t take it and the illiterates they have no idea. I mean if you tell someone “your heart is enlarged” the person would probably get worse.

Dr. Asare emphasized the importance of weighing a patient’s level of acceptability and coping mechanism before presenting him/her with information:

I would say most patients understand a stroke. With manageable conditions such as diabetes and hypertension, I try to get patients cooperation and explain to them that they are their own healers and doctors are here to help. However, with cases like HIV for which they receive counseling, some of the patients I treat tell me
they don’t believe they have HIV. The reality is some patients choose to live in denial.

On a similar note, Dr. Zak also confirmed patients’ reluctance to accept diagnosis which connotes some form of stigmatization:

In terms of chronic and diseases of stigmatization, patients are always reluctant to receive the facts. What I usually do is to break-up the news to the patient gradually through counseling. I look at their mood and tell them what I have seen, the good part. Then gradually fit into the reality. I believe that the patient must know the facts about their illness. If it is something that will scare them or related to disease of stigmatization, cancer, sexually transmitted infection, or terminal conditions, I still tell them but I release the information bit by bit and look at their reaction. If I realize that I have to pause, I do that and continue another time. At times some of them may need psychotherapy and I may have to refer them to a specialist.

While Dr. Zak argued that a patient needs to have full knowledge of their condition, he was also sensitive to the possible psychological distress that a patient might experience. Concurring to Dr. Zak’s comments, Dr. Yussif noted, “to be honest with patients, I say we are trying a particular course of management and if it doesn’t work, we will change it. But, I have come to realize that sometimes patient don’t want the bad news.”

These excerpts suggest that physicians make efforts to convince patients to “cope” with their chronic illness. Yet, it is not uncommon for patients to assume a denial or disavowal mode (Stephenson, 2004).
Patients’ Involvement Level

In addition to physicians’ comments about patient disengagement and disavowal behaviors, I interacted with patients in order to establish how they make meaning of their respective illnesses, and the roles they play in enhancing their health. Basically, I asked each patient to share whatever knowledge that they had about their health condition.

During my interactions with Ama, a 38 year old seamstress, who was recuperating from a surgical procedure, Ama expressed uncertainty and anxiety about her situation because she had heard that fibroids could cause infertility. I then asked if she had shared her worries with her physician. With some hesitation in her voice, Ama said, “the doctors have given me pain medicine and examined me after the surgery, so I am sure they are doing their job.” Thus, Ama expressed no need to inquire further.

The desire to know more about his health condition did not seem to be a priority for Kofi, a 62 year old mechanic who had been on admission for two weeks. During our interaction, Kofi explained, “although the doctors haven’t said anything about my illness, they have given me some medicine and they assured me that, they will take care of me, so I trust them.” I later got to know that Kofi had been diagnosed with prostate cancer.

At the diabetic ward, I spoke with Abena, a 55 year old woman with a sore foot. Abena seemed to be in mild pain but in a good mood. I asked if she knew what caused her sore. She took a deep breath and said, “Hmm! not much, different doctors have treated me for this sore; I remember one doctor said I had sugar disease but that’s all I know.” When asked if she felt the need to probe further about the nature of her illness, Abena responded, “I think the doctors know what they are doing.”
Kojo, another diabetic patient initially narrated how “the doctor said something like sugar disease, and that they’ll have to do series of test to verify it.” Kojo further indicated that he had told the doctor that he [Kojo] did not have sugar disease. I asked Kojo if the physician had provided additional explanation about the diagnosis. Kojo replied in the negative and said, “although I don’t believe I have sugar disease, I know the doctor is the expert, so I don’t want to be too inquisitive.” In this particular instance, although Kojo did show some level of engagement by asking questions about his condition, the underlying concept of his [Kojo’s] lack of knowledge versus the physician’s expertise lingered.

Another patient from the surgical ward was Adjoa, a 43 year old hairdresser. She seemed to be in good spirits when she spoke with me. Adjoa narrated how she was rushed to the hospital due to severe abdominal pain, and after a series of tests, she had to undergo surgery. Adjoa then added “the doctors say I have something called appendix…I am not sure if that’s how it is pronounced, but I haven’t been told exactly what it is.” When asked if she would like to know more about her condition, Adjoa said, “I am thankful this pain is over and I feel better again.” Although not entirely different from other responses, Adjoa focused more on relief from pain, than a desire to know about her illness.

Related to the seemingly lack of interest in enquiring about their illness, patients at the point of full recovery had no idea when they were likely to be discharged from hospitalization. Yet, they did not deem it necessary to ask their physician. Based on
what I gathered from observations and interviews, patients accept passively what is going
to be done for them and avoid asking questions.

However, before we blame patients for their lack of involvement, we also have to
explore the potential reasons for such behavior. For example, studies suggest that
patients with limited literacy tend to opt for little participation in their health care
discussion (Shalowitz and Wolf, 2004). Charmaz (2002b) noted that patients’ lack of
knowledge about their prognosis or diagnosis can foster silence. Charmaz also
maintained that because some patients tend to view their physicians as experts and trust
their judgment, these patients remain silent even when they have the leverage to engage
in their health care decisions. The seemingly dichotomy of speech and silence which
appear embedded in this study will be further explicated in the discussion chapter.

**Controlling Agency**

Although a greater part of responses from both groups of participants imply that
illiterate patients more likely relinquish agency, a few responses suggest otherwise.
Notably, some patients expressed an eagerness to know more about their illness. For
example, Afia, a 48 year old hair dresser and a diabetic patient, commented that, “if I
know what’s causing my illness… and it’s a lifestyle issue I can change it, or if it’s
hereditary then I and my family will be informed of what precautions to take.” Afia
added that she would wish for her doctors to at least chat with her, and so she could ask
lingering questions about her condition. Yaa, a vegetable seller and a patient recovering
from fibroid surgery, mentioned that physicians should at least provide some
explanations to allay patients’ anxiety and uncertainty. Yaa narrated her previous experience:

I remember I was admitted at this hospital sometime back for ectopic surgery. After the surgery, I had numerous questions on my mind because I had heard that if you have ectopic pregnancy you will not be able to have a child. I was very anxious and was crying because I had been married and didn’t have a child yet. When I tried to bring up the topic with the doctor, she told me that everything was fine so I shouldn’t worry.

Yaa further stated that, although she believed the physician, she still experienced a great deal of uncertainty. Similar to earlier comments, Kwame mentioned that he desired to engage in further discussions about his condition, but his physician did not provide the opportunity. According to Kwame, “some of the doctors are very nice, but are too busy to spend enough time with you. These doctors rush through everything, making it difficult to understand, and some doctors don’t even ask if you [patient] have questions.”

Elaborating on the lack of information from physicians, Kojo, a diabetic patient, noted that, “the only information the doctor provided was that my leg would have to be amputated in order to save my life.” Stating how depressed he felt, Kojo indicated that, “first of all, no one told me how I got this sugar disease, and all of a sudden my leg is gone.” Kojo also mentioned that he experienced a high level of uncertainty and was forced to speculate about his health condition. Patients’ excerpts reveal that, even as they acknowledged that physicians get very busy especially at the clinics, patients also
expected their physicians to make a conscious effort at ensuring that patients’ concerns are addressed.

Excerpts within the category “controlling agency,” project an expression of physician autonomy during clinical interaction. Damico et al. (2005) maintained that when one individual has more power than the other in a discourse, the power imbalance is collaboratively constructed as the more powerful individual employs behaviors control on the interaction. As far back as the 1980’s, Mishler (1984) and other authors began interrogating the asymmetric nature of physician-patient relationship (Beckman & Frankel, 1984; Sharf, 1988). Ellingson (2005) argued that “illuminating the taken-for-granted power relations within the health care system will help in questioning how communication patterns are developed, negotiated, maintained, and modified” (p.113).

In this study, physician autonomy is revealed in various ways. First, comments in the disclosure section suggest physicians rebuke patients who report late for treatment. Consequently, patients conceal relevant information from their physician. Second, some patients expressed concern that their physicians do not provide adequate answers to their questions. Last, but not least, physicians asked closed-ended questions during consultations, thereby leaving little room for patients to fully express themselves. In reference to clinical interviews, Sparks and Villagran (2010) noted that, “although medical training and decision trees often call for close-ended questioning when it comes to talking with patients, as in all relationship-building communication more open-ended question formats will elicit longer and more thorough answers” (p. 5). The authors
further noted that allowing patients to fully express themselves proves useful in diagnosis and treatment plans.

Clearly, the dialogic and relational aspect of care is muffled by a power differential. Dialogue, which involves interaction, voicing otherness, acknowledging difference, and genuine listening (Bakhtin, 1981; Buber, 1958; Cissna & Anderson, 1994), is not reflected by physician behaviors. With the findings from this study, we cannot establish that patients and physicians experience some level of partnership. In earlier discussions, physicians expressed the desire for patients to be more involved with decision making. However, it is uncertain how physicians help with the process. Feedback from patients in this study reveals a degree of vulnerability mostly due their state of health and illiteracy status. For example, these patients struggled with illness uncertainties, and did not know where to seek support since their physicians did not provide them with enough information. Consequently, patients experienced an underlying tension of being assertive or assuming apathy.

Hope versus Breaking Bad News

Hope

In the previous section, patients expressed their dissatisfaction over how little information they received from their physicians about their illness. However, physicians noted during their interviews that sharing minimum information was a way of providing hope for their patients. In his experience, Dr. Kaiko explained, “after I share a diagnosis, some patients never come back, so I always try to provide hope. Until I am sure a patient will be able to cope, I don’t use ‘leukemia’ and ‘cancer’ during explanations.” Making
reference to cancer cases, Dr. Afram contextualized the high level of family involvement and financial cost associated with treatment, hence the need to provide a positive outlook for patients’ relatives:

I have to confess that I have not been fair to the patient because I tend to lean too much towards the positive, because for our peculiar situation chemotherapy is expensive so if a person loses hope probably because of how they perceive the side effects of chemo, or if relatives think that the treatment is not going to end well, they might not support the patient.

Dr. Yussif also shared Dr. Afram’s perspective on reassuring patients and he added that, the desire to provide hope is part of the Ghanaian culture:

I always believe that it is important to give hope to the patient by reassuring them that they will be well, even if you know they will die, and the patient also knows they are dying. But it’s [in our culture not to take away hope from people even to the last moment]. It’s not that you are being deceitful, but you are letting them hope so that they live one day at a time.

