

**COMMUNICATION EXPERIENCES OF PATIENTS AND HEALTHCARE
PROVIDERS IN MANAGING CHRONIC ILLNESSES AT JARAMOGI OGINGA
ODINGA TEACHING AND REFERRAL HOSPITAL**

BY

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DECLARATION

Declaration by the Candidate

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DEDICATION

I dedicate this thesis to my mother Jescah Kasamba Onamu, thank you for sacrificing so much that I may learn. You also instilled in me diligence, determination and self-discipline.

To my daughter Faith Lauryn, may this inspire you to reach for the stars.

To Benard Odhiambo, thank you for the love and support.

To all who courageously face life despite the challenges posed by chronic illnesses, I salute you.

ABSTRACT

The Ministry of Health in Kenya projects that deaths from chronic illnesses will increase by 65% in 2030. To efficiently manage chronic diseases, effective communication between patients and healthcare providers is of crucial importance. However, studies have shown that many patients lack knowledge about their conditions and the treatment processes. This study aimed to investigate the experiences of patients and caregivers while communicating with healthcare providers on managing chronic illnesses. The study sought to answer the following questions: How do healthcare providers communicate with patients about managing chronic illnesses? What are the healthcare providers' perceptions regarding communication with patients with chronic illnesses? How do caregivers influence communication between healthcare providers and patients on managing chronic illnesses? How do patients and their caregivers perceive the communication approaches used by health providers in the management of their illnesses? The study was undertaken at the Jaramogi Oginga Odinga Teaching and Referral Hospital in Kisumu County. It adopted the relativist-interpretivist paradigm and qualitative approach to generate and analyse data. An instrumental case study design was used in the study. Purposive and snowball sampling techniques were used to identify 10 patients and 5 caregivers who were drawn from patient support groups at the hospital. In addition, 10 healthcare providers (2 medical officers, 2 clinical officers, 3 nurses, 1 counselling psychologist, and 2 nutritionists) were sampled. Data was generated through in-depth interviews and focus group discussions. Recorded interviews and focus group discussions were transcribed and analysed using a thematic approach. Study findings indicate that health providers are knowledgeable, and they believe that patients needed to be provided with information. However, the literacy levels of the patients, disease progression, condition of the patient and health providers' personality influenced how much information was provided to the patients. English was the main language used by health providers, which often created a language barrier among patients who did not understand the language, and often created opportunities for misinformation where interpreters were used. The hospital lacked trained interpreters; hence caregivers and hospital staff acted as interpreters. This was found to affect patients' privacy and disclosure especially where the patient did not want their health information to be accessed by a third party. Patients often felt that the information they received from healthcare workers about their condition was inadequate. The study concludes that patients felt they did not get adequate information that would enable them to effectively manage their conditions hence there is need for patient-centred communication.

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LIST OF ABBREVIATIONS

CAT	- Communication Accommodation Theory
CDC	- Centre for Disease Control
CRD	- Chronic Respiratory Disease
CVD	- cardiovascular disease
FGDs	- Focus Group Discussions
HP-	-Healthcare provider
IREC	-Institutional Research and Ethics Committee
JOOTRH	-Jaramogi Oginga Odinga Teaching and Referral Hospital
KDHS	- Kenya Demographic Health Survey
MoH	- Ministry of Health
NCD	-Non-Communicable Disease
URT	-Uncertainty Reduction Theory
WHO	-World Health Organization

OPERATIONAL DEFINITION OF TERMS

This section provides a definition of the key concepts and words that have been used in the study. It begins by defining caregiver and other key terms used in the study.

Caregiver: Family, relative or friend who willingly offers to take care of a patient.

Chronic illness: Chronic illness/long-term conditions denote an illness which has a prolonged duration; it is one that can neither be cured completely nor spontaneously resolved. For the purposes of this study, chronic illnesses include diabetes, hypertension, cancer, arthritis and heart condition.

Communication strategies: These are the blueprints of how information will be transferred between a sender and receiver. It denotes the process by which two parties mutually attempt to agree on a meaning where the meaning requisite structures are not shared. Also, it can refer to conscious plans which have the potential to solve what presents as a challenge in reaching a particular communication goal.

Healthcare provider: A healthcare provider is identified as a person involved in the diagnosis, prevention, treatment and overall management of the patient's illness or disability. A health professional may also be an expert working for the common good of the society. In this study, health care providers include doctors, nurses and clinical officers who attend to patients with chronic conditions.

Message: This refers to communication that contains information, news, advice or request sent via speech, telephone, email, or other means from one person to another. In this

study, messages will mainly be concerned with health-related information exchanged between patients and healthcare providers.

Patient: A patient is a person who is receiving medical care from a health professional such as a doctor. A patient also refers to a person who receives medical attention, care and treatment. In this study, the word patient will be utilized for individuals suffering from long-term diseases such as diabetes, cancer, hypertension and arthritis who seek medical attention from the hospital.

CHAPTER ONE

BACKGROUND TO THE STUDY

1.1 Introduction

This section describes the background information to the study. It begins by discussing communication and the management of chronic illnesses at global level. It also looks at the healthcare provider-patient communication and the management of chronic conditions in developing countries generally and then Kenya in particular. This background helps to conceptualize the study aims and problem clearly. This chapter also provides the statement of the problem, scope of the study, limitations of the study, justification of the study and the significance of the study.

1.2 Context of the Study

This section brings to perspective chronic illnesses as a worldwide problem. The challenges faced in the communication and management of chronic illnesses from the global angle, the African perspective and finally the Kenyan situation are examined. Therefore, the chapter highlights the challenges faced by the healthcare providers as well as patients and their caregivers in relation to the management of chronic illnesses.

1.2.1 Global Situation of Chronic illnesses

There has been a steady increase in life expectancy in the world in the 20th Century, as a result of technology-aided advancement in modern medicine as well as public health. This has in turn increased the number of the aging population in the world, resulting in these population living with more than one chronic condition (Fabbri *et al.*, 2015). There is evidence that chronic illnesses have increased globally and are undeterred by region or

social class. There is also a significant increase in chronic diseases in developing countries (De Graft *et al*, 2010). It is estimated that the burden of disease will increase with the largest contributors being: heart disease, stroke, depression and diabetes (World Health Organization [WHO], 2014). Chronic illnesses are also estimated to account for nearly 90% of all deaths and 87% of lost healthy years in the European Union (WHO, 2018). Singapore has also experienced a rise in the prevalence of chronic illnesses in the years between 2010 and 2017. The most prevalent chronic conditions in Singapore were hyperlipidaemia, hypertension and diabetes. Adults aged 60 years and above were also found to be disproportionately affected by multiple-chronic conditions with an average of 40% having three or more chronic diseases in 2017 (Choo, 2019). To enhance service delivery, the Ministry of Health initiated focus on care beyond the hospital community, which emphasized the greater involvement of community and primary care providers who are usually the patients first point of contact (Choo, 2019).

