MEDICAL PRACTITIONERS' PERCEPTION OF CULTURAL AND LANGUAGE BARRIERS TO PATIENT-CENTRED INTERACTION IN A TERTIARY HEALTH INSTITUTION IN EKITI STATE

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Abstract

Interaction is central to medical practitioner-patient consultations that go on in hospitals. Patients visit hospitals with the hope of getting positive health outcomes and a lot will be done in order to achieve this. The interaction engagements that ensue between the doctor and the patient would go a long way to influence the quality of healthcare delivery to the patient. This is because good interaction will assist the patient to make certain informed decisions that can help improve the patient's health. In recent years, emphasis is laid on communicating with patients rather than communicating to them. Good communication that is void of barrier can educate patients about their illness, its treatment and how it can affect their lives. However, as important as communication/interaction is in hospital engagements, there are certain barriers that hinder its effectiveness. These barriers include: culture, language, gender, race and religion among others. Various health institutions serve diverse populations all over the world. Nevertheless, Nigeria communities are more culturally and linguistically divers than any western country. Taking care of these diversities is paramount to achieving efficiency in health care delivery. How medical practitioners perceive these diversities would go a long way to influence how they will manage them for good and proper health care delivery. This paper therefore investigated how medical practitioners perceive cultural and language barriers to medical practitioner-patient interaction during hospital engagements. Two research questions were raised and three null hypotheses were formulated. The population consisted of all medical practitioners in Federal Medical Teaching Hospital, Ido-Ekiti. A sample of 120 respondents was selected through random sampling. The instrument for data collection was a questionnaire titled "Questionnaire on Medical Practitioners' Perception of Cultural and Language Barriers to Patient-Centred Interaction" designed by the researchers. Data collected were analysed using descriptive and inferential statistics. Results obtained showed that medical practitioners perceived language and cultural barriers to be jeopardising interaction with patients during hospital engagement. Gender was found not to significantly influence the perception of medical practitioners. There was no significant difference in the perception of doctors and nurses and years of experience did not significantly influence medical practitioners' perception. Based on the findings, it was recommended among others that medical practitioners be exposed to more techniques for communicating with patients of various linguistic backgrounds and there is the need to foster synergy between medical practitioners and linguists in order to find better means of overcoming language and cultural barriers to interaction with patients in hospitals.

Key Words: Practitioner-Patient, hospitals, engagements, Language, Barriers.

Introduction

The need for patient-centred interaction is born out of the necessity to build trusting relationships with patients in order to achieve improved health outcome among the patients. Physicians employ some interaction techniques to secure their patients' confidence and trust. Patients visit hospitals to seek medical care and they come with a lot of concerns, anxieties

and fear. It has been suggested that healthcare providers and professionals should fully engage patients and their families in the care process in meaningful ways (Kwame and Petrucka, 2021). There is need for good communication/ interaction between the physician and the patient to help the patient obtain information that could lead to appropriate health decisions. Ability to understand healthcare information on the part of the patient will help him/her participate in arriving at meaningful decisions about his/her own healthcare. According to the Canadian Medical Association (2019), patients can be their own best risk managers if they have information on the reasons for a proposal investigation or treatment as well as the risks, benefits and alternatives which may include no treatment.

The interaction between the patient and the medical practitioner could go a long way to influence the quality of healthcare delivery to the patient. The interaction is majorly conveyed by one form of communication or the other. Communication is more than what is expressed through speech. A lot of communication can take place through body language. Michaud, Davis and Gaines (2007) submitted that good communication with patients leads to the following:

(1) Making patients more active in their healthcare more satisfied and have better outcomes.
(2) Help physicians facilitate patient involvement in healthcare, and
(3) Make what seem like simple communication and skill-building strategies charge the capacity of patients to self-manage disease and advocate for quality care.

It is therefore evident from their submission that understanding patient-doctor communication is vital to a successful relationship that could lead to better health decisions.

As important as good interaction/communication may be, it is not devoid of certain variables that are capable of jeopardizing its effectiveness and such variables that can serve as barriers include both cultural and language barriers. This is what Berg (2016) calls linguo-cultural barriers. Patients come from varying background and possess different characteristics.