The comments about providing hope for patients reveal how cultural connotations inform health care delivery. Previous studies show that differences exist between individualistic and collectivistic cultures on how bad diagnosis and prognosis is communicated to patients (Gongal, Vaidya, Jha, Rajbhandary, & Watson, 2006; Miyata, Takahashi, Saito, Tachimori, & Kai, 2005). For example, Torres and Rao (2007) found that, due to legal and ethical implications, physicians in the United States utilize a direct approach in communicating bad news to their patients. One the contrary, physicians in Brazil, India,
and Argentina either used half-truths or delivered the news in smaller doses. Physicians in the latter situation focused on the emotional needs and readiness of the patient to receive such news.

**Breaking Bad News**

Although physicians maintained that providing hope allowed patients and relatives assume a positive attitude, physicians in this study elaborated on their personal challenges when delivering bad news to patients or relatives. In health care contexts, bad news refers to information that creates a negative view of a person’s health (Ray, 2005), such as threat to a person’s mental or physical well-being and/or a feeling of no hope (Lloyd, 2009; Ptacek & McIntosh, 2009). Overall, physicians worried about the most effective way to communicate bad news to their patients because they did not receive such training during medical school. Dr. Awuku, from the oncology department acknowledged difficulty with sharing information about potential terminal illness with his patients:

Well, I have found out that if you break it piecemeal, or you start sensitizing patients and their relatives by saying things like “at this stage we are trying our best but you should all have hope…” And if it comes to a diagnosis of say cancer, again it becomes difficult to break bad news and I find out that sometimes I end up not actually giving them the bad news but watering it down which may not also be right in the sense of preparing them. For example, I had a patient who was very upbeat about his diagnosis, but unfortunately after remission, just about two months or so later, he relapsed. So it came to a point where I had to tell him that
‘you have known all along that your chance of survival for this illness is not guaranteed.’ Immediately I said that, he broke down and wept. And I must say as a physician I sometimes struggle with that.

Apart from sharing devastating information about poor prognosis with patients directly, physicians occasionally must communicate to relatives about a patient’s death. Although Dr. Asare boasts 20 years experience in the medical field, she recognizes many challenges associated with delivering bad news:

…when I lose a patient and its visiting hours and their family walks in, I meet the person and say, ‘come and let’s have a seat’ normally I take them to a private setting and then I review the patient’s condition and break the news as gently as possible. I have also had situations where there is really no time to do all that preparatory work…there are cases where I haven’t done enough processing; let alone share the devastating news with the patient’s relatives…it can be difficult especially when we are all in shock.

Dr. Asare’s statement suggests that, even after many years of practice, a physician might still be nervous delivering bad news, due to the inherent emotional stress involved. Dr. Asare also emphasized the importance of training physicians on how to communicate bad news:

I am thinking of what it would take to bring everybody on board in terms of good communication skills…with something as basic as breaking bad news, but you can’t just tell someone you have cancer or even tell a relative ‘sorry you’ve lost him’ you can’t no… there has to be a way of going about it.
The need for physicians to receive some form of training was re-echoed by Dr. Sackey, an orthopedic surgeon:

I remember my first experience; we had just completed medical school and were doing our house-job. Usually, we are not privy to management of a patient. It is either the senior resident or consultant. But that morning, we had been assigned to a ward. Unfortunately, a patient died and my colleague burst into tears. Our professor took us to his office and explained that when the patients’ relatives are crying, we don’t also cry, and that we have to be calm and explain the state of affairs to the family.

Dr. Sackey also shared an occasion where another physician broke the news of terminal cancer to a patient. According to Dr. Sackey, the patient went into a mental state of shock, and it took months of counseling before the patient recovered from the shock.

Overall, the desire to be knowledgeable about how best to deliver bad news echoed in physicians’ comments. Those who had just began their practice and others with many years of experience all admitted that the medical school curriculum barely covered topics on communication skills.

**Physician Frustrations**

**Patient Load and Time Constraints**

In terms of how physicians perceive their relationship with patients, all physicians openly vented about issues, such as patient load, time limitations for consultations, and patient behavior as pertinent issues which hindered the relational aspect of care. When asked how many patients they treat in a day (between 8:00 a.m.-5:00 p.m.) all physicians
in this study provided a range of 30-45 patients. In addition to heavy caseloads, physicians must juggle operation and emergency room responsibilities as well as ward rounds.

As stated by Dr. Afram, the number of patients waiting to be treated can be so overwhelming that “when it gets to about 4:30 p.m., I am so tired that sometimes I am not able to give all the formation the patient deserves. My focus is on finishing the folders in front of me.” Likewise, Dr. Akwetey added, “the work is stressful; there are so many patients. I wish to spend 20 minutes explaining things to my patients, but if I do that, I may end up treating only half of the 40 patients waiting to see me.” Explaining his daily routine, Dr. Ayivor confessed that, “I feel patients don’t get the quality attention they deserve…the reason being that I treat 35 to 40 patients within eight hours, I am forced to rush and unable to provide detailed information as I would wish.”

Similar to previous responses, Dr. Konadu admits that sometimes she feels rushed and does not provide thorough care. She noted that, “due to the nature of dentistry, patients spend at least 30 minutes with the doctor. Sometimes, I wish to spend more time but I realize that a lot more patients are waiting to receive treatment.” Commenting on patient load, Dr. Offei noted:

Sometimes I have a gut feeling that I should have handled a patient a bit better. There are situations where I feel I haven’t provided sufficient information about the management of chronic illness. Unfortunately, I have to cut corners, otherwise, I would end up spending the whole day in the clinic…don’t forget I
have to do other duties such as operation room, ward rounds, and emergency room.

Explaining how to manage the patient load and time constraints, Dr. Ayisi contended that restricting the clinical dialogue to a short questions and answer format seems to be the most convenient option:

To be honest with you some patients want to spend a long time in the doctor’s office so I usually do the quick question-answer conversation. The reality is, I have about 30 or more patients waiting to see me and if I spend the next 15 minutes explaining to one patient what the conditions and outcomes of management is…I mean I don’t know if you can picture it, but there is a lot of pressure from the ones out there who have been waiting for over three hours when you are in with one patient.

Dr. Ayisi further explained “I want to spend time with my patients but sometimes it’s practically impossible. [However], when clinics are less busy, I entertain multiple questions and provide thorough explanations.” Concurring with other colleagues, Dr. Issaka argues that, while physicians would like to ensure that each patient receives the required attention, physicians should be cautious of hurrying the interaction:

I try not to seem to be in a hurry too much, but in our setting here, the clinics can be very heavy. So you discover that if you don’t slow down yourself consciously, you tend to be in a haste to quickly dispatch a patient so that you can see others. Sometimes after a sentence or two from the patient, the doctor thinks he/she already knows what the problem is and proceeds to write a prescription without
providing additional platform for the patient to express themselves. There have been occasions where patients have honestly told me that they felt rushed and couldn’t expressed themselves during a prior appointment…and I must admit, I feel very bad when that happens.

Dr. Issaka also noted that the patient load is exacerbated because the facility is a referral center which receives cases from all over the country. According to physicians, another probable reason for the huge patient load and time restraints can be linked to the lack of appointment scheduling for clinical visits. Dr. Ntuklu noted that, “70% of the departments and units in this hospital utilize the walk-in system of [first come, first serve] meaning that physicians have to push their limits to treat all patients who visit on a particular day.”

Time constraints and patient load not only served as a worry for physicians but for patients as well. During my field observations, I spent time at the surgical, diabetes and orthopedic OPD’s. For each unit or department, approximately 150-200 patients visited between 7:00 a.m.-5:00 p.m. daily. Sometimes huge numbers resulted in seating problems, thus, patients could stand for over an hour before they could find an empty seat. On multiple occasions, I listened as patients lamented to each other or nurses about how long they had been waiting to see a physician. Others complained that they lived so far away they had to wake up at dawn and travel over three hours in order to arrive early at the facility and avoid joining a long queue for treatment.

The findings in this section highlight the tensions that physicians experience between juggling huge patient cases and the need to thoroughly explain health conditions
or management plans to their patients. Moreover, concerns emerge over whether or not patients understand whatever little explanation they receive from their physician.

**Patient Behavior**

In addition to patient load and time constraints, physicians expressed frustrations over particular behaviors by patients. Notably, reporting late to the hospital and not being truthful about the duration of their condition. Addressing the situation, Dr. Afram observed that seeking immediate attention for health care needs did not seem to be a priority for patients:

I feel that if you are concern about your health you expect that when the disease or illness starts you get to hospital early. But most of the patients I see only visit when they have had the disease for a long time, or if it’s getting worse. Prior to visiting the hospital, they would have engaged in various herbal medications and tried all sorts of unorthodox forms of treatment… It’s like people know their health is important, but chose not to be proactive in seeking early treatment.

Dr. Konadu also emphasized the complications associated with reporting late. She explained, “You will be amazed at the number of preventable cases which we see at the dental unit mainly because patients prefer herbal medication, don’t present early, and arrive with complications.” Reiterating Dr. Konadu’s point, Dr Abdul noted, “based on my experience, I will say that a greater percent of Ghanaians only visit the hospital when their illness is in the acute stage. And sometimes they risk losing their life.” Dr. Abdul further suggested educating the public about assuming a proactive position with their
health. Dr. Opoku also reinforced a focus on health education to improved patient behavior:

I think that health education which focuses to early reporting to the hospital should be a key issue, the reason I am saying this is because when a person is a little bit literate they have an idea of what to do to prevent diseases. In this unit, I get a lot of cases on typhoid, cholera and some easily preventable illness. I feel that due to illiteracy some people cannot appreciate symptoms that are dangerous and only come to the hospital when their situation becomes worse.

Dr. Boyeman was particularly concern about patients’ reluctance to undergo a surgical procedure:

Hmm! At times it’s very difficult and frustrating at the clinic. Let me give you one example. Not too long ago, about two weeks I had a patient with a dental tumor which if immediate intervention is not done, the patient would definitely loose his life. When I explain that he had to undergo surgery, this patient refused and rather said I should give him oral medication, it took a lot of convincing from his relatives before he agreed to do the surgery.