Apart from chronic conditions being a challenge, in some countries, multi-morbidity (the presence of two or more chronic conditions in a single patient) is the biggest challenge. Epidemiological studies of chronic diseases show that multiple chronic diseases are the norm in people over the age of 65 (Valderas *et al.*, 2009). A study conducted in Scotland showed that 23% of patients were multi-morbid, with a prevalence of 65% for the 65-to 84-year-old group (Barnett *et al.*, 2012). Multi-morbidity leads to poor health outcomes, including high mortality, impairs quality of life and increases utilization of inpatient and outpatient health care. Studies conducted in Canada, the United Kingdom, Sweden and Singapore have shown that multiple-chronic conditions are associated with lower self-efficacy and quality of life, predisposition to depression and other psychological

problems. Individuals with multiple chronic diseases are unable to receive adequate care. Patients face challenges in coordinating care, communicating with providers and gathering information (Ploeg *et al.*, 2019; Nguyen *et al.*, 2020).

Countries, such as the United States, Switzerland and Asia, have also faced problems related to treating and managing chronic diseases. These include healthcare fragmentation, communication problems and making decisions acceptable for both patients and caregivers. Research shows that some patients rely less on their caregivers than ever before and have difficulty in decision-making and self-management as a result of other barriers at the community, institutional and system levels. In addition, studies have found that patients do not always understand their prescribed medications, which can lead to medication errors (Perez-Jover *et al.*, 2019). Based on the information provided, there is need for greater patient involvement especially for those patients with chronic conditions since they need to self-monitor for vitals such as blood pressure and blood glucose levels. Patients are also required to interpret the blood pressure and sugar levels and to comply with nutrition and health guidelines.

Kourakos *et al.*, (2017) believe that patients should be included as partners in care. They believe that when health care is delivered effectively and efficiently, patients can become full partners in the process because they will have more control. Since chronic illness lasts a lifetime, managing the illness helps patients maintain independence.

1.2.2 Communication and management of chronic illnesses

Effective communication is central and important to good medical practice. It plays a key role in achieving quality healthcare (WHO, 2018). Quality of health is defined and viewed differently by different stakeholders in the medical field. Healthcare providers,

such as doctors, define quality based on the number of successful treatments a patient has received. Nurses on the other hand, define it on the basis of providing care thereby improving a patient's life. For patients, quality care includes timely, efficient and affordable care provided in a friendly environment that fosters good interpersonal relationships with healthcare providers (Tunsi *et al.*, 2023). Effective communication therefore, ensures the achievement of optimal health outcomes and the patients' well-being (Onyechi & Babalola, 2020).

Markides (2011) emphasizes the importance of communication stating that medical practice is not only about making the correct diagnosis but also considering the patient's interests through effective doctor-patient interaction. Communication skills play an integral role in building trust in the doctor-patient relationship. They also promote better information provision to patients and better information retrieval by healthcare providers. Moreover, appropriate, timely and relevant information improves self-management and medication adherence among patients.

Nwabueze and Nwanko (2016) opine that doctors communication and interpersonal skills encompass the ability to gather information so as to facilitate diagnosis, counsel appropriately, give therapeutic instructions and establish caring relationships with the patients. Although a doctor's medical knowledge is important, the application of that knowledge is only as effective as the doctor's communication skills. The patient's physical well-being is heavily reliant on technical expertise, supported by strong and effective interpersonal communication (Ambady *et al.*, as cited in Adam, 2014). To a great extent, the technical expertise affects the decisions and subsequent actions that optimize the patient's ability to live as long as possible with that particular disease

(Thorne, 2006; Kwame & Petrucka, 2021). Several studies indicate a correlation between effective communication and improved health outcomes of the patient (Grilo *et al.*, 2017). A review conducted by Narva *et al.*, (2016) advocates for service delivery that is patient-centred. These scholars argue that self-management and healthcare interventions are common interventions with positive outcomes for patients with chronic illnesses. Chronic illnesses last a lifetime thus managing the illness helps patients maintain independence (Kourakos *et al.*, 2017).

Language, an important factor in the doctor-patient communication, can either facilitate or hinder communication based on the context and the individuals involved. Language barriers have a negative impact on the relationship between the healthcare provider and patient. A study carried out by Jungner *et al.* (2019) found that language barriers affected parents' role in caring for their cancer affected children. Language barriers led to miscommunication, hence decreased possibilities of understanding information that was essential for the provision of quality care. This is because paediatric oncology involves a complex communication and information context in that the healthcare providers expect to relay complex medical and nursing information to parents who are also emotionally stressed. The parents need to understand the provided information since they are the primary care givers to children in between hospital stays (Jungner *et al.*, 2019).

Another study carried out in Canada established that linguistic challenges faced by minority groups contributed to risks and affected the quality of care. The study established that the use of interpreters contributed to poorer patient assessment, misdiagnosis and/or delayed treatment, incomplete understanding of patient condition

and prescribed treatment affected patients' confidence in the services received (De Moissac & Bowen, 2018). Another study carried out in Saudi Arabia revealed that healthcare providers at times failed to correctly diagnose and treat patients due to language barriers. This led to great frustration among patients. The study emphasized on the need to build patient- physician relationship and enhance the work environment by ensuring it is culturally sensitive. In the study, some participants were unable to express themselves in both Arabic and English hence their shared stories/ experiences were lost (Alshareef *et al.*, 2020).

In a study done in India, both patient and clinician related factors were noted as critical in the management of diabetes (Shrivastava *et al.*, 2013). The study noted that accurate understanding of the patient contributes to diabetes treatment and outcome. Kadirvelu *et al.*, (2012) posit that effective patient-physician communication may be particularly important, since evidence indicates that patients practiced better self-management when their providers had superior communication skills. From the previous researches done (Jungner *et al.*, 2019; Alshareef *et al.*, 2020; De Moissac & Bowen, 2018), it is evident that communication between patients and healthcare providers can be impaired by language barriers hence affecting the accessibility and quality of health care. This study mainly focused on the communicative aspect between patients and healthcare providers on the management of chronic illnesses. This is because communication is an important aspect in helping patients manage their illnesses. In the next section, we look at communication of chronic conditions in Africa.

1.2.3 Communication of Chronic Illnesses in the African Context

In the African context, studies have shown that healthcare provider-patient communication is affected by several factors. One such factor is multilingualism; most African communities are multi-lingual and this affects communication. A case in point is South Africa where consultations are frequently characterized by incidences of language discordance. This creates barriers to the access of healthcare and has led to the undermining of trust between healthcare providers and patients (Anderson *et al.*, 2003). Fiscella *et al.*, (2002) corroborate this assertion by noting that language discordance has resulted in diagnostic and therapeutic errors. Schlemmer and Mash (2006) conducted focus group discussions with patients and they identified inefficient working environment, decreased satisfaction with care and cultural misunderstanding within the hospital environment as factors that hindered their access to quality medical care. To overcome language related barriers, healthcare providers have to grapple with in their quest to provide quality medical care to their patients, research has been devoted to developing medical terminology in different African languages where none exist as well as defining existing words in local communities and documenting these terms (Madzimbamuto, 2012; Engelbrecht, 2010). Despite these efforts, a few challenges have been experienced. For example, one word in one community may denote something entirely different in another community making it difficult to come up with local medical terminology (Nxasana, 2005). The multilingual contexts in Africa have forced the health personnel, patients and caregivers to use interpreters.