Nigeria is a multilingual and multicultural nation where many ethnic groups migrate and live together in the different parts of the country. Apart from the three major languages of Yoruba, Hausa and Igbo, there are other minority languages that exist in their numbers. In addition to this there are many Nigerians who do not speak English language which is the Lingua Franca of the country. There are a vast majority who only speak the indigenous languages. Patients with limited English language proficiency seem to face significant language barriers that keep them from fully participating in their care and in patient-medical practitioner communication. According to Sulaiman (2019), language is at the heart of communication and any exchange of information. When there is a breakdown, vital information that both patients and medical practitioners rely on is not captured, not delivered, not accurate, delayed or just not correct. This in turn leads to errors, mismanagement and injury. Language barriers keep these patients from both engaging in seamless conversations with their doctors and interacting with the healthcare industry at large.

Coupled with the linguistic diversity is the cultural diversity. Different cultures believe and practice different things. For example, in some culture, a woman is not expected to discuss with a man; when a woman patient therefore appears before a male physician, it could constitute a barrier to their communication. Doughes, Souza and Yudin (2017) examined barriers to full

disclosure and open communication between patients and their health care provider during gynaecology appointments and found that male gender is the greatest barrier to full disclosure of information by the female patient.

Furthermore, different culture perceived different ailments/diseases differently. Some diseases are seen as taboos in certain culture. This kind of belief could pose a great challenge to the kind of interaction that will ensue if a patient with such cultural belief appears before a physician for consultation. Paternotte, et al (2015) asserted that one of the challenging areas of healthcare communication is communication with culturally diverse patients. The cultural orientation of individuals impacts their communication behaviour during social interaction (Kwame, 2023)

Cultural and language barriers keep patients from building strong relationships that foster positive experience. According to Patient Engagement Hit (2019), cultural and language barriers get in the way of a positive patient experience in urban and multicultural community health centres. Shamsi, Almutairi, Mashrafi and Kalbani (2020) submitted that language barriers have a major impact on the cost and quality of healthcare and regardless of language barriers, healthcare providers are required to deliver high-quality healthcare that adheres to the principles of human rights and equity to all their patients.

Perception has to do with how people select, organise, process and interpret information received. Perception makes individuals to interpret information differently. Certain factors are believed to influence perception among which are:

i. Personal Experiences,
ii. Age, and
iii. Gender

Personal experiences may influence the way an individual will perceive something. What individuals have experienced over the years especially in professional practice may impact on such individual's perception. As one gets older, one's perception about people and things generally change over time based on the fact that what is important to us at a particular age may not be important to us at another age and vice versa. Gender has been found to influence perception. Male and female may perceive things differently.

Weintraub, Thomas-Maddox and Byrnes (2015) opined that perception is key to how we assign meaning in our interactions with others and thus has a significant impact on how we communicate and how we understand the communication of others. They further categorised the perception process into three, namely: selection, organisation and interpretation. Selection is how we focus attention on a particular thing and ignore other elements within the environment. The second phase, organisation is to focus attention on particular aspect/ characteristic of what we have selected. Interpretation is to attach meaning to what has been selected and organised. Perception, especially when it is negative can lead to distortions and biases that can cause inaccurate judgement and interpretation.

This study is hinged on the cognitive theory which was brought to prominence by Donald Broadbent's book *Perception and Communication* in 1958. Cognitive theory is based on cognitive psychology which explores the internal mental processes of human beings. It emphasizes complex, abstract intellectual processes such as thinking, problem solving, perception and so on (Gagne, 1980). Since then, the dominant paradigm in the area has been the information processing model of cognition that Broadbent proposed. The focus is on the way of thinking and reasoning about mental processes in the brain.

Cognitive psychology was coined by Neisser (1967) in which people were characterized as dynamic information processing systems whose mental operations might be described in computational terms. Neisser emphasized it is a "point of view" that postulates the mind as having a certain conceptual structure. It therefore presupposes that responses are affected by the point of view of the receiver of the stimulus as well as by his or her environment. Advocates of cognitive theory seek information about ways individuals think or engage in cognitive activities while solving problems.