Dr. Boyema had to convince her patient to undergo a surgical procedure to which the patient might otherwise object. Also, patients’ preference for herbal medicine and spiritual healing appeared to be in contrast with physicians’ expectation of patients. Moreover, physicians in this study failed to acknowledge their patient’s choices. Dr. Sackey commented on a “difficult” patient:
There are some patients that are impossible, and there is nothing that seems to satisfy them so I eventually tell them; you can either have this or that. On an occasion, I had this patient who came in with a broken leg and said he did not want the solid plaster. Meanwhile, his fracture was not suitable for fixation. But I had to find a way of making him comfortable; I can’t send him home with the broken leg, and I do not have the beds to keep him in the hospital for six weeks because he doesn’t want to wear a plaster. Well, I ended up giving the patient two options. That he can either have the plaster or have another doctor offer him the treatment he’ll be happy with. It took a lot of convincing because he realized that I was getting mad, so he finally went for the plaster. He came back to the clinic the following week and he was so excited because he felt comfortable in the plaster.

Dr. Sackey’s excerpt reveals the extent to which patients are allowed to make choices or decisions. Additionally, previous comments suggest that physicians do not take time to explain to their patients why certain procedures are necessary, hence, patients’ uncooperative behaviors. Based on my data, physicians rarely listen to patients’ preferences, nor do they allow patients any form of autonomy regarding their own health. As detailed earlier, physicians expressed the desire for patients to assume active roles in decision-making. However, it is unclear how such partnerships can be achieved when physicians are not providing the necessary support for their illiterate patients.
Physicians’ Self-Assessment

In spite of the general frustrations over infrastructure, time constraints, case loads and patient behaviors, physicians acknowledged a need to commit to building a supportive relationship with their patients. Dr. Sackey noted:

I would say there is always room for improving the way doctors relate with patients, but in Ghana, the patients out-number the health providers. For instance, when I was practicing in Britain, my house officer was covering two teams: orthopedics and urology, and he had to admit seven patients in one night; the guy was virtually in tears. I can tell you that with one team, I see five times that number in a day…but I keep finding ways to ensure that my patients are satisfied with the care they receive.

Dr. Agyei discussed how appreciative patients are when they realize that their physician cares about various aspects of their lives and not just the disease:

What I have noticed is that if patients have confidence in you as somebody who really cares about them, then they are willing to do whatever you tell them. But if they see you as somebody just there to render service, it becomes very difficult for them to follow the instructions you give them. So care and love you know…establish a very good relationship with them and it goes a long way.

Dr. Edem also focused on moving beyond the professional barriers that exist between patients and their physicians:

I discovered that doctors learn how to take histories but we don’t learn the art of making patients comfortable and sometimes when a patient becomes your friend
and tells you something he/she didn’t like that’s when you discover that you didn’t make the person comfortable the very first time he/she came to see you.

Dr. Issaka noted that self-evaluation comprised one way through which physicians can enhance the relational aspect of providing care. Dr. Issaka maintained that, “I am someone who believes in self-assessment and want to make sure that at the end of the day, my patient is satisfied and would not want to switch to a different doctor.”

Commenting on how to improve relationships with patients, Dr. Zak, stressed the need for physicians to encourage patients to share their knowledge, however little about their illness. According to Dr. Zak:

I think the relationship between the doctor and patient should be that of mutual understanding. The doctor should not think she/he knows everything and the patient doesn’t know anything. The doctor should ask the opinion of the patient as well. For example, “what do you think might be the cause of your illness?”

Similarly, Dr. Yussif, elaborated on a more holistic approach through which physicians can address the needs of their patients. She criticized behaviors which undermine patient care:

You know there is a difference between the science and art of medicine and to be honest, some doctors still do not understand the art of medicine or how to properly interact with a patient. For instance, when I was in this other hospital, I was working with these nurses who would always yell at patients. One day, I told them that they had no right to reprimand the patient. Over the years, I have had conversations with patients and realized that food and even money to take
transport to the hospital is an issue…some doctors think the patient is terrible, non-compliant, and so on. But getting to know the patient a little more beyond the physical illness is very important.

Comments by physicians suggest that the relational aspect of care is not unknown in their practice. However, physicians in this study mentioned infrastructure and logistics reasons which impeded their ability to offer efficient care. Nonetheless, physicians noted that they must work to improve how they relate and interact with their patients. What needs to be addressed is how physicians can incorporate patient-centered care (Clancy, Corrigan, & McNeill, 2009; Kanter & Horowitz, 2009; Stewart et al., 2003; Watson & Frampton, 2009) into their daily routine of high patient load and time constraints. The possibilities will be explored in chapter five.

Patient Education

After explaining the need to improve how they relate with patients, physicians in this study also emphasized patient education as a means to enhance clinical interaction.

Dr. Konadu commented on the non-existence of health education programs:

We must encourage health education programs in Ghana. For example, in the dental unit, we realize that the patient doesn’t know anything until they arrive here. And even when they are sick they use various herbal medication which leads to complications. We need health educators to visit the cities and villages and inform people about the importance of visiting early.

Dr. Safo suggested the need for health education programs on local radio and television.

According to Dr. Safo, “I know that our television stations have adult education
programs, it would be a good idea if they can focus on health issues.” Dr. Awuku concurred, and noted that, “from what I have seen, patients who listen to breast cancer programs on radio are more cooperative with treatment and management plan than those who have no idea at all.” Dr. Asare also added that, although some units within the hospital offer patient education at the out-patient clinics, those are insufficient. According to Dr. Asare, “patients rarely listen to that information because they are so ill. However, having health education programs in local languages on radios and in churches will be helpful.”

Dr. Akwetey reiterated earlier suggestions and added, “I can tell you that some patients are ignorant even about our common malaria. Usually, people are misinformed and the messages going around are in English so it’s difficult for patients to understand their illness.” Commenting on the importance of health education, Dr. Edem was specific about topics which should be emphasized during such education, she noted:

I think that health education which focuses on reporting early to the hospital should be a key issue. The reason I am saying this is because when a person is a little bit literate, he/she has an idea of what to do to prevent diseases…in this unit, I get a lot of cases on typhoid, cholera, and some easily preventable illness…but due to illiteracy, some patients cannot appreciate symptoms that are dangerous and only visit the hospital when their situation is worse.

Overall, comments from physicians not only focus on patient education, but connect to high levels of illiteracy and unavailability of health information in indigenous languages.
Conclusion

The data from this study revealed certain taken-for-granted assumptions about physician-patient interactions. For example, the lack of indigenous language equivalent for certain medical terminologies resulted in the use of analogies to describe conditions, diagnosis, and prognosis. Unfortunately, such explanations generated little understanding, especially for patients. In other instances, the set-up of the consulting room, and physicians’ reprimands to patients for reporting late were merely normal and routine. Yet, these factors influenced whether or not patients’ will to disclose health information. Other findings include tensions that patients and physicians experience over information exchange, and collaboration on decisions about management and treatment plans. Physicians also discussed how they could improve their relationship with patients despite infrastructural constraints. Finally, physicians suggested health education as a tool to help illiterate patients understand their health condition.

Chapter Summary

In this chapter, I provided responses from participants and used that evidence to answer my research questions. Notably, I sought information about language barriers, interpreters, patient disclosure behaviors, and the relational aspect of physician-patient interaction. In the process, I developed various categories such as limited vocabulary, assumed meaning, interpreters, fear of reprimand, patients’ involvement, hope versus breaking bad news, physician frustration, physician self-assessment, and patient education. I worked to discover the similarities or differences among these categories.
and to represent the taken-for-granted challenges and constraints which engulf physician-patient interaction in Ghana.

The next chapter comprises a discussion of my findings. I use evidence from the data to make claims and interrogate concepts, and I support these with relevant literature where applicable. I then move on to discuss the implications of the study, limitations, and suggestions for future research.
Chapter Five: Discussion

Summary of Key Findings and Discussion

In this dissertation, I developed a data-driven interpretation of physician-patient communication in Ghana. My investigation focused on language barriers, use of interpreters, patient disclosure, as well as the relational and dialogic aspects of care. In this chapter, I present an overview of my findings by addressing each research question and its related categories. My discussion includes similarities between my dissertation and prior studies, unique findings, practical implications, limitations of study, and suggestions for future research.

Research Question 1

My first research question focused on the Ghanaian languages used within health care facilities (see literature review), and whether or not it shaped clinical interactions in anyway. Responses from participants revealed the existence of language barriers, especially where the patient could not speak English, and the physician did not understand the patient’s dialect. While participants noted that fluency in an indigenous dialect proved useful for one-on-one interactions, they also referenced various challenges. Dr. Amartefio elaborated:

Translating certain health conditions even to people who speak English can be tough. Although I speak fluent Twi, I don’t know the names of diseases such as pneumonia, sickle cell anemia, ulcer, hernia, chlamydia, and many others. So you can imagine how difficult it will be if I have to explain certain diseases to the less educated person in order for them to understand their diagnosis.
Physicians reported that, because they are trained to use discipline specific vocabulary or medical terminology, it is only when they are confronted with patients who do not speak English that they realize certain words or phrases prove difficult to transfer from English to the indigenous dialect. A previous study on vocabulary and medical terms found that “patients’ limited vocabulary, compounded by physicians’ overuse of medical terms, is perhaps the major source of inadequate communication between patients and their health care providers” (Davis, Williams, Branch, & Green, 2000, p. 128). Kanter and Horowitz (2009) also provided support to the problem about medical vocabulary and noted that “medical knowledge is a specialized area of understanding that requires intensive study to comprehend. It uses specialized language or jargon that is unfamiliar to most patients. Therefore, it falls to the physician to translate for the patient” (p. 216).

Unfortunately, the translation process is not as seamless as it might appear. Physicians in this study noted that certain medical vocabularies in English do not exist in the indigenous dialect, and, even if vocabularies existed, physicians did not know them and therefore could not use them. Dr. Sackey explained:

Most of the patients that I see on a regular basis don’t have an idea of the human anatomy so I have to make sure they get the concept before I proceed with describing their condition. For a disease such as osteoporosis I do not know the exact word in the Twi dialect. Usually, I say that it occurs in the bone, and in severe situations, it can impede normal movement. The other day, a colleague and
I were chatting and she informed me that she had been trying to find the Twi name for multiple sclerosis, but realized that most doctors didn’t know it. Patients also expressed their inability to capture appropriate terminologies to express their health condition. For example, Kwame, who was recovering from a hernia surgery noted, “I don’t even know the name of the disease which resulted in my operation. I remember the doctor tried to explain it but I forgot.”