A study in Ghana looked at how illiterate patients and doctors interacted at a hospital. The study noted that indigenous dialects are used in such interactions. However, medical

terms did not have equivalents in native dialects and even when they did, patients were unaware of them. This made it difficult for the doctors to understand their patients. As a result, the patients felt that their relational needs were not met. The study further revealed that because of having to deal with heavy caseloads, time constraints, and disengaged patients the doctors resorted to using the services of interpreters who were primarily relatives, friends and healthcare workers (Acquah, 2011). The training and use of interpreters has equally been an area of concern as posited by Kilian *et al.*, (2016) who note that the use of ad hoc interpreters has led to numerous communication errors, negative attitude of staff and patients. It has also led to decreased satisfaction with care and adverse health outcomes.

Patients in the contemporary world want to be partners in healthcare decision-making; they no longer want to be told what to do. They want to be involved in all the activities that relate to their health as well as in the management of their health conditions. They expect a shift from the traditional approach in which during interactions, health care providers displayed ‘know-it-all’ tendencies which led patients to blindly trust them to a modern approach that is not only relaxed but also accommodative. In the latter approach, patients are given opportunities to reason with their health care providers and to come to a consensus on issues that touch on their health. Having sufficient information on health issues is pivotal. This assertion is supported by Nwabueze & Nwankwo (2010) who posit that when patients participate in care as informed partners, they are more satisfied and have higher compliance and retention rates. For example, in South-eastern Nigeria, people living with diabetes are responsible for managing their condition on a day-to-day basis, communicating regularly with their health care

providers throughout the year and seeking advice when needed. Effective self-management of diabetes requires patients to recognize symptoms of emerging health crises, adhere to complex medication regimens and make long-standing lifestyle changes such as diet and physical activity.

To further corroborate the significance of patients being actively involvement in health care, Adisa and Fakeye (2014) opine that primary care providers are expected to ensure active participation of patients in diabetes treatment plans so as to consistently guarantee improved adherence which leads to optimal glycaemic outcomes. Language barriers between physicians and patients have been studied as possible sources of frustrations, misunderstandings and miscommunication (Garrett *et al.*, 2018). Language barriers may also affect the patient's ability to understand the health provider's instructions thereby affecting disclosure. This may in turn affect the patient's satisfaction with the care provided.

Chronic illnesses affect an individual and the entire society. They affect the individual's health status and productivity. According to Megari (2013), chronic illnesses have psychological dimensions since they cause disruptions to the physical capabilities of the patient. Patients suffering from asthma, cancer, diabetes and sickle-cell anaemia in the sub-Saharan Africa indicate that their health experiences were accompanied by depression, chronic unhappiness, psychiatric disturbance and suicidal tendencies. This view is supported by Kollings *et al.*, (2010) who bring to perspective the experiences of diabetics among the poor of Tanzania. In their findings, they indicate that poverty breeds a double burden of disease in the households. Many parents living with diabetes are forced to make a tough choice between paying for their healthcare or sacrificing the

health of their children who are suffering from infectious diseases. This indicates that chronic illnesses not only affect patients but also have an impact on their families and the society.

1.2.4 Effects of Chronic Illnesses on Society

There is evidence that chronic illnesses affect the entire economic systems of countries. Due to long-term health costs, these illnesses negatively affect productivity and labour supply leading to decreased human capital accumulation (Gustafson *et al.*, 2010; Dowling *et al.*, 2013).

Chronic conditions affect health and productivity. Productivity is measured by both the quality (how productive an individual is) and the quantity of labour (the hours of work an individual is able to work) (WHO, 2005). Reduced productivity is equally proportional to a reduction of income and can lead to poorer health. In their view, chronic diseases also affect households and individuals through the long term out of pocket expenditure that is required for treatment. This is the case in many developing countries where treatment of chronic diseases can drain family resources. As such, the families affected have to make a choice between buying medicine or other basic household commodities. This view is supported by Kočiš *et al.* (2021) who argue that chronic diseases are likely to contribute to increase in out-of-pocket expenditure leading to income crowding on health-related issues. It is thus evident that chronic illnesses pose an economic burden on the poor and uninsured individuals and households. This may result in a downward spiral.

De Graft *et al.* (2010) argue that the downward spiral has psychological consequences. For example, poverty may intensify healer shopping. Alternative healers are sought

because they offer a cheaper option. In addition, they offer spiritual and psychological support which often lacks in formal care. They also argue that the management of chronic illnesses makes demand on time, emotions and physical capabilities of caregivers. The high dependence on family members and on significant others for self-care and medical care can cause emotional conflict leading to the breakdown in marital and intimate relationships which may in turn result to abandonment (De Graft *et al.*, 2010).

In support of this view, Stangl *et al.* (2019) argue that persons with chronic illnesses are at risk of marginalization and stigmatization in their communities. Similarly, De Graft *et al.* (2010) observe that in many African countries' physical chronic conditions like diabetes, cancers and epilepsy are stigmatized. People with these illnesses face other limitations when it comes to education and employment opportunities. Women suffering from chronic illnesses are likely to be less empowered in terms of education and financial capability. WHO (2002) reports that chronic conditions lead to lost opportunities especially for young members of the household who may be forced to leave school so as to take care of the sick or find jobs to support the household economy.

Research findings indicate that chronic illnesses affect the quality of family life. A study carried out by Golics *et al.* (2013) found that 92% of family members were emotionally affected by a patient's illness, 35% were worried, 22% felt frustrated, 15 % were angry and 14 % felt guilty. The findings further indicated that family members bottled up their feelings and found it difficult to express them. Some family members were affected emotionally and confessed to crying when alone. Up to 69% of the participants reported

that having a patient with chronic conditions resulted in an increase in stress and tension within the family.

Chronic illnesses affect the individual and the society as a whole. They affect an individual's health status thus affecting his/her productivity. A study conducted by Megari (2013) revealed that chronic diseases have psychological dimensions in many African countries; diseases such as diabetes, cancers and epilepsy are stigmatized. This could be due to ignorance or lack of understanding about the feelings and experiences of the patient.

According to Forbes *et al.* (2010), wages are normally used as an indicator of labour productivity because of scarcity of data on productivity. Reduced labour productivity results in reduced labour income. Less income could lead to poorer health hence creating a spiral effect. The two-way causality makes it hard to measure the determinants and consequences of chronic disease. Chronic diseases also affect households and individuals through the long-term out-of-pocket expenditures needed for the treatment of chronic disease. This treatment may drain the family's resources, driving families to deeper poverty. The WHO estimates that over 100 million people are pushed into poverty due to the cost of managing and treating chronic diseases (WHO, 2008).

Many families use savings, sell assets, consumables and borrow money to finance the treatment of a chronic disease (Sauerborn *et al.*, 1996; Xu, 2004). As a result of this, the family's ability to generate future income is limited leading to long-term economic consequences (Okediji *et al.*, 2017). Based on the facts provided on chronic conditions by different studies (De Graft *et al.*, 2010, Kocis *et al.* 2021 & Sauerborn *et al.*, 1996) it is evident that they have ramifications on individuals and by extension societies therefore,

there is a dire need to address this issue. Communication is one of the strategies that can be used in the management of chronic illnesses. If people are empowered and given access to information, they will be in a position to obtain, process and understand their conditions hence manage them appropriately. Poor communication has been attributed to malpractice suits, misdiagnoses, failures in patient compliance and at times cross-cultural misunderstandings between the healthcare provider and patient.