Ekiti State is located in southwest, Nigeria and it is majorly an agrarian state. Many ethnic nationalities migrate to the State for farming purposes. Many of these farmers are not well educated and cannot communicate in English language. Apart from these groups of people, quite a number of the indigenes don't speak in English language. These categories of people have various health challenges that make them attend hospitals. The Federal Medical Teaching Hospital located at Ido Ekiti is attended by people of varying background from across the state and beyond. Medical practitioners in the hospital have to communicate with these patients from various linguistic and cultural backgrounds. It is therefore pertinent to investigate how they perceive the language and cultural barriers to effective communication during hospital engagements. Perception is vital to how we assign meaning in our interaction with others and thus, it has a significant impact on how we communicate and how we understand the communication of others (Weintraub, Thomas-Maddox, and Byrnes 2015).

Statement of the Problem

The inability of healthcare providers to communicate with patients effectively constitutes a major barrier that can lead to emotional stress, dissatisfaction and uncertainty on the part of the patient. Often, patients hold different opinions that are culturally biased about the origin of disease that are not in tandem with the knowledge of the health care providers' about the origin of such diseases. Language and cultural barriers could compromise the quality of healthcare provided and the level of access patients can have to good quality healthcare delivery if not attended to by relevant stakeholders. There is the need therefore to explore how medical practitioners perceive how these barriers (language and cultural barriers) affect the level of interaction between them and their patients in their bid to deliver quality healthcare to the patients. Patients see language barriers as significant hurdles to managing their health. Though the issue of language and cultural barriers to quality healthcare delivery are attested to all over the world, little is being done in the area of research on the issues.

Objectives of the Study

The study was carried out in order to:

(1) find out how medical practitioners perceive language barriers to patient-centred interaction engagement in hospitals;
(2) investigate how medical practitioners perceive cultural barriers to effective patient-centred interaction during consultations;
(3) examine whether there will be significant difference in the perception of male and female medical practitioners;
(4) examine whether there will be significant difference in the perception of medical doctors and nurses;
(5) investigate whether the years of experience of the medical practitioners would significantly influence their perception.

Research Questions

The following Research Questions were raised to guide the study:

(1) How do medical practitioners perceive language barriers to patient-centred interaction?

(2) How do medical practitioners perceive cultural barriers to patient-centred interaction?

Hypotheses

Three hypotheses were also formulated for the study:

1. There is no significant difference in the perception of male and female medical practitioners on language and cultural barriers to patient-centred interaction.
2. There is no significant difference in the perception of medical doctors and nurses about language and cultural barriers to patient-centred interaction.
3. Years of experience of the medical practitioners will not significantly influence their perception of language and cultural barriers to patient-centred interaction.

Methodology

The study adopted the descriptive research of the survey type in that it used responses from a chosen sample to describe an existing phenomenon without any manipulation of variables. The design specifically allowed respondents to give their perception of language and cultural barriers to patient-medical practitioners' interaction during hospital engagements. The population for the study consisted of all doctors and nurses at the Federal Medical Teaching Hospital, Ido Ekiti, Ekiti State. They include male and female with different qualifications and years of experience. The sample for the study was One Hundred and Twenty respondents randomly selected from the entire population.

The instrument used for data collection was a questionnaire designed by the researchers and validated to ensure its face and content validity by giving it to experts in the field of Language, Language Education and Test, Measurement and Evaluation. Their corrections and suggestions were affected before the production of the final copy that was used. The reliability was ascertained by administering twenty copies of the questionnaire on respondents outside the sampled area twice within interval of two weeks and the two responses were correlated using Person Product Moment Correlation and a coefficient of 7.4 was obtained which was adjudged reliable for the study. Copies of the instrument were administered with the help of research assistants after obtaining necessary permission. The copies administered were collected and the responses were coded and analysed and the results are presented as follows:

Results

Research Question 1

How do medical practitioners perceive language barriers to patient-centred interaction?