Vocabulary limitations meant that patients and physicians often engaged in lengthy descriptions and explanations about symptoms and in certain cases encountered problems understanding each other. Such an assertion might be warranted because translation issues surrounding medical vocabulary and indigenous African languages exist within health care facilities (Deumert, 2010; Levin, 2006b, 2007). For example, studies by Levin (2006a, 2006b, 2007) at various hospitals in South African revealed that, while medical staff spoke English or Afrikaans, many patients spoke Xhosa. Therefore, patients visited clinics with cultural specific labeling of a disease which differed significantly from physicians label for the same disease. Such incidents resulted in misunderstanding and sometimes misdiagnosis.

The vocabulary constraints are not peculiar to Ghana or South Africa, nor are they limited to spoken language. Küper (2003) contended that the difficulty in vocabulary translation occurs because African languages are not used in mainstream education. Moreover, scientific concepts are not developed nor explained in African languages. Bowden (2007) also argued that, although multilingualism provides a rich cultural diversity for Sub-Saharan Africa, “there are so many different dialects of each language;
a variation which can hinder understanding…language barriers can make managing issues such as education and health problematic, and few governments can afford to produce public information in every language” (p. 39).

In cases where publications of health related messages have occurred in indigenous dialects, various constraints have been noted. For example, De Wet and Krige (2009) conducted a study in South Africa to examine the readability and cultural competence of patient information leaflets. The findings revealed that these leaflets used jargon or terminologies that were unknown or confusing to patients, thereby rendering the intended message less effective. Other research on printed health information from pharmaceutical companies indicated that when materials are written in Royal Academy Spanish, people in Latin America or Mexico have difficulties with comprehension (Sparks & Villagran, 2010).

As noted in this discussion, non-existent health vocabularies in Ghanaian languages create constraints for physicians and their patients. Yet, participants mentioned a preference for one-on-one interaction amid the vocabulary limitation, as opposed to using an interpreter. For example, Dr. Ofori noted that, “when treating cancer, which is a long-term management process, I will prefer to speak directly with the patient in spite of vocabulary challenges than depend on an interpreter.” Although communicating in the same language proves more engaging, data from this study also suggest that concerns exist over mutual understanding. For example, during consultations, physicians assumed that patients had understood and were satisfied with
explanations only to realize that a huge miscommunication had occurred. Dr. Ofori explained:

Hmm...! Let’s say I have learnt a lot from the patients; not to make an assumption, because I used to make assumptions. I feel I have explained things fully so I go like “any questions” and the patient says [no] then I continue “do you understand”? And they say [Yes]…am happy but the patient comes next time and I realize they are asking questions I thought I had covered in their previous visit.

So I have learnt to always try and review what we’ve discussed.

Likewise, patients also had difficulty understanding physicians’ explanation although both were speaking the same language. Potential misunderstandings were only discovered during patients’ follow-up visits. Incidents of this nature have been observed elsewhere (Sudore et al., 2009).

The concept of language convergence and meaning divergence (Dougherty et al., 2009) sheds some light on the situations described in this study. Dougherty et al. (2009) argued that although individuals interact using the same language, “there was evidence that actual meanings assigned to the similar language were quite divergent…. and illusions of shared meaning can be difficult to notice or penetrate” (pp. 27-36). Sparks and Villagran (2010) expanded the discussion on shared meaning and noted that:

Patient and provider interaction, as defined from a global perspective grounded in health communication theory and research, involves creating shared meaning about health care and conditions in the patient and provider encounter. Shared meaning is essential to competent communication, but it is not always easy to
achieve due to differences in language, culture, and experiences. Patients come to
each medical encounter for a variety of reasons, and typically have specific goals
for their medical visits. Unfortunately, patients leave the interaction without
achieving their communication goals. (p. 5)

Previous studies (e.g., Dougherty et al., 2009, 2010; Sparks & Villagran, 2010) as well as
findings from this research give credence to the potential miscommunication and
dissatisfaction which engulfs the clinical interaction. In terms of this study, I argue that,
in the midst of limited vocabularies and assumed meaning, patients are the most affected,
as care might be compromised (Kanter & Horowitz, 2009; Smith, 2011; Sparks &
Villagran, 2010). Moreover, findings from this study suggest that illiterate patients either
chose to disengage in treatment decision or do not possess enough knowledge to
interrogate their physicians.

Analysis of research question one revealed that translating medical terminologies
appear more challenging than had been discussed by previous studies. Scholars have not
yet examined whether or not indigenous language forms are used in clinical interactions
and how those shape explanation and understanding of health information. In the case of
Ghana, the use of English as the lingua franca undermines the linguistic development of
indigenous dialect (Opoku-Amankwa, 2009), which explains why vocabularies for
medical terminologies are either non-existent or unknown to health care providers and
patients. Apart from the vocabulary limitations which occur when the same language is
used, major challenges arise when a patient and physician cannot communicate in the
same language (which happens often) thereby forcing both parties to require the services on an interpreter.

**Research Question 2**

The second research question examined whether or not the services of interpreters are utilized if patients and physicians encounter language barriers during clinical interactions. Findings from this study revealed that interpreters help to facilitate communication between patients and their physicians. Typically, individuals who offer interpretation at the health care facility include patient relatives or friends, nurses, health workers, or other patients. Dr. Afram explained:

> Most of our patients come with their relations. If their relations speak English, I use them as interpreters. In the absence of that, I call on some of the nurses around who could give me that interpretation service, when that doesn’t work then I may have to find around the hospital, whoever is available and understands that particular language to help me with the interpretation.

The utilization of interpreters to bridge language barriers have been well documented in physician-patient literature (e.g., Angelelli, 2004, 2008; Garret, 2009; Hsieh, 2006a, 2006b, 2009, Hsieh & Hong, 2010; Hsieh, et al., 2010; Jacobs et al., 2006). While the majority of research on health care interpreting has been conducted in North America and certain parts of Europe, such studies have focused on professional or trained medical interpreters (e.g., Angelelli, 2008; Diamond et al., 2009; Hsieh, 2010; Rosenberg et al., 2008).
In the case of Ghana, findings from this study revealed that no policy exist on health care interpreting, and the health care system lacks standardization or control over who should be invited to offer interpretation. Thus, the unavailability of institutionalized interpreting services suggest that persons who offer interpreting services at health facilities do not receive any form of training about ethics or guidelines in health care interpreting. Answering questions about interpreters, physicians reported various frustrations and challenges they encountered, Dr. Agyei noted:

There is always some doubt about the quality of information received and passed on from and to the patient respectively...sometimes what I mean is not exactly what is communicated...at times the interpreter gives answers in way he/she understands and not the way they were said by the patient.

The above fragment, and similar ones provided in chapter four reflect arguments by Angelelli (2008) and Garret (2009) that, because interpreters are individuals with varied experiences, attitudes and beliefs, they can certainly shape the construction and representation of the clinical discourse. The authors further contended that an interpreter’s ability to shape the clinical discourse includes accuracy during interpretation; a process for which physicians in this study expressed concern. In terms of accuracy, Hsieh et al. (2010) found that “providers often emphasized the necessity to find equivalent medical terms and transfer the exact information across different languages” (p. 173). Based on participants’ quotations as well as evidence from existing literature, I would argue that health care interpreting is not just about language fluency. It is a matter of bridging a language barrier which should yield an expected satisfaction
for both the patient and physician (Angelelli, 2008; Hsieh, 2010; Hsieh et al., 2010). Consequently, interpreters perform a vital role in facilitating clinical interactions.

Notably, Bezuidenhout and Borry (2009) contended that:

Medical interpretation, as with all professional interpretation, requires a high level of skill and fluency in both languages, memory for what is being said, a good understanding of the predictable differences between the two languages, the ability to rapidly process information, and good pronunciation and diction.

Furthermore, a good understanding of medical terminology and medical ethics are vital for adequate interpretation. (p. 161)

The data from this study also suggest that, while the healthcare system cannot function without interpreters, the quality of interpretation might sabotage clinical interaction (Hsieh, et al., 2010). Physicians noted that working with individuals who have no training in medical interpreting can be problematic. Dr. Zak explained that, “even though I may not speak or understand a language, there have been cases where the interpreter just summarizes. For instance, the patient will speak at length, and the interpreter only says a sentence or two.”

Various errors have also been associated with using untrained interpreters. For example, Kilian, Swartz, and Joska (2010) found that during translation from English to Xhosa, untrained interpreters were unable to find equivalents for words such as “anxiety” and “depression” and were forced to use additional or alternative words. In another study on multilingual issues in three different hospitals in South Africa, Deumert (2010) noted that formal interpreting services did not exist at any of these hospitals. Moreover,
physicians reported problems with using patient relatives as interpreters. Existing research has elaborated on the positive and negative aspects of using untrained medical interpreters (e.g., Bezuidenhout & Borry, 2009; Meeuwesen, Twilt, Thije, & Harmsen, 2010; Rosenberg et al., 2007, 2008).

Based on this study, untrained medical interpreters prove useful in bridging linguistic barriers during clinical interactions. However, we must consider issues regarding ethics, privacy, and confidentiality. As mentioned earlier, unavailability of trained interpreters sometimes force patients and physicians to utilize the services of a stranger. Hence, a patient’s privacy might be violated because patients feel compelled to divulge personal information to total strangers (see physicians excerpts from chapter four as well as the researcher’s notes on being asked to offer interpretation).

The question of untrained interpreters and patients’ privacy can be examined in the larger context of the patients’ charter initiated by Ghana Health Service (n.d.). The tenets of the charter include the patient’s right to privacy during consultation, examination, and treatment, the patient’s right to confidentiality of information obtained from him or her, and the patient’s right to provide consent before his/her information is disclosed to a third party. However, with the present state of affairs, a key question remains to be answered: can the privacy of a patient be guaranteed when interpreters have not received any training in medical ethics? Only one physician in this study referenced the patients’ charter. Dr. Boyeman noted “I know we have the patients’ charter which talks about patients’ rights and what they have to expect, and do when they visit the hospital.” Unfortunately, we lack evidence on the extent to which patients possess
knowledge about the existence of the charter. However, with the current state of using untrained interpreters, physicians have a responsibility to ensure that their patient’s privacy is protected (Baillie, 2009; Bezuidenhout & Borry, 2009; Lin & Tsai, 2011). As such, another important question remains to be answered: to what extent do physicians make attempts to protect the privacy of their patients?