1.2.5 Healthcare Providers and Patient Communication of Chronic Illnesses in Kenya

Many studies have been conducted in Kenya and globally on chronic illnesses. Most of the researches have looked at the prevention aspect, trends and related issues. A study by Rafferty (2015) looked at parents' communication about uncertainty, hope and hopelessness while managing complex paediatric chronic conditions. The study mainly examined the experiences of parents as they took care of their children suffering from chronic conditions. It focused on parents' interactions which influence their social constructions of certainty, hope and hopelessness in relation to their child's health. The findings indicated that parents support network and spiritual support facilitated their ability to maintain hope. Parents also emphasized that positive communication was essential. Communication is therefore crucial in the management of chronic conditions especially in Kenya where it is on the rise.

Statistics indicate that Kenya has a heavy disease burden with an average life expectancy of 67.21 years (United Nations, 2021). Kenya, like the rest of the world, also faces the challenge of chronic conditions. The most common chronic conditions reported in Kenya include cancer, diabetes, cardiovascular diseases and chronic obstructive

pulmonary diseases. Cancer is the second cause of deaths among non-communicable diseases (NCDs) related deaths (Ministry of Health, 2021). Data from the Kenya Health Information System (KHIS) posit a 54% and 62% increase in the incidence of outpatient visits attributed to hypertension and diabetes, respectively, between 2016 and 2019. According to KHIS data, the incidence of hypertension in Kenya was 2059 per 100,000 outpatient visits in 2016 and increased to 3149 in 2019 higher than the Kenya Health Sector Strategic and Investment Plan (KHSSP) end-term target of 3053 (KHIS,2019). The Ministry of Health (2021) also notes that approximately 32% of deaths in Kenya result from non-communicable diseases. This marks an increase from 27% in 2017. It is projected that deaths from chronic conditions will increase by 65% while those from injuries will increase by 25% in 2030 (MOH, 2014; MOH, 2022). Although early diagnosis and treatment can lead to positive outcome and prognosis, it is estimated that in Kenya, 80% of the reported cases are detected at an advanced stage when very little can be done. This is generally attributed to low awareness of chronic illnesses including their signs and symptoms in the population (MOH, 2022). In addition, many hospitals have inadequate detection services, weak referral systems, poor treatment and poor palliative services.

A study by Gatune and Nyamongo (2005), carried out at Kenyatta National Hospital, explored the awareness and prevention of cervical cancer. It also looked at the attitude of women to cervical cancer. The main purpose of the study was to encourage women to undergo screening hence early detection and treatment. The study examined the barriers to healthcare and psychosocial challenges in the management of cervical cancer in Kenya. This study employed a qualitative approach, and the data was collected from 41

participants using in-depth interviews. The findings indicated that some of the challenges that cervical cancer patients and caregivers encountered include the high cost of cancer treatment and management especially in terms of money and resources.

Cervical cancer patients also felt that a part of their womanhood had been interfered with due to the nature of the treatment that they received and self-esteem issues. Due to fear of stigmatization, some had kept their conditions to themselves. In relation to barriers to quality health, the patients cited lack of access to healthcare facilities especially for those whose homes were not within Nairobi area. This in a way delayed their treatment. Patients cited inadequate information on cervical cancer as another challenge. Many were unaware of the disease they suffered from and only sought treatment at advanced stages. This indicates that patients have a desire to be informed about their conditions (Gatune & Nyamongo, 2005).

Gakunga *et al.*, (2019) carried out a study to describe the feelings and lived experiences of participants in accessing breast cancer care in Kenya. The study found that, in as much as women are the main decision-makers and health information seekers in the family in Kenya, majority of them have difficulties accessing, comprehending and using health information to improve their health. This not only affects the women but also their families. In the opinion of Gakunga *et al.*, health literacy affects women's ability to read, understand and act on preventive health messages, healthcare plans, medical instructions and other health information.

In agreement with the above findings, the health communication challenges women face have also been reported to affect their ability to navigate the healthcare system, to share information and to effectively manage chronic conditions and self-care (Gatimu, 2018).

When physicians communicate to the female patients using medical jargon, they are not able to understand the information communicated. These women struggle with health literacy demands and few claim to have adequate skills for communicating with their physicians and following up with self-care instructions due to limited background of health knowledge. Most health workers in Kenya are not aware of the magnitude of the problem (Gatimu, 2018). Some of the barriers identified by Gatimu (2018) include inadequate knowledge, distance to health facilities, challenges in communicating with health providers, medicine stock-outs, long waiting periods, limited or no counselling at diagnosis, patient vulnerability and limited access to rehabilitation items. In their earlier study, Wasike and Tenya (2013) also found that language is an issue when it comes to medical information since majority of the available print information on health is written for a level above the ordinary individual. Medical terminologies are complex and most times the consumers are not able to understand.

According to Osborne (2004) who interviewed healthcare professionals in Kenya, found there are language and communication breakdown because doctors are trained in English yet majority of their clients can hardly understand or communicate in the English language. In addition, medical labels are in foreign languages and not in Kiswahili or vernacular. Lastly, the number of illiterate people is high hence affecting communication.

According to Henry *et al.* (2021), healthcare providers struggle with vocabulary limitations when they communicate in indigenous languages since medical terminology do not have equivalents in most local languages. Due to vocabulary inadequacies, most patients and physicians maintained different levels of understanding of the diagnosis. In

some cases, physicians thought that they had given a detailed explanation only to later realize that the patient did not understand. Communication between healthcare providers and patients is, in fact, difficult enough already even when they speak the same language. Medical language differs greatly from everyday language and this may lead to miscommunication. Based on the statistics provided by the studies previously carried out (Osborne, 2004; Gatimu, 2018; Henry *et al.*, 2021), it is evident that there are communication challenges in the interactions carried out between healthcare providers and patients with chronic illnesses hence the need to address this concern.

Management of chronic illnesses calls for effective communication between healthcare providers and patients. Patients with such conditions should be sensitised on the need to get adequate information so that they are not only aware of their conditions but are equipped with vital information that will enable them make informed decisions about their health. Poor communication has drastically contributed to the state in which most patients with chronic conditions have found themselves in. Therefore, the role of health communication and the significance of effective communication cannot be downplayed if the mortality rate attributed to chronic conditions is to be reduced.

1.2.6 Background of Jaramogi Oginga Odinga Teaching and Referral Hospital (JOOTRH)

Jaramogi Oginga Odinga Teaching and Referral Hospital (JOOTRH) also referred to as Russia Hospital, was founded as a modest hospital in the early 1900s. It was established to meet the medical needs of Kisumu's labour force. Originally known as the Kisumu Hospital, it was reconstructed in the post-independence period with help from the Soviet Union. This happened when Nikita Khrushchev, the Soviet Union's then-prime minister,

met with Jaramogi Oginga Odinga, the vice president at the time. The successful meeting resulted in a hefty donation to build a new hospital in Kisumu Town. Russia designed and constructed the hospital. In 2025, it was elevated to a national teaching and referral hospital, Level 6, and a state corporation. This move allows for more investment and specialized care in the Western region. It is important to note that at the time of data collection JOOTRH was a level 5 teaching and referral hospital.