Table 1: Medical Practitioners' Perception of Language Barriers to Patient-Centred Interaction

S/N	ITEMS	SA	A	D	SD	MEAN
1	Inability to communicate with patients in the language they understand can lead to dissatisfaction on the part of the patient.	62 51.7%	53 44.2%	4 3.3%	1 0.8%	3.47
2	Language barriers can interfere with work efficiency.	43 35.8%	65 54.2%	9 7.5%	3 2.5%	3.23
3	Using interpreter between patient and medical practitioner is not as efficient as being able to communicate in the same language by the two.	55 45.8%	58 48.3%	4 3.3%	3 2.5%	3.37
4	The importance of language in healthcare communication is vital.	73 60.8%	41 34.2%	3 2.5%	3 2.5%	3.53
5	Inability to communicate with medical practitioner effectively adds to patients' emotional stress.	45 37.5%	62 51.7%	11 9.2%	2 1.7%	3.25
6	Miscommunication due to language barrier can lead to life-threatening misdiagnosis.	33 27.5%	48 40.0%	35 29.2%	4 3.3%	2.92
7	Miscommunication due to language barrier can lead to mismanagement of diseases.	28 23.3%	58 48.3%	30 25.0%	4 3.3%	2.92
8	Medical terms are usually difficult to explain when patients cannot communicate in English Language.	31 25.8%	61 50.8%	27 22.5%	1 0.8%	3.02
9	Patients that do not speak the same language with medical practitioners may be hesitant and fearful when interacting with the doctor.	24 20.0%	67 55.8%	27 22.5%	2 1.7%	2.94
10	Interpreters modify information provided by the overall medical practitioner in order to conceal poor diagnosis.	20 16.7%	74 61.7%	22 18.3%	4 3.3%	2.92
11	The use of non-equivalent interpretation cannot be avoided when using an interpreter.	31 25.8%	82 68.3%	6 5.0%	1 0.8%	3.19
12	Miscommunication impacts the development of trust and may impair health outcomes.	39 32.5%	70 58.3%	8 6.7%	3 2.5%	3.21

Table 1 presents the medical practitioners' perception about language barriers to patient-centred interaction. The result shows a wide disparity between the Agree and Disagree responses and all the items had mean scores above the cut-off point of 2.50. This implies that medical practitioners perceived language barriers to patient-centred interaction to exist,

Research Question 2

How do medical practitioners perceive cultural barriers to patient-centred interaction?

Table 2: Medical Practitioners' Perceived Cultural Barriers to Patient-Centred Interaction

S/N	ITEMS	SA	A	D	SD	MEAN
13	When patient and medical practitioners do not come from the same cultural background, it constitutes a barrier to their interaction.	39 32.5%	58 48.3%	12 10.0%	11 9.2%	3.04
14	Patients most times hold some culture-specific beliefs about certain diseases that can hinder interaction.	48 40.0%	66 55.0%	5 4.2%	1 0.8%	3.34
15	Some culture based gender opinion/beliefs by certain patients can hinder proper interaction between two opposite sex.	47 39.2%	69 57.5%	4 3.3%		3.36
16	Addressing cultural needs among practitioner can help improve and impact on effective health care delivery.	55 45.8%	55 45.8%	5 4.2%	5 4.2%	3.33
17	Cultural differences can lead to miscommunication between medical practitioner and patient.	46 38.3%	60 50.0%	11 9.2%	3 2.5%	3.24
18	Unaddressed cultural barriers can lead to some devastating health effects.	37 30.8%	63 52.5%	15 12.5%	5 4.2%	3.10
19	Cultural beliefs can cause misconceptions on the part of patients.	42 35.0%	72 60.0%	4 3.3%	2 1.7%	3.28
20	A medical practitioner may require different styles of interaction for patients from different cultural background.	56 46.7%	58 48.3%	3 2.5%	3 2.5%	3.39
21	Cultural beliefs can lead to patient's non-adherence to prescriptions.	38 31.7%	71 59.2%	9 7.5%	2 1.7%	3.21
22	Intercultural consultations are often complex and stressful.	26 21.7%	69 57.5%	19 15.8%	6 5.0%	2.96
23	Interaction can be more patient-centred if there is mutual cultural understanding between health practitioner and patient.	64 53.3%	47 39.2%	8 6.7%	1 0.8%	3.45
24	The social and cultural diversity of patients who come for consultation in the hospital poses a great challenge.	37 30.8%	61 50.8%	20 16.7%	2 1.7%	3.11

Table 2 presents the medical practitioners' perceived cultural barriers to patient-centred interaction. The result shows a wide disparity between the Agree and Disagree responses and all the items had mean scores above the cut-off point of 2.50. This implies that medical practitioners perceived cultural barriers as a jeopardy to patient-centred interaction.