This study also suggests that issues surrounding untrained interpreters have been subsumed in the debate of cost versus efficiency. Physicians in this study shared various opinions over whether or not trained medical interpreters are required. More than half of the physicians rationalized the need for interpreters. For instance, Dr. Zak noted:

I think that currently what we are having now is not the best, using the nurses and patient relatives as interpreters…it would be good that we train interpreters to assist the situation when there is a language barrier. However, the challenges that we have are the multiplicity of the dialects in this country… all the same I think professional interpreters would facilitate our work and enable us provide better quality services and the privacy concerns will be avoided and patient care enhanced.

On the contrary, using untrained interpreters also seemed to work well with some physicians. Dr. Yussif explained that providing interpretation services will add to the operational cost. She noted that “there will be someone in the hospital who speaks [that] local language. I personally don’t think that we need medical interpreters. In my experience I would say that health workers “get by” regardless of language barriers.”
Let us examine the implications of “getting by” with untrained interpreters. First, physicians mentioned that they would prefer to use nurses and other health personnel for interpretation needs, and justified that translation error and confidentiality issues will be minimized. However, health personnel must fulfill specific job requirements, and they might not be readily available to provide interpretation services. Another drawback of “getting by” implies that, if an interpreter is not available in cases of emergency, treatment of a patient could be delayed. In a previous study about working with interpreters, Diamond et al. (2009) discovered that resident physicians who worked in a teaching hospital with excellent interpreter services found it convenient to use family members instead of professional interpreters. The study further noted that resident physicians’ decisions were based on personal judgment, time constraints, and unperceived importance of communication. However, this study did not cover how untrained interpreters resolved privacy and confidentiality concerns.

Considering the feedback from some physicians as well as existing literature about untrained interpreters, I would argue that the benefits of providing trained medical interpreters far out-weigh the cost (Bagchi, Dale, Verbitsky-Savitaz, & Andrecheck, 2010). For example, Gill, Shankar, Quirke, and Freemantle (2009) noted that effective interpreting services were required in England to improve clinical access and health outcomes for non-English speakers, and to reduce health inequalities. In a similar manner, the existence of language barriers marginalizes illiterate patients. And evidence from this study suggests that patients are less likely to express their objection of an interpreter. Dr Edem noted:
Patients’ don’t usually speak up, if they tell you forthright that they are not comfortable with somebody else translating then it becomes easier, then I can find out what they are comfortable with. But what I have observed is that when the doctor invites somebody else to translate, whether the patient is comfortable or not they will be [quiet]. But what I am not so sure of is whether they will give all the information.

Physicians in this study also noted that even if the interpreter is known to the patient, the patient may obscure information about sensitive issues. Judging from participants’ response about interpreters, I would argue that providing trained interpreters would mean that patients could feel safer in sharing private information, and physicians could have more accurate information to determine a proper diagnosis and prognosis (Rosenberg et al., 2008; Sparks and Villagran, 2010).

**Research Question 3**

The third research question in this study pertained to patient disclosure patterns. Specifically, I inquired what information patients would or not share, and under what circumstances. Findings showed that a patient’s decision to disclose was influenced by (a) presence of an interpreter, (b) sensitive topics, (c) set up of consulting room, and (d) fear of reprimand. As discussed earlier, language barriers called for the use of interpreters. Consequently, patients would prefer to have their relatives do the interpretation if they are able. Otherwise, physicians generally ask the services of a nurse, or whoever speaks the patient’s language. Clearly, sharing pertinent health information with a relative or an unknown person can be unnerving. Dr. Ofori explained:
When I was working at GU (genitourinary) and patients who have gonorrhea are unlikely to disclose in the presence of another person. Usually, if the story presented by the patient doesn’t make sense or correlate with lab tests, I send the relative away to go and get medication or pay for services or something. I then find someone else; either another doctor or nurse who speaks the language and ask direct questions. Even then, patients feel uncomfortable.

The data suggest that, even in consultations that did not have interpreters, patients seemed reluctant to discuss issues bothering on sex, genitals, or sexually transmitted diseases. Patients also avoided discussing topics such as HIV/AIDS and tuberculosis because they consider those illnesses to be stigmatizing. My findings echo with previous studies which have argued that patients are reluctant to disclose stigmatizing diseases and even embarrassed to discuss it with their physician (Caughlin et al., 2009; Mitchell & Knowlton, 2009). Mwinituo and Mill (2006) also noted that due to the perceived stigmatization associated with persons living with HIV/AIDS, caregivers in Ghana go to great lengths to hide their patients and would not share any information with extended family members.

A major finding in this study regarding patient disclosure behaviors is the lack of privacy in consulting rooms (especially the surgical clinics). As clearly elaborated in the previous chapter, up to four physicians shared a room with their patients and relatives. As a result, no privacy exists for patients to share concerns which they consider confidential. Although sharing of consulting rooms does not occur in all departments or units within the health facility, various issues arise. For example, participants in this
study clearly expressed their dissatisfaction about the state of affairs. While physicians admitted that the set-up of the consulting room compromised patient privacy and confidentiality, they did not state how else the situation could be resolved. Let us not forget that infrastructural problems might account for the current state of affairs. What appears to be overlooked is the absence of initiative by physicians to protect the privacy of their patients. I make this claim because, as discussed earlier, a charter on patients’ rights exists in Ghana. However, my findings suggest a lack of connection between the tenets of the document and what is actually happening in the health care environment.

A rather peculiar finding in terms of patient disclosure patterns is linked to the “fear of reprimand.” Results from this study indicate that patients avoid sharing pertinent information, such as, how long they have had a disease. Notably, patients expressed fear about being reprimanded by their physicians for visiting the hospital with a degenerate condition. In a previous study on problematic disclosures by patients to doctors, du Pré and Beck (1997) discovered that sometimes patients engaged in exaggerated self-disparagement to avoid their physician’s disapproval and seek reassurance. In this study, physicians justified their reprimands and indicated that instead of reporting early, some patients seek unorthodox treatment and arrive at the hospital when their illness is in a worsening stage. Dr Konadu explained:

In the patient’s mind, the fear is that if they divulge that they’ve problem for this number of weeks or months, the health worker is going to shout on them. And this sometimes makes them scared to the extent that they are untruthful about how
long they have had the disease just so they avoid that kind of condemnation or reprimand.

The concern about reprimand is subsumed in patients’ use of herbal medicine which in physicians’ opinion only exacerbates their condition. Patients struggle with choosing between herbal or orthodox treatments. As mentioned by physicians, some patients administer herbal medicine at home and only visit the hospital if their illness gets worse. Thus, while physicians clearly expressed their disapproval of herbal medicine use by their patients, reprimanding patients have so far not yielded positive results. A related study (Vickers, Jolly, & Greenfield, 2006) about herbal medicine use in the United Kingdom found that there is a lack of disclosure of herbal medicine use by patients to doctors. Vickers et al. (2006) also noted that reasons why patients did not share their use of herbal medicine with their physicians was because physicians did not inquire about it, and patients feared they might receive a negative response if they shared such information with their physicians.

The various aspects of disclosure patterns which emerged from this study can be examined within the framework of communication privacy management (CPM) (Petronio, 2002). Petronio noted that sometimes confidentiality and privacy are in tension with each other, which influences individual decisions to reveal or conceal their private information. The theory further posited that individuals develop privacy rules based on their cultural values, gender, assessment of risk-benefit and the situational context. Moreover, individuals determine to share information with others based on the relationship they have with them and the conviction that the other person will keep the
Petronio (2002) identified various types of confidants such as shareholders (those who are perceived as serving a functional role and providing the original owner a needed outcome), reluctant confidants (those who receive unsolicited private information), and deliberate confidants (those who request private information from others directly, indirectly or gain permission from them to know the information) (see also Petronio & Reierson, 2009). According to Petronio and Reierson (2009) examples of deliberate confidants include physicians as they “depend on learning private medical information either through directly receiving descriptions about the medical symptoms from the patient or through the results of medical tests for which they have been given permission to know” (p. 374).

Using CPM theory to understand my data, I would argue that patients in this study do not to regard their physicians as confidants. Rather, they choose whether or not they want to share certain information with the physician. For instance, men in the focus group discussion were less likely to inform their physicians about sexually transmitted diseases such as gonorrhea. They presumed that they will be perceived by physicians as promiscuous. Other patients mentioned that they will be reprimanded by their physicians if they disclosed particular information. For example, Kojo was aware that his alcoholic behavior contributed to the aggravation of his diabetes and limb amputation. Yet, Kojo was still not ready to inform his physician about his drinking habits. Such behaviors constitute preemptive privacy control (Petronio & Reierson, 2009). According to
Petronio and Reierson, “people use a strategy of preemptive privacy control to thwart anticipated privacy violations…people retain control over their information by setting up thick boundary walls preventing disclosure or permission for access” (p. 378).

Thus, it can be reasonably argued that patients interpret physicians’ reprimand as a compromise of trust. Consequently, patients guard the information that they share by utilizing preemptive privacy control strategies and invariably exercise their autonomy over what information to give to their physicians. The above notwithstanding, we can also interpret patients’ behavior as a reaction to physician power. For example, Sparks and Villagran (2010) found that “patients who perceive their provider to be significantly more powerful than themselves may not be completely honest about certain habits, risky behaviors, or lack of adherence to a medical treatment plan” (p. 44). We can infer from the findings in this study, that, the dominant position of the physician plays a role in patient disclosure decisions.

**Research Question 4**

In my last question, I sought to understand the relational and dialogic aspect of physician-patient encounters. However, majority of the response captured physicians’ experiences. Nonetheless, patients vocalized their experiences as best as they could. With regard to the clinical experience, physicians referenced behaviors such as patients’ lack of interest in learning about their health conditions, disengaging in the management or treatment plan, and relying on the physician to make all decisions. For example, Dr. Ofori noted that “…increasingly, we are dealing with conditions that require patient participation. The patient must be in full control of their treatment plan…diabetes,
hypertension, chemotherapy, etc. the patient must be a partner.” Particularly, physicians in this study contended that, with the increasing nature of chronic illness, they need patients to assume a more active role in managing and monitoring their own health, but this is not happening. Instead, patients expect their illnesses to be fixed by the physician. Moreover, physicians expressed concerns over patients’ refusal to ask questions during clinical interaction, and the possibility to speculate myths and misconceptions about their illness.

Previous studies indicated that physician-patient collaboration in the treatment of illness has been found to increase patient autonomy as the patient is able to make informed decisions more effectively (e.g., Ellingson, 2005; Forbat et al., 2009; Sparks & Villagran, 2010; Thompson et al., 2003). However, findings from this study suggest that not all patients are willing to be active participants in health care decision making. Notably, illiterate patients disengaged in treatment and management plans.

The idea of patient participation in treatment and management decisions may be further understood within the concept of shared-decision making (King, Eckman, & Moulton, 2011; Robertson et al., 2011; Shalowitz & Wolf, 2004; Thistlethwaite, Evans, Tie, & Heal, 2006). Among other things, share-decision making involves information exchange between physicians and their patients, deliberation, decision, and personalized care (Cullati, Courvoisier, Charvet-Bérard, & Perneger, 2011; Fulford, 2011). In terms of patients with low literacy, Shalowitz and Wolf (2004) noted that, while the concept of shared-decision making is a laudable approach for clinical interactions, we must realize
the potential barriers that lower literate patients might experience with the process. Shalowitz and Wolf stated:

In most cases, the patient’s vocabulary will limit the terms and concepts the physician is able to use when explaining health and disease processes…a physician may also be unable to judge adequately the amount of information that a lower literate patient understands. (p. 760)

Other studies about shared-decision making have established that, regardless of patients’ educational levels, some patients prefer to have their physicians guide the course of their health, and may or may not play a role in decision-making (Cullati et al., 2011; King et al., 2011; Müller-Engelmann et al., 2011; Say, Murtagh, & Thomson, 2006).

Using previous studies to understand findings from this research, I would contend that, the desire by physicians for patients to assume active roles in their health care, though praiseworthy, should be approached with caution. I have already established, using previous research, the varying levels of willingness by low literate patients to engage in shared-decision making. However, findings from this study suggest that physicians are yet to realize the scope of illiteracy problems with some of their patients.

According to a report on adult learning and education in Ghana, as of the 2000 national census, “only 53.3% of the population (15 years or older) are literate either in English or a known Ghanaian language” (Ministry of Education, Science, & Sports, 2008, p. 2). The report further noted that 45.9% of adults are illiterate; 12.7% are literate in English only; 6.4% are literate in Ghanaian language only, and 0.8% literate in another language. These statistics indicate that, in order for physicians to accomplish the process
of shared decision-making, they would have to consult with their illiterate patients to establish an understanding of a patient’s level of comfort with the process.

Another important finding for research question four centered on patients’ reports about physician control. While some patients preferred to relinquish decisions to their physicians, others opted for some amount of explanation about their health condition. For example, Yaa, who had previously undergone surgery for ectopic pregnancy and recovering from a fibroid surgery at the time of our interview, stated that “I wish the doctors would explain whether or not the fibroid surgery would affect my ability to bear children.” Similarly, Kwame added that “the doctors rush through everything making it difficult to understand, some doctors don’t even ask if you [patient] have questions.” These responses from patients are in contention with physicians’ suggestion about patients’ lack of participation. Consequently, these dimensions highlight the need for physicians to make a conscious effort at listening to their patients concerns, and reassuring patients that their opinions matter (Cullati et al., 2011; Smith, 2011; Stewart et al., 2003; Thompson et al., 2003).

Findings illuminated the specific problems that illiterate patients encounter with the health care system, such as, inability to fully engage in treatment decisions or follow through with management plans, and visiting the hospital with degenerate illness. Literacy in health information, even for those with some level of functional literacy continues to be a struggle (Ferguson, Lowman, & DeWalt, 2011; Smith, 2011). Sparks and Villagran (2010) indicated that:
Health literacy includes the ability to understand instructions on prescription drug bottles, appointment slips, medical education brochures, doctors’ directions and consent forms, and the ability to negotiate complex health care systems. Health literacy is not simply the ability to read. It requires a complex set of reading, listening, analytical, and decision-making skills, and the ability to apply these skills to health situations. (p. 12)

In view of the above explanation about health literacy, illiterate patients constitute a vulnerable population in health care settings and confront a huge maze whenever they encounter a health problem. As a result, physicians must be cognizant of their patients’ educational background and how that shapes patients’ health care experiences. In this regard, it would be useful for physicians to pay more attention to the needs of illiterate patients. For example, it is possible to help patients through the “teach back” or “visual cues” method (Houts, Doak, Doak, & Loscalzo, 2006; Peregrin, 2010; Rowan, 2008). These approaches involve the patient repeating information to the physician about a diagnosis or treatment plan, so that the physician can verify whether or not the patient fully understands medical information or instructions (Sparks & Villagran, 2010).

Additional findings from research question four highlights physicians’ lack of expertise in breaking bad news. Physicians in this study recounted the various struggles they experienced when sharing a bad diagnosis to a patient, or conveying information about death to a patient’s family. They also referenced the absence of communication skills training in medical schools as probable reasons why they struggle with delivering such news. Studies have shown that delivering bad news within health care settings vary
depending on various cultures (Gongal et al., 2006; Torres & Rao, 2007), nonetheless physicians continue to struggle with conveying such information (Llyod, 2009; Ptacek & McIntosh, 2009). With respect to communication skills, studies elsewhere (Lane & Rollnick, 2007; Nestel, Calandra, & Elliott, 2007) have shown that stimulated patient training programs have proved useful in enhancing clinical communication skills, and as such, have become standard components of medical and pharmacy school curricular.

Evidence from this study suggests that what is lacking in terms of clinical communication in Ghana is the interpersonal dimension, which is apparent in the overwhelming responses provided by physicians as opposed to patients. Previous scholars (e.g., Beck, 2001; Cegala & Street, 2010; Sparks & Villagran, 2010; Thompson et al., 2003; Whaley, 2000) have argued that broadening and deepening our understanding of interpersonal communication in health provides insights to how individual health beliefs, decisions about health, and experiences of illness are negotiated by patients and their physicians.

In terms of the dialogic and relational aspect of care, I caution how we might interpret patients’ “silences.” In the field of health communication, some studies (e.g., Carabas & Harter, 2005; Umefa, 2005; Zhang & Siminoff, 2003) have characterized silence as marginalization, oppression, and lack of power. While I acknowledge that patients’ responses to questions were rather minimal, the “speech/silence” dichotomy (Acheson, 2008) would not be an accurate representation of this research process. Moreover, not all researchers agree that silence signifies a lack of power (Ehrenhaus, 1988; Kim, 2002). For example, Charmaz (2002b) noted that while silences could be
intended or imposed, these are specific to cultural contexts and that unlike Western cultures that view silence as problematic, non-Western cultures value silence. In relation to patients in this study, their lack of knowledge about diagnosis and prognosis could be reasons why they shared very little information.

**Practical Implications**

This dissertation contributes to existing research by highlighting specific aspects of language barriers, interpreters, and self-disclosure issues which have not been captured by health communication research in Ghana. Findings revealed that, while a consciousness exists among physicians about how to better relate and communicate with their patients, they lack guidance on how to enhance the clinical experience. More so, concerns exist over how to support illiterate patients so that they can assume more active roles in their health. In this section, I provide practical implications of my research.

With regards to limited vocabularies, we find that participants struggled with translating medical terminologies in the indigenous dialects. However, it is unclear whether or not such terminologies exist in the various Ghanaian languages. We do know that indigenous languages are taught from primary school to university level, and used on radio and television stations. We also have the Ghana Institute of Languages which focuses on indigenous language forms. Therefore, physicians can work with hospital administrators, as well as the Ghana Institute of Languages to provide a glossary of medical terminologies in the nine major dialects. This glossary could also be made available as information leaflets for patients.
Apart from vocabulary issues, the multiplicity of languages constitutes a major concern in terms of clinical interaction. Compared to other multilingual countries, the situation in Ghana differs not in terms of migrant languages, but the indigenous dialects of different ethnic groups for which we lack medical interpreters. However, I have illustrated, based on data from this study, the inadequacies that untrained interpreters bring to the clinical encounter. For example, concerns emerged over translation accuracy and linguistic proficiency. Given that more than half of the physicians in this study advocated for providing formal medical interpreting services, there is a clear indication of a need which must be met.

In my opinion, working to initiate a policy framework for medical interpretation is feasible. Based on findings from this study we know that language barriers do exist, and the services of interpreters are utilized regardless of their training. We also know, based on existing literature (see chapter two) and findings from this study that using untrained interpreters though valuable is fraught with multiple challenges which invariably influences patient health outcomes.

I must caution though that while I am advocating that the Ghana Health Service and Ministry of Health should consider incorporating interpreting services in the health care system, I do acknowledge the potential costs, infrastructural, logistical, human resources, and other possible constraints that this might pose for a developing economy such as Ghana. However, the platform already exists because nine major indigenous languages are already taught in schools and used in the media. For example, the state-owned television presents adult education programs in the major languages. Moreover,
initial interpretation services can focus on a few languages and limit services to large health care facilities which receive huge patient populations with diverse needs.

In terms of how to initiate the process, various health care interpreting models are available and can be adapted to suit the Ghanaian health care system. For example, in the United States, the National Council on Interpreting in Health Care (NCIHC, 2002) stipulates policies for offering interpreter services for those who need it. Further, NCIHC (2002) provides a document which identifies various models for interpreter training. These include, tertiary institutions which offer academic programs, bilingual health employee training programs, community training programs, intensive training for at least 40 hours, and agency training programs.

In terms of adapting any of these models to the Ghanaian health care system, a cost efficient option would be to utilize bilingual or multilingual employees who work at a particular health facility. As already detailed in this study, the services of such personnel are already being used regardless of any training in medical interpreting. Specific examples include nurses, thus, instead of seeking other individuals with no medical background, bilingual or multilingual health personnel who opt to train as medical interpreters can receive additional compensation for this added skill. On the contrary, some constraints to using in-house staff will include budget accommodations for the training programs as well as compensation for interpreters. Another constraint could be the frequency with which employees who double as interpreters might have to leave their regular job (for which they were employed) to offer interpretation services.
A second option which could be reviewed would be for the Ghana Health Service and Ministry of Health to sublet interpreting services to a private agency, yet, assume oversight responsibilities. With such an arrangement, the agency could be monitored to ensure that it is complying with relevant ethical guidelines. The potential benefits in terms of agency services are that health care facilities will not have to worry about recruiting or training medical interpreters. In addition, patients and physicians will have access to interpreters whenever they need them.

Patient disclosure behaviors did not prove helpful in enhancing their own care, and this study indicated that physician behaviors largely influenced patients’ disclosure decisions. Physicians also enumerated the struggles that they experience with delivering bad news, and they referenced the absence of communication skills courses in medical school curricular. An important approach to optimize patient level of trust and comfort at sharing information will have to begin with providing periodical communication training skills for physicians who are already practicing.

An attempt at addressing these concerns at the remote level could begin with collaboration between the Ministry of Health and the public Universities which have medical schools to incorporate communication skills courses in the medical school curricula. In this regard, content areas or syllabi must be specific as to which areas of competency medical students need training. For example, in previous studies (Cegala & Lenzmeier Broz, 2002) found that topics such as explanation of symptoms, negotiated treatment options, and shared decision-making seemed to be areas that physicians needed further communication skills training.
Other findings from this study indicates that illiteracy comprise a major obstacle to health care delivery. With the high illiteracy rate in Ghana, physicians should collaborate with health educators to design simple and comprehensible health promotion campaigns in indigenous dialects. Adult education programs which occur in indigenous dialects and air on national television, serve a ready platform for patient education (Ministry of Education, Science & Sports, 2008).

In terms of how best to support their patients, the concept of *patient-centeredness* (e.g., Cegala & Street, 2010; Epstein & Street, 2007; Kanter & Horowitz, 2009; Watson & Frampton, 2009) has proved useful in clinical interactions, and has universal appeal in terms of the benefits (de Haes, 2006). Basically, the idea is for physicians to move from merely focusing on a patient’s illness and more towards the concerns, preferences, and feelings of the patient, and also allow patients to participate in decision-making to the degree that they wish. Since physicians in this study already acknowledged that they need to relate better with patients, they can begin to incorporate patient-centered care into their clinical interactions and focus on a more relational approach with their patients.

Another concern which emerged in the study relates to physicians’ frustrations over huge patient case-load and time constraints. This issue could be addressed by incorporating scheduled clinical appointments in order to ease physician work-load and enhance patient care.

Finally, I must mention that compared to mainstream communication programs such as journalism, public relations, and advertising, health communication as an academic field is still evolving in Ghana (De Beer, 2009). Furthermore, a host of health
issues (e.g., onchocerciasis, guinea worm disease, tuberculosis, adolescent reproductive health, child and maternal health, etc.) in Ghana seek the attention of health communication scholars. With momentum growing toward global health (Sparks & Villagran, 2010) such research would not only benefit African academics, but would enrich the field of communication both in research and theory. Recently, scholarly forums in communication journals raised the question, “Has communication research made a difference?” (Hample, 2008; Timmerman, 2009). In Ghana, research by communication scholars especially the in health care settings has potential for making huge difference by identifying pertinent health care issues, and enhancing interactions between health care seekers and health care professionals.

**Limitations of the Study**

This study required locating illiterate patients who would be willing to spend time on interviews and focus group discussions. Hence, an important limitation of this study was the small number of patients compared to physicians. A larger group of patients could have provided more depth and richness to the study. Thus, the research questions captured more of physicians’ experiences as opposed to patients. Consequently, additional research is needed to understand the sequential analysis of talk (e.g., clinical interview) between patients and physicians.

Since my research agenda focused on illiterate or low literate patients, the results may not be characteristics of all individuals or groups. I also suggest that we use caution when applying these results to other physician-patient relations that bother on language barrier, use of interpreters, and patient self-disclosure.
Finally, I worked hard to limit my personal bias, and I ensured that links between the data, categories, and emerging analysis encompass a representative interpretation of participants’ experiences. However, I do not dispute that my analysis might incorporate some form of subjectivity. Therefore, I respect an alternative interpretation which adds scope to my study but does not diminish its credibility.

**Suggestions for Future Research**

In my opinion, this dissertation generates more questions than answers. Thus, great potential exists for future research into various aspects of physician-patient interactions in Ghana. First, future studies can focus on identifying particular medical terminologies for which patients and their physicians encounter difficulties. Such studies can then be used to guide the development of a medical terminology glossary list in the indigenous dialects.

Second, the huge language diversity and the associated language barriers present a ready avenue for investigating medical interpreting processes for health care facilities. Specifically, an exploratory study will be useful to determine which indigenous dialects require interpreter services, as well as the cost and benefits of incorporating medical interpreting services into health care delivery. Although this study discussed interpreters and their roles in clinical interactions, it captured through the lens of patients and physicians. Thus, future studies can focus on various consulting processes which utilize interpreters and depict their experiences in the roles that they are required to play.

A third avenue for research could focus on the patients’ charter which is provided through the Ghana Health Service. Such an investigating should seek to understand the
extent to which physicians know about the tenets of the charter and choose share this document with their patients.

Fourth, future studies can examine illiterate patients’ preferences to engage in treatment decision-making and also the differences between illiterate and literate patients in terms of how they perceive their relationship and interaction with their physicians.

Finally, physicians in this study expressed frustrations over patients visiting the hospital only when their illness is worse, and they linked this pattern to patients’ reliance on herbal medicine. Future studies can focus on understanding patients’ treatment preferences and reasons why they choose to visit the hospital only when their condition begins to degenerate.

**Chapter Summary**

In this chapter, I discussed major findings from my research, interrogated various concepts in my data, and used relevant literature to support my arguments. I also provided my understanding and interpretation of the data and noted the implication of this study. Further, I acknowledged the limitations in the study, and offered suggestions for future research.
References


role_of_health_care_interpreter.pdf


Bowler, I. (1993). 'They're not the same as us': Midwives' stereotypes of south Asian
doi:10.1111/1467-9566.ep11346882

health disparities? A review and conceptual model. [Supplemental material].
*Medical Care Research and Review, 57*, 181-217.

interaction. In T. L. Thompson, A. M. Dorsey, K. I. Miller & R. Parrot (Eds.),

Theory and Application, 4*, 25-42.


reported use of anti-malarial drugs and health facility management of malaria in


Burgoon, J. K., Floyd, K., & Guerrero, L. K. (2010). Nonverbal communication theories
of interaction adaptation. In C. R. Berger, M. E. Roloff, & D. R. Roskos-
Ewoldsen (Eds.), *Handbook of communication science* (2nd. ed.) (pp. 93-108).


doi:10.1080/03637750802378799


doi:10.1080/17513051003611628


doi:10.1207/s15327027hc1701_6


Levin, M. E. (2006b). Different use of medical terminology and culture-specific models of disease affecting communication between Xhosa speaking patients and


Robertson, M., Moir, J., Skelton, J., Dowell, J., & Cowan, S. (2011). When the business of sharing treatment decisions is not the same as shared decision making: A


Appendix A: IRB Approval

Project Title: Physician-Patient Communication in Ghana: Multilingualism, Interpreters, and Self-Disclosure

Researcher(s): Shirley Acquah

Amendment: Title Change
Facility Advisor (if applicable): Christina Beck
Department: Communication Studies

Anne Loucks, Ph.D., Chair
Biomedical Institutional Review Board

Approval Date: 05/04/2010
Expiration Date: 05/03/2011

This approval is valid until expiration date listed above. If you wish to continue beyond expiration date, you must submit a periodic review application and obtain approval prior to continuation.

Adverse events must be reported to the IRB promptly, within 5 working days of the occurrence.

The approval remains in effect provided the study is conducted exactly as described in your application for review. Any additions or modifications to the project must be approved by the IRB (as an amendment) prior to implementation.
Appendix B: Recruitment Information for Interviews

My name is Shirley Acquah, I am a doctoral student in the School of Communication Studies, Ohio University, Athens-Ohio, USA. I would like to invite you to participate in a study which seeks to investigate how language barriers and use of interpreters influence the doctor-patient interactions. If you agree to take part in this project, I will give you a form and explain further details about the research. You will be asked to sign this form, which means that you have agreed to take part in the project.

As part of the process, you will be invited to take part in an audio recorded interview which will last for approximately 30 minutes. The questions that I would ask during the interview are not sensitive in nature, and pertain to your experiences. Participation in this project is voluntary and you can stop at any time. I would like to assure you that your identity will remain confidential since your actual name will not be included in my field-notes.

Thank you.
Appendix C: Recruitment Information for Focus Group Discussions

My name is Shirley Acquah, I am a doctoral student in the School of Communication Studies, Ohio University, Athens-Ohio, USA. I would like to invite you to participate in a study which seeks to investigate how language barriers and use of interpreters influence the doctor-patient interactions. If you agree to take part in this project, I will give you a form and explain further details about the research. You will be asked to sign this form, which means that you have agreed to take part in the project.

As part of the process, you will be invited to take part in a group discussion which will last for approximately 2 hours. This discussion will be audio recorded. The questions that I would ask during the discussion are not sensitive in nature, and pertain to your experiences. Participation in this project is voluntary and you can stop at any time. I would like to assure you that your identity will remain confidential since your actual name will not be included in my field-notes.

Thank you.
Appendix D: Interview Protocol for Physicians

Demographics

1. Gender: (a) female  (b) male

2. Age:  (a) 25-35  (b) 35-45  (c) 45-55  (d) 55-65  (e) 65 and above

3. Which Ghanaian language(s) do you speak?
   (a) Akan (b) Dagaare-Wali (c) Dagbani (d) Dangme (e) Ewe (f) Ga (g) Gonja (h) Kasem (i) Nzema (j) other ____________

4. What are the most common Ghanaian languages you speak with your patients?
   (a) Akan (b) Dagaare-Wali (c) Dagbani (d) Dangme (e) Ewe (f) Ga (g) Gonja (h) Kasem (i) Nzema (j) other ____________

Questions

1. Let’s talk about your interaction with your patients, how do you normally start?
   Probe: what are some exciting or challenging interactions you have had with your patients?
   Probe: if you would change something that happened in your interaction with a patient, what would you change and why?

2. How would you describe your relationship with your patients? For example, is it professional or informal? Why do you maintain a particular approach?

3. How do you know if your patient is satisfied, bothered or unhappy during and after a medical encounter?
4. Tell me about your experiences with patients that you do not share a common language with.
   **Probe:** how do you communicate with your patients in a language barrier exists.

5. Describe some of the most challenging or frustrating situations you have encountered as a result of a language barrier?
   **Probe:** how did you handle those situations?

6. Tell me about some of the most satisfying moments you have had in spite of a language barrier?
   **Probe:** what might have accounted for this situation?

7. Is the hospital administration aware of the language difficulties that you encounter with patients?
   **Probe:** if yes, how has the situation been addressed, if not, why?

8. In medical consultations where you encounter language difficulty, who have you depended on for interpretation?
   **Probe:** in situations where you have had to depend on and interpreter, how has it influenced your communication with patients?
   **Probe:** in situations where you depend on an interpreter to communicate with your patient, how do you assess the extent of information a patient would like to have?

9. When using interpreters, how do you convey the existence of a terminal illness and treatment options to your patients?
   **Probe:** how do you ensure that the interpreter is conveying the appropriate information to your patient?
10. Tell me a little about how the use of an interpreter might shape your interaction/relationship with your patients?

11. Please share some suggestions on how to bridge language barriers between doctors and their patients.

   Probe: what additional information would you like to share in terms of how language barriers influence your communication with patients?

12. How would you describe patient’s behavior in terms of sharing or disclosing information about their illness

13. What are some possible reasons why patient might not disclosure health information?

14. Based on our discussion, what ideas or recommendations do have for improving the relationship and communication between physicians and patients?
Appendix E: Interview Protocol for Patients

Demographics

1. Gender: (a) female (b) male

2. What Ghanaian language(s) do you speak?
   (a) Akan (b) Dagaare-Wali (c) Dagbani (d) Dangme (e) Ewe (f) Ga (g) Gonja (h) Kasem (i) Nzema (j) other ____________

3. Which is the most common Ghanaian language(s) you speak with your doctor?
   (a) Akan (b) Dagaare-Wali (c) Dagbani (d) Dangme (e) Ewe (f) Ga (g) Gonja (h) Kasem (i) Nzema (j) other ____________

4. Age: (a) 18-25 (b) 25-35 (c) 35-45 (d) 45-55 (e) 55-65 (f) 65 and above

Interview questions

1. When you meet with your doctor, what are some of your expectations?
   Probe: how would you describe your relationship with your doctor?
   Probe: what are some of the things that you would wish your doctor should tell you about your health condition?
   Probe: what are some things you would rather not want to know about your health condition, and why?

2. How would you describe interaction with your doctor?
   Probe: are you able to express your thoughts clearly? If so how, if not, why?

3. What are some of the things that make you happy or satisfied when interacting with your doctor? Why?
4. Tell me about a situation you have encountered in communicating with doctors who do not speak the same language as you.
   Probe: how did you manage the interaction process when you both could not speak the same language?

5. In situations where you and your doctor did not speak the same language who have you relied on for interpretation?
   Probe: if you were to depend on an interpreter during your interaction with your doctor, who would you prefer? For example: a trained a medical interpreter, a nurse, other health workers, family members, friends, or other patients.
   Probe: explain the reason for your choice

6. In cases where you depend on an interpreter, how much of your personal health information would you be willing to share? Explain the reason for your answer.
   Probe: kindly share some thoughts on how the presence of an interpreter might shape your interaction with your doctor?

7. When you visit the hospital, what type of information would you rather not disclose to your doctor, and why?

8. Please share some thoughts on how you would like your doctor to relate and interact with you.
Appendix F: University Consent Form

Ohio University Consent Form

Researcher: Shirley Acquah, (School of Communication Studies, Ohio University, USA)

You are being asked to participate in research. For you to be able to decide whether you want to participate in this project, you should understand what the project is about, as well as the possible risks and benefits in order to make an informed decision. This process is known as informed consent. This form describes the purpose, procedures, possible benefits, and risks. It also explains how your personal information will be used and protected. Once you have read this form and your questions about the study are answered, you will be asked to sign it. This will allow your participation in this study. You should receive a copy of this document to take with you.

**Explanation of Study**

The purpose of this study is to explore how multilingualism shapes the physician-patient communication. In order for me to undertake this study, I will be asking for your voluntary participation. If you agree to take part in this study, I will ask you a few questions which will last for approximately 30 minutes. I will use a digital audio recorder to record our conversation.

**Risks and Discomforts**

There are no potential risks or discomforts associated with this study. You will be asked to provide answers to short questions. None of these questions involve sensitive information. As a voluntary participant, you can choose to disengage in this process at any time you wish and there will be no consequences.

**Benefits**

You will receive no direct benefit from this study. However it is my hope that data generated will be used to provide training aimed at enhancing communication between patients and their physicians.

**Confidentiality and Records**

All materials collected in this study will be kept in a locked office and not seen by anyone who is not working directly on the study. No summaries or other reports of the research findings will contain information about particular individuals. During the transcription process, pseudonyms will be assigned to all participants to protect identities. All audio recordings (tapes) will be destroyed by May 31, 2010.

Additionally, while every effort will be made to keep your study-related information confidential, there may be circumstances where this information must be shared with:
* Federal agencies, for example the Office of Human Research Protections, whose responsibility is to protect human subjects in research;
* Representatives of Ohio University (OU), including the Institutional Review Board, a committee that oversees the research at OU;

**Compensation**

You will receive no financial or any form of compensation for participating in this study.

**Contact Information**

If you have any questions regarding this study, please contact: Shirley Acquah at (021) 221537/024-262-9147 or Dr. Christina Beck, beck@ohio.edu, (001) 740-593-9167,

If you have any questions regarding your rights as a research participant, please contact Jo Ellen Sherow, Director of Research Compliance, Ohio University, (001)740-593-0664.

By signing below, you are agreeing that:

- you have read this consent form (or it has been read to you) and have been given the opportunity to ask questions
- known risks to you have been explained to your satisfaction.
- you understand Ohio University has no policy or plan to pay for any injuries you might receive as a result of participating in this research protocol
- you are 18 years of age or older
- your participation in this research is given voluntarily
- you may change your mind and stop participation at any time without penalty or loss of any benefits to which you may otherwise be entitled.

Signature: __________________________________________ Date: ______________

Printed Name: __________________________________________
Appendix G: Ohio University Oral Consent Form

Ohio University Consent Form
(Oral consent process for focus group discussion with patients)


Researcher: Shirley Acquah - School of Communication Studies, Ohio University, (USA)

I am undertaking a research for my academic work and I need volunteers. For you to be able to decide whether you want to participate, you should understand what the research is about, as well as the possible risks and benefits in order to make an informed decision. This process is known as informed consent. The form that I am holding describes the purpose, procedures, possible benefits, and risks. It also explains how your personal information will be used and protected. I will verbally translate and explain the information on this form to you. You will need to verbally confirm (by saying yes you voluntarily want to participate). This will allow you to take part in the discussion. I will also give you a copy of this document to take with you.

Explanation of Study
The purpose of this study is to explore how different languages affect the communication between a doctor and a patient. For example, if you do not speak the same language as your doctor. Do you rely on an interpreter? How comfortable or uncomfortable do you feel sharing your health informing with a third person. In order for me to undertake this research, I will be asking for your voluntary participation. If you agree to take part, you will be asked to come to a particular location where you and a group of other people who are also participating in my research will be discussing the topic. In order to gather the information which I need, a digital audio recorder to will be used to record the discussions.

Risks and Discomforts
Please do not discuss any medical conditions during our group discussion. This is because I (the researcher) cannot assure the confidentiality. In other words, if you reveal information about your medical conditions in the focus groups, I cannot guarantee that other group members will keep the information confidential. In terms of risks and discomforts, I would like to state that the purpose of the discussion is for you to share any communication difficulties you have experience with your doctor due to the fact that you do not speak the same language. None of the questions involve sensitive information. Also the information you provide in this discussion will not in any way affect your clinical information/medical records/treatment process. As a voluntary participant, you can choose to disengage in this process at any time you wish and there will be no consequences.
**Benefits**
You will receive no direct benefit from this study. However it is my hope that data generated will be used to provide training aimed at enhancing communication between patients and their physicians.

**Confidentiality and Records**
All materials collected in this study will be kept in a locked office and not seen by anyone who is not working directly on the study. No summaries or other reports of the research findings will contain information about particular individuals. During the transcription process, pseudonyms will be assigned to all participants to protect identities. All audio recordings (tapes) will be destroyed by May 31, 2010.
Please do not discuss any medical conditions during our group discussion. This is because I (the researcher) cannot assure the confidentiality. In other words, if you reveal information about your medical conditions in the focus groups, I cannot guarantee that other group members will keep the information confidential.
Additionally, while every effort will be made to keep your study-related information confidential, there may be circumstances where this information must be shared with:
* Federal agencies, for example the Office of Human Research Protections, whose responsibility is to protect human subjects in research;
* Representatives of Ohio University (OU), including the Institutional Review Board, a committee that oversees the research at OU;

**Compensation**
The discussion will last for approximately two hours. You will receive 35 Ghana cedis (the equivalent of 25 US dollars) if you participate in the discussion till the end. If you choose to stop participating at a certain point in time you will receive 15 Ghana cedis (10 US dollars).

**Contact Information**
If you have any questions regarding this study, please contact: Shirley Acquah at (021) 221537/024-262-9147 or Dr. Christina Beck, beck@ohio.edu, (001) 740-593-9167,

If you have any questions regarding your rights as a research participant, please contact Jo Ellen Sherow, Director of Research Compliance, Ohio University, (001)740-593-0664.

---

By providing oral consent, you are agreeing that:
- this consent form has been read/translated to you and you have been given the opportunity to ask questions
- known risks to you have been explained to your satisfaction.
- you understand Ohio University has no policy or plan to pay for any injuries you might receive as a result of participating in this research protocol
• you are 18 years of age or older
• your participation in this research is given voluntarily
• you may change your mind and stop participation at any time without penalty or loss of any benefits to which you may otherwise be entitled.

Witness: Shirley Acquah (Researcher) Date: ______

Witness signature: ________________________________
Appendix H: Focus Group Discussion Guide for Patients

Opening

1. Tell me your name and something interesting about you

2. Think back to when you first visited this hospital, what were your impressions about the healthcare providers (nurses, doctors, etc)

Key questions

3. What Ghanaian language(s) do you speak fluently?
   
   Probe: Are you able to read or write any of these languages?

4. When you visit the clinic, what language do you speak with the doctor?

5. Have you ever experienced a situation where you and the doctor did not speak the same language? If so, how were you able to convey messages about your health situation?

6. What challenges if any, have you encountered because of your inability to express yourself due to language differences between you and your doctor?

7. If you were to depend on an interpreter because you and the doctor did not speak the same language, which would you prefer, someone who has been trained as a medical interpreter, a nurse, other health workers, family member, friend, other (provide example).
   
   Probe: Explain the reason for your choice.

8. If you had a health situation which you considered very personal/private, would you be comfortable sharing that information through an interpreter?
   
   Probe: Explain the reason for your answer.
9. What suggestions do you have for doctors to improve the way they communicate with you?

**Ending questions**

10. What should your doctor do to help you better understand your illness, and treatment?

11. If you had the chance to give advice to doctors regarding how they interact with you, what would you suggest?