1.3 Statement of the Problem

Health care delivery processes demand a communicative interaction between a healthcare provider and patient. Communication is one of the strategies that can be used in the management of chronic conditions. It involves empowering patients by giving them access to information which will enable them to obtain, process, understand and effectively manage their conditions. Most studies have shown that direct communication between patients and healthcare providers is important for efficient management of chronic illnesses. However, there are those patients who cannot communicate with healthcare providers due to communication barriers which entail language barriers and illiteracy. Communication breakdown could compromise the quality of healthcare. Communication barriers between the healthcare providers and patients increase the risks of inaccurate language interpretation and miscommunication, which have been associated with misdiagnoses, wrong treatment and dissatisfaction with care. Poor communication also hinders chronically ill patients from making informed choices about their health.

Kenya has in the last few years, experienced an increase in the number of people suffering from chronic conditions. According to the Ministry of Health (2021), chronic

conditions contribute to about 32% of total mortality rate in Kenya. Kenyans faces challenges due to general lack of understanding and knowledge about chronic conditions among the public. Moreover, only a small percentage of the population has access to affordable medical services and facilities. This study was conducted in Kisumu County because it has a high number of people suffering from chronic conditions. Moreover, the doctor-patient ratio in Kisumu is 1: 144,634 and one nurse to 2,383 people. The World Health Organization (WHO) recommends 1 physician per 1,000 people to ensure quality care. This is a clear indicator that healthcare providers hardly get enough time to meaningfully interact with the patients. Patients desire to have information about the diagnosis, treatment and management of chronic conditions. Therefore, this study seeks to explore communication challenges affecting healthcare provider/patient and caregiver communication among patients with chronic illnesses in JOOTRH in Kisumu County.

1.4 Research Questions

This study sought to investigate the communication dynamics between patients and healthcare providers on management of chronic illnesses. It was guided by the following research questions:

- i. What are the perceptions of healthcare providers on communication with patients with chronic illnesses?
- ii. How do healthcare providers communicate with patients on management of chronic illnesses?
- iii. How do caregivers influence communication between healthcare providers and patients on the management of chronic illnesses?

- iv. How do patients and their caregivers perceive the communication approaches used by healthcare providers in the management of their illnesses?

1.5 Scope of the Study

The first research question sought to identify the healthcare providers' knowledge and attitude towards the provision of messages to patients with chronic conditions. The content scope of this research question, in the first place, covered healthcare providers' knowledge towards the provision of information. In this regard, the study sought to find out the opinions of healthcare providers in relation to information needs of patients. It examined how health care providers ensure their communication is in line with the needs of their patients. In addition, the study explored the extent to which healthcare providers disclosed or withheld information from the patients. Secondly, the study sought to establish healthcare providers' attitudes towards the provision of information to patients with chronic conditions. It sought to find out the healthcare providers role during treatment and whether they encouraged shared decision-making with the patients they managed.

The second research question sought to investigate how healthcare providers communicated with patients on management of their chronic illnesses. This question sought to generate information on the communication strategies that healthcare providers used in providing information. It also sought to identify the linguistic and non-linguistic barriers to communication and find out the strategies they used to overcome communication barriers.

The third research question sought to find out how communication between healthcare providers and patients was impacted by caregivers who also act as interpreters. The

fourth research question sought to look at how patients and their caregivers evaluated the messages given and strategies employed by healthcare providers in the management of the diseases. In relation to this question, the study sought to establish if patients play an active role in their interaction with doctors. The study sought to determine patients' views on the relevance of the information provided in relation to the management of their health.

The study was carried out in Kisumu County, Kenya. This is because Kisumu faces a high chronic disease burden, considering that the doctor to patients' ratio is 1: 144,634 and every one nurse serves 2,383 people. The World Health Organization (WHO) recommends 1 physician per 1,000 people while nurse to population ratio stands at 1:435. Based on the doctor-patient ratio, the study sought to find out if the numbers affect effective communication between the healthcare providers and the patients. The county also faces high malaria incidences and HIV prevalence. The study was limited to JOOTRH, a public referral hospital that attends to patients from various backgrounds hence it was expected to provide rich data.

The study adopted a qualitative approach through the use of an instrumental case study. This is because JOOTRH is a replica of any public referral hospital in Kenya where there is low doctor to patient ratio, hence would provide rich data. The study mainly looked into the communication between the patient and healthcare providers in matters concerning the management of chronic conditions. Although a mixed method study conducted in all the three referral hospitals in Kenya would have provided more insight and various perspectives on the doctor-patient communication, the study was limited to the qualitative approach. In order to overcome this limitation, the study chose JOOTRH,

which was deemed capable of providing a rich case for in-depth data analysis. A small number of respondents had been selected to enable the researcher gain insight of their views and perspectives.

The study also limited itself to non-probability sampling techniques. Hence, the researcher interviewed 15 patients, 5 caregivers and 10 healthcare providers. Three focus group discussions, comprising six members each, were also held. The data was analysed qualitatively. More details on methodology are discussed in chapter three.

1.6 Justification of the Study

Kenya faces an increase in chronic illnesses and it is estimated they contribute to 32% of total mortality rates. Chronic illnesses lead to death and equally affect the economic growth of the nation. These conditions are becoming a challenge to both individuals and the nation as a whole. Many studies on chronic conditions in Kenya have mainly focused on scientific aspects of illnesses especially prevention, trends and related issues. Many of them have also been quantitative in nature. Therefore, the current study is necessary as it looks at chronic conditions from a macro-perspective, especially from the angle of communication. The study investigated aspects of communication between healthcare providers and patients on the management of chronic conditions. Specifically, it looked at the communication competencies of healthcare providers with regard to the passing of useful, meaningful and relevant information to patients on management of chronic conditions. The study also sought to establish the patients' positions with regard to their right to information about their health.

The study was conducted qualitatively in order to provide deeper insight into the lived experiences of patients with chronic conditions and the challenges they face in communicating with healthcare providers. The study provides an insight into the communication needs of these patients and their desire to be informed about their conditions. The study also sought to investigate the health providers' knowledge and attitudes towards the provision of information to patients. Such an investigation fosters the understanding of patients' lived experiences on communication with their healthcare providers. The study also sought to fill the research gap on the management of chronic conditions from the perspective of communication. This is made necessary by the fact that information and communication are powerful tools for the adoption of healthy lifestyles as well as the management of chronic conditions.

1.7 Significance of the Study

The findings of this study will be of use to healthcare providers particularly doctors and nurses who deal with patients suffering from chronic conditions. The study highlights the challenges both patients and healthcare providers face as they find and share relevant information to manage chronic conditions and will enable them meet patients' expectations with regard to information about their illnesses.

The study also helps healthcare providers gain an in-depth understanding of chronic conditions information needs of patients suffering from such conditions. In so doing, the study will contribute to minimising misinformation and other consequences of patient-doctor communication problems.

This study also contributes knowledge to communication studies. The study highlights both the linguistic and non-linguistic barriers to communication in the healthcare

context. It identifies some ways of overcoming these barriers and ensuring effective communication in the health setting for effective management of illnesses. Future researchers on the role of communication in healthcare will also find this study an insightful point of reference. Lastly, decision and policy makers in the health sector will find the study useful particularly regarding the management of chronic conditions.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

The main purpose of this chapter is to review existing literature on healthcare and communication, particularly in relation to the management of chronic illnesses. The first part endeavours to situate the study within the field of Communication. In this section, the role of interpersonal communication in health communication has also been discussed. Next, there is a review of literature on doctor-patient communication and on patient-centred communication. The chapter also looks at the views of patients and their experiences in relation to communication of information on chronic conditions in the healthcare sector.

2.2 Situating study in the field of Communication Studies

This research mainly focused on communication between patients and healthcare providers in the management of chronic illnesses. Therefore, this subsection begins by situating the study within the field of Communication Studies. In particular, the study deals with health communication. The study explores the intersection between health-literacy communication and interpersonal communication. Health literacy is defined as the degree to which individuals have the ability to obtain, process and understand basic health information and services needed to make appropriate health care decisions (Healthy People, 2010). This sub-section thus begins with an examination of interpersonal communication and its principles before moving on to health communication.

Interpersonal communication plays an important role in health and in the provision of healthcare services. When there is effective interpersonal communication between the people involved in healthcare situations, the delivery of high-quality healthcare is facilitated. On the contrary, ineffective communication can deter the delivery of quality healthcare.

At the interpersonal level of communication, meaningful relationships are developed between the patients who are seeking healthcare services and the providers. Developing rapport between healthcare providers and patients ensures appropriate exchange of health information, provision of emotional support to the patient and management of their conditions. According to Terrasi (2022) ineffective communication has been found to have many negative effects, such as lack of patient compliance, misinformation, miscommunication and dissatisfaction occasioned by the feeling that the doctor did not address the patient's needs.

Better skills at interpersonal communication leads to an extended dialogue, which promotes disclosure of information from the patient regarding his/her health problems and facilitates health providers to make accurate diagnosis. Effective communication would thus enhance healthcare counselling and education resulting in appropriate management of the condition and better compliance from the patient regarding his/her medication and treatment plan. Terrasi (2022) posits that effective interpersonal communication has the potential to benefit the entire healthcare system by increasing the efficiency of administrators, doctors, clients and policy makers thereby leading to an improved client-provider interaction. The study also looks at how interpersonal communication can be affected by the presence of an intermediary.

2.2.1 Interpersonal communication and healthcare

Definitions of interpersonal communication are not limited to the specific number of people involved; it is not simply a matter of quantity. Scholars of communication view interpersonal communication as qualitative, occurring when individuals communicate with one another as unique parties. According to Solomon & Theisis (2013), interpersonal communication is viewed as a continuous process whereby even when one person talks, the other communicates through body position, eye contact, and facial expressions. It is also a dynamic process in which meanings change and unfold over time, and previous messages influence how subsequent messages are created and understood. Wood (1999) defines it as “communication intended to build shared meanings and gain knowledge of each other.” Thus, the process of interpersonal communication involves exchange of words or signs where those involved have a motivation or desire to understand each other as individuals. A notable feature of interpersonal communication is direct face- face conversations.

Interpersonal communication plays a role in self-disclosure. Through this communication we get to understand others and their unique characteristics mainly through self-disclosure. The level of self-disclosure varies depending on the individuals concerned and how deep their relationship is. It may range from what is considered relatively safe such as revealing your favourite sport, favourite food, hobbies and music preferences to what is private and confidential. As the relationship deepens and strengthens, so does the trust and self-disclosure (Turner & West, 2012).

West and Turner (2009) posit that there are three stages of interpersonal communication. The first is called the phatic stage. In this stage, people use conventional messages to

either break the ice then establish rapport or to end the conversation. It is important to note that the patterns of this stage are dictated by rituals, cultural and social norms. The second is called the personal stage; it is at this stage that a personal element is introduced in the conversation. Moreover, individuals are more open and are prepared to share about themselves and their feelings. They share their very own essence when they allow others to know their hearts. Individuals are more comfortable to talk about private matters. Doctors can take advantage of the opportunity that this stage offers to help their patients by sharing their feelings thereby sharing into their hearts. In so doing, they give patients a feeling of belonging. The third is the intimate stage. This stage is characterized by intimate revelations; it is reserved for family, relatives and friends. The closeness that is exhibited in this stage is as a result of friendship or relationship that determines the degree of intimacy. This stage is restricted to those who have developed a deeper union based on respect, love and understanding. In terms of the doctor-patient relationship, the level of disclosure that takes place will depend on the kind of relationship that has been established. Patients can only feel free to express their feelings and thoughts if they have developed good rapport and intimate relationships with the doctor.

2.2.2 Principles of Interpersonal Communication in Doctor-Patient Communication

To gain a better understanding of interpersonal communication, it is essential to explore some of its major principles. Turner and West (2009) posit that in interpersonal communication, communication is irreversible, unavoidable, symbolic and rule-governed. It also has both relationship levels and content.

Interpersonal communication is unavoidable. Watlawick *et al.* (as cited in Hargie, 2021) asserts that one cannot avert communication. Basically, this implies that no matter the effort, one cannot prevent another person from deriving meaning from their behaviour. Thus, communication is unavoidable and inevitable. Even through avoidance of eye contact and silence, we are still communicating. It is thus imperative for doctors to communicate with their patients for positive medical care outcomes. Patients tend to read more into the doctor's non-verbal behaviour in terms of posture, gaze, physical distance maintained and facial expressions. These expressions act as cues for the different interpretations that patients may attach to them. Patients are very observant and sensitive to the non-verbal behaviour of the doctor. Due to illness, patients are anxious, fearful and may have emotional uncertainty. Hence, they are always on the lookout for information reflecting the aspects of their illness. If they misinterpret the doctor's non-verbal behaviour, it can in turn impair the relationship that has been built and impede the consultation process. It is therefore crucial for both the doctor and the patient to be careful about their non-verbal behaviours.

Interpersonal communication is equally irreversible. Irreversibility means that what has been said to another person cannot be reversed (Bakiner, 2021). This calls for sensitivity on the doctor's part when communicating to the patients about their state of health and the effect of the disease on their lives. Furthermore, interpersonal communication is symbolic. Use of symbols is part of a study that deals with the theory of semiotics (Lawes, 2019). Semiotics means use of signs and symbols (content and form). The use of mutually agreed upon symbols and signs allows for interpersonal communication. Symbols are representations of concepts, feelings, events, objects or arbitrary labels. For

example, the term ‘drug’ is used to refer to an element that is used to prevent, cure or treat a disease. It may be interpreted as a substance that can be used to improve mental and physical well-being of the patient. It is important to develop transactional viewpoint because communication requires mutual understanding. There should be a common understanding of communication signals, concepts or linguistic terminologies used between the patient and the doctor. Doctors should go an extra mile to ensure that patients understand the health information provided.

In addition, interpersonal communication is rule-governed. Rules dictate what the individuals taking part in the communication process view as appropriate ways to interact within their relationship. They have a choice and the participants may choose to ignore a specific rule. People also learn interpersonal communication. Although the ability to communicate is at times taken for granted, as individuals we have to cultivate and refine communication skills with respect to a wide assortment of people. In a study by Anestis *et al.* (2020), doctors were found to spend inadequate time relaying information to their patients. The study revealed that the average time that they spent was about one minute in an encounter which could have taken place for 20 minutes. In some cases, oncologists withheld information from their patients altogether. These doctors reasoned that the adverse reactions from patients could elevate their stress and worsen their illness.

Lastly, interpersonal communication has both relationship and content levels. Every message communicated bears information at both levels. The level of content refers to the information which is carried in the message and this entails both the verbal and non-verbal components (Solomon & Theiss, 2022). Any message also contains a relationship

level. This implies that the sender expects the receiver of a message to interpret it correctly. The relational dimension of messages indicates how the listener and speaker feel towards each other. Since relationship and content levels work hand-in-hand within the message, it is imprudent to consider sending a message that does not reflect in some way the relationship between the receiver and the sender (Knapp & Vangelisti, 2000). Basically, it is not possible to separate the two levels. One can always express an ideal thought (content) but the idea is always presented within a relational framework of the interpersonal relationship. In the doctor-patient communication, interpersonal communication takes centre stage that is, it essentially facilitates the encounter. The next section gives a brief background on doctor-patient communication.

2.2.3 Historical Background on Doctor-Patient Communication

To begin with, it is important to briefly examine the nature of patient-provider relationships as a precursor to understanding the doctor-patient communication. From the time when Hippocrates instructed his students on how to relate with their patients, doctor-patient communication has been a subject of interest for healthcare providers and researchers alike. Bulger and Barbato (2000) aver that Hippocratic medicine was committed to the understanding of the whole person. It can thus be argued that Hippocrates put emphasis on the person and not the disease. This view is supported by Sak (1994) and Polter (1999) who state that between fifteenth and nineteenth century, medicine was run like a trade than a profession and there was a range of practitioners available. The practitioners included herbalists, midwives, wise women and physicians.

In the 19th century, there were developments in science that inspired changes in policies and in medical institutions. With the development and introduction of the microscope,

stethoscope and discovery of x-rays, medicine became more objective and analytic since diagnosis was less reliant on the patients' subjective account. More developments in the medical field were witnessed in the 20th century where doctors had access to thermometers and laboratories. In addition, the introduction of antibiotics and penicillin improved therapeutic power (Burke,2008). Porter (1997) opines that due to advancements in knowledge on bodily and physiological investigation, the position of doctors and medical institutions were elevated in society. Burke (2008) supports this assertion by noting that doctors were held in high esteem due to improved diagnosis and treatment. Moreover, they were accorded a higher status than other professionals by virtue of the admiration and respect accorded to them.

Doctors applied scientific knowledge to facilitate patients' recovery before the age of information (Luke *et al*, 2021). Hence, they maintained professional authority which subsequently accorded them privileges. On their part, patients played a more passive role, which meant they were entirely dependent on the doctors' expertise to improve their health. Consequently, power relations between the doctor and the patient were introduced. The doctor occupied a higher position since he was autonomous and dominant while the patient played a passive role (Kaba & Sooriakumaran.2007).

Doctors in the 1960s and 70s, controlled the amount of information disclosed about their patients' treatment and the decisions about treatment. However, in the 1980s, there was a shift where patients moved from the passive acceptance of doctor's view on the disease. During this period, the unquestioning admiration of scientists reduced and patients began to take greater responsibility for their health. Apart from demanding for accountability for their lives, patients were more health-seeking and concerned about

health awareness and expectations. With access to health information, more patients questioned their doctors (McMullan, 2006).

The basic tools of western medicine such as history taking and medical examination are being neglected more and more in medical practice with the advancements in medical technology (Silvano, 2021). Without the element of effective communication, conventional medical practices fail to meet patients perceived needs and expectations. Inadequate communication between a patient and health provider can result in adverse outcomes, such as non-compliance, medical complications and litigation (Alanazi & Alharby, 2022).

Davies (2021) argues that patients resent when machines dominate doctor-patient interactions and reduce the time in which a patient can narrate their unique story and experience. This is because the basic premise of health provider and patient communication is to enable the doctor to take care of the unique needs of the patient. This is necessary in the provision of healthcare. In recent years, more attention is being given to doctor-patient communication since it is regarded as a complex venture. Mushaandja, Mlambo and Sabao (2022) note that this interaction is unique since it is non-voluntary and it also deals with issues of great importance. It is communication between individuals with non-equal positions and it is emotionally laden. For this communication to be successful, it requires the co-operation of both parties. Although sophisticated technology is useful for diagnosis and treatment, it is through interpersonal communication that the patient and physician are able to exchange information. In support of this view, Brown (2008) argues that in medical education, the ability to communicate has been recognized as a core skill and medium through which medicine is

practiced. He estimates that about 60-80% of diagnoses made are based on the history a physician elicits from a patient in the medical interview. It is evident that communication plays a crucial role in the success or failure of the doctor-patient encounters. It is a pivotal tool that acts a foundation upon which the doctor's relationship with the patient is built (Turabian, 2019).

A medical interview is an instrument or tool that enables a doctor to know and understand the patient so that he/she treats him/her humanely not like a medical problem that needs to be resolved. Effective communication creates an opportunity for the doctor to understand the patient's problem and his/her expectation hence provides an enabling environment for mutual satisfaction. Aspects of the doctor-patient communication such as adherence to treatment and satisfaction with treatment, are likely to have an effect on the patients' well-being and behaviour (Alanazi & Alharby, 2022). It is also likely to affect the patient's understanding of medical information and aspects of coping with disease since this largely affects the state of health and quality of life.

It is essential that doctors treat patients with respect since they are key partners in the health communication process. Stein *et al.* (2019) support the view that communication and interaction are of great importance, especially when it comes to diseases that are life-threatening. They are of the view that it is essential especially when it comes to breaking bad news to the patient and family. The concept of 'bad news consultation' is increasingly becoming an important topic for research (Ngwenya, Farquhar & Ewing, 2016). From the discussion above, communication between doctors and patients is a critical function in the management of patients suffering from chronic illnesses.

2.2.4 Role of Health Communication in the Management of Chronic illnesses

This section provides a conceptualisation of communication and health communication and then briefly discusses the role of health communication in the management of chronic illnesses.

2.2.4.1 Communication

Communication is one of those human activities that has no satisfactory definition although its value is accepted universally. According to Fiske (1990), there are various ways of looking at communication. In his view, communication underscores the process of spreading information and talking to one another. Communication is also regarded as a process in which one person affects the behaviour and state of mind of another. It is also the process of sending (encoding) and receiving (decoding) information. Communication is deemed to have failed if the recipient decodes lesser information or a different form from what was originally intended by the sender.

Keyton (2011) argues that communication represents the process through which information is relayed from one person to another through a common understanding. In his definition, he highlights the element of common understanding as a key pillar in the achievement of effective communication. The implication therefore is that in the absence of this understanding, communication will not have taken place. He further asserts that the audience is central to the process of communication. Communication is considered one of the most complex human activities.

A more accurate way is to consider communication as a dynamic process that significantly influences through meaning. It significantly influences individually

ascribed elements such as non-verbal behaviour. Communication can also include strategies such as use of clear unambiguous messages to ensure effective dissemination of information (Burgoon, 2021). According to the US Disease Prevention and Health Promotion (2004), the main aim of communication is to establish and monitor relationships, initiate actions, beliefs, attitudes and ideas. From this perspective, it can be said that communication plays an indispensable role in healthcare service delivery and promotion.

2.2.4.2 Health Communication

According to Beato and Telfer (2010), health communication is the study and application of communication strategies to inform and influence individual and community decisions regarding elimination of unhealthy behaviours and adoption of healthy ones. Thomas (2006) opines that health communication brings together two aspects namely: health and communication and it is regarded as a necessary tool to improve both personal and public health. Health communication is at the centre of a society's access to healthcare systems and interactions between patients and the doctors. It also influences peoples' capacity to engage in proper self-care and management of chronic conditions and the understanding of the clinical recommendations and outcomes. Health communication is also a component of relationships among health professionals for example, doctors and nurses. It is also very critical in the interaction between the healthcare providers and patients in the improvement of health.

Health communication, an important tool for promoting public health, takes place at different levels. The Centres for Disease Control and Prevention (CDC) (2001) identifies

four levels namely: the individual, social network, community and the society. Some of the roles of health communication highlighted by the CDC include:

- i. Increase knowledge and awareness of a health issue, problem, or solution
- ii. Influence perceptions, beliefs, attitudes, and social norms
- iii. Prompt action
- iv. Demonstrate or illustrate skills
- v. Highlight the benefits of behaviour change
- vi. Increase demand for health services
- vii. Reinforce knowledge, attitudes and behaviours
- viii. Refute myths and misconceptions
- ix. Help coalesce organizational relationships

The doctor-patient relationship is a very unique yet problematic form of human relationship (Hellman, 2003). A study conducted among nurses and doctors in six countries concluded that the relationship between patients and physicians is a crucial foundation of a stable society and can only be compared to family relationships (Magee,2003). The effectiveness of communication between the patient and health provider depends on the willingness of both parties and especially on the health provider's ability to communicate. However, a number of studies suggest widespread dissatisfaction due to the poor quality of patient-physician communication (Dalma *et al.*, 2020; Fernández-Ortega *et al.*, 2023). The dialogue that takes place between the doctor and patient often determines their future interactions and patient compliance (Fernandez-Ortega *et al.*, 2023). Many patients' expectations when in hospital is that the health provider will explain to them their conditions in a language they can understand. It is on

this basis that the current study sought to determine the patterns of communication employed by health practitioners in providing information to chronically ill patients.

2.2.4.3 Role of Communication in Healthcare Provider and Patient Relationship

As earlier mentioned, interpersonal communication plays a significant role in establishing rapport between the two individuals involved in the communication process. It is essential in patient-healthcare provider communication. Hoff and Collinson (2017) identify three significant aspects of communication that play crucial roles in the doctor-patient relationship. The first is the relational aspect. Regarding this aspect, the patient has the cognitive need to be informed (the need to know), need to be understood and emotionally they require to feel known (Kruijver *et al.*, 2000). The physician is in response assumed to possess relational task related skills and affective behaviour. The relational behaviour deals with the skills of probing and providing the needed information. The relational aspect dictates that there has to be a balance between the affective and instrumental behaviour in the patient-health care provider communication. (Hoff & Collinson, 2017).

In addition, the structure of conversations in patient-healthcare provider communication is multifaceted, involving initiation, information exchange, clarification, shared decision-making, conclusion, and follow-up. Secondly, the structural aspect should be considered. It is important for the communication to have asymmetry so as to cater for the patient's needs. The asymmetry is reflected in the way communication is organized and structured in terms of sequences of initiatives and responses (Drew & Sorjonen, 1997). The third aspect which is turn-taking. It is important since it defines and establishes relationships.

Having touched on the important aspects of interpersonal communication in doctor-patient communication, it is important to look at the different functions that communication between the doctor and patient serve. Some of these functions include the creation of a good rapport between doctors and patients (Ward, 2018). Communication also builds trust and enhances understanding between patients and healthcare providers. Ward states that talk is a great ingredient in medical care and a fundamental instrument by which the doctor-patient relationship is crafted. It is also a channel through which therapeutic goals are achieved. This perspective places emphasis on a good interpersonal relationship to ensure good medical care (Ward, 2018).

Different scholars have defined a good interpersonal relationship in the context of medical care. From the communicative perspective, interpersonal communication is defined by the quality of communication and the number of participants in the communication process (Boies, Fiset & Gill, 2015). This occurs when individuals interact and treat one another uniquely. This definition places emphasis on the uniqueness of the treatment as well as on the conversation which is respectful to both parties (Boies *et al.*, 2015). The transactional process has also been embraced by some interpersonal communication scholars. According to Wood (1998), during communication human beings always link the conversation to what came before as they anticipate what may come later. This perspective brings to the fore the interrelations aspect of the communicators. Hence, a good interrelationship has necessary ingredients like being friendly, being honest, sharing compliments, showing interest in the conversation and having a non-judgmental attitude.

From a medical perspective, Pellegrini (2017) sees interpersonal communication as interaction whose purpose is to establish and sustain an effective working relationship based on mutual trust between the interactants. A good medical interview should take care of both the patient and the doctor. The patient should be given a chance to explain his/her symptoms, preferences and concerns whereas the doctor should show that he/she understands. Moreover, by virtue of his/her expertise the doctor should give details of the disease and the treatment procedure to be adopted.

The essence of medical communication is to facilitate the exchange of information between the doctor and the patient (Mushaandja *et al.*, 2022). This is done through the exchange of both verbal and non-verbal communication by both parties. This exchange entails both information seeking and giving. In the doctor-patient encounter, the patient visits with the need to know and to understand. A patient with a chronic condition is interested in finding out what the matter is, why he/she experiences pain in one part of the body or the other, the effect of the condition on his/her life among other things. The patient also wishes to be accepted by the doctor. For the illness to be properly diagnosed and effective treatment administered, the doctor and patient need to play their roles well. The doctor needs to actively seek information from the patient and the patient needs to open up to the doctor about the symptoms of the illness, his/her perception about the illness and his/her expectations. This will help the doctor determine the kind of information to offer.

Research findings reveal that the quality of doctor-patient communication influences patient satisfaction and adherence to the prescription (Alanazi & Alharby, 2022). For instance, a review of randomized controlled trials and analytic studies of physician-

patient communication carried out established that better communication during history taking and a better discussion on the way to manage the ailment influences patient outcome (Riedl & Schüßler, 2017). These patient outcomes include emotional health, physiological measures such as blood pressure, sugar levels and pain controls.

Medical communication enables the doctor and patients to make decisions about treatment. In the past, the doctor had an upper hand in that he/she directed care and made decisions about the treatment (Silvano, 2021). This view gradually changed in the 1980s. Patients were no longer the passive recipients; they started taking part in their own treatment. This approach is termed as shared decision-making. In addition, in the 1990s, a number of policy initiatives were introduced to strengthen public involvement in healthcare provision. For example, in the United Kingdom, patients were involved in decision making in two distinct areas that is, general and personal healthcare (Ocloo *et al.*, 2021).

A report of public inquiry carried out to find out the importance of communication between the doctor and patient was produced in the UK by Bristol Royal Infirmary Inquiry (2001). The report noted that negative culture towards empowerment of patients and lack of awareness among doctors on the benefits of empowering the public were some of the issues that hindered effective involvement in the doctor-patient communication. The report emphasized the importance of involving patients in making decisions about their care whenever possible. Emphasis was also placed on need to access information, the importance of providing training and adequate funding on issues related to medical education of the patients. It further stressed the significance of

involving different groups, the need to provide training funds and ensure access to information (Inquiry, 2001).

In relation to this, England in 2003, established a commission that sought to establish involvement of the public in health (Cushing, 2015). It was meant to ensure patient involvement in decision making about health and health services in England. Opinion and information were gathered from patients about national health services and primary care trusts. This indicates that from early 1990s the UK government had shown interest in