Testing of Hypotheses

Hypothesis 1

There is no significant difference in the perception of male and female medical practitioners on language and cultural barriers to patient-centred interaction.

Table 3: t-test Showing Medical Practitioners' Perceived Cultural Barriers to Patient-Centred Interaction by Gender

Sex	N	Mean	SD	df	t	Sig.
Male	50	76.08	6.117	118	1.040	0.301
Female	70	77.29	6.366			

p>0.05

Table 3 shows that the calculated t-value is 1.040 with degree of freedom of 118 calculated at 0.05 level of significance. Since the calculated sig (0.301) is greater than the critical sig (0.05); the null hypothesis is hereby not rejected. This

implies that there was no significant difference in the perception of male and female medical practitioners on language and cultural barriers to patient-centred interaction.

Hypothesis 2

There is no significant difference in the perception of medical doctors and nurses about language and cultural barriers to patient-centred interaction.

Table 4: t-test showing Medical Practitioners' Perceived Cultural Barriers to Patient-Centred Interaction by Status

Status	N	Mean	SD	df	t	Sig.
Medical Doctors	44	77.07	5.93	118	0.378	0.706
Nurses	76	76.62	6.49			

p>0.05

The result on Table 4 shows that the calculated t-value is 0.378 with degree of freedom of 118 calculated at 0.05 level of significance. Since the calculated sig (0.706) is greater than the critical sig (0.05); the null hypothesis is hereby not rejected. This implies that there is no significant difference in the perception of medical doctors and nurses about language and cultural barriers to patient-centred interaction.

Hypothesis 3

Years of experience of the medical practitioners will not significantly influence their perception of language and cultural barriers to patient-centred interaction.

Table 5: ANOVA of Medical Practitioners' Perceived Language and Cultural Barriers to Patient-Centred Interaction Based on Years of Experience

Source	SS	Df	MS	F	Sig.
Between Groups	169.598	4	42.399	1.083	.368
Within Groups	4502.769	115	39.155		
Total	4672.367	119			

p>0.05

Table 5 shows that the calculated F-value is 1.083 with degrees of freedom of 4 and 115 calculated at 0.05 level of significance. Since the calculated sig (0.368) is greater than the critical sig (0.05); the null hypothesis is hereby not rejected. This implies that years of experience of the medical practitioners did not significantly influence their perception of language and cultural barriers to patient-centred interaction.

Discussion

Result from the study shows that medical practitioners perceived that language and cultural barriers could jeopardise patient-centred interaction during hospital engagement. This finding is in line with the submission of Patient Engagement Hit (2019), that cultural and language barriers get in the way of a positive patient experience in urban and multicultural community health centres. This could also be as a result of the fact that when a problem is obvious, its perception will not compromise. Also, gender, status and years of experience did not significantly influence medical practitioners' perception in this study. These seem to contradict many findings that showed significant difference in male and female perception.

Conclusion and Recommendations

Based on the findings of this study, it is concluded that medical practitioners

perceived that there are certain language and cultural barriers to patient-centred interaction. There was no significant difference in the perception of male and female medical practitioners on language and cultural barriers to patient-centred interaction. Medical doctors and nurses did not differ significantly in their perception of language and cultural barriers to patient-centred interaction during hospital engagements. Years of experience of the medical practitioners did not significantly influence their perception on language and cultural barriers to patient-centred interaction.

It is therefore recommended that medical practitioners be exposed to more techniques for communicating with patients of various linguistic backgrounds. There is the need to foster synergy between medical practitioners and linguists in order to find better means of overcoming language and cultural barriers to interaction with patients in hospitals. The curriculum of medical schools should be improved in the area of learning of effective communication with patients in hospitals.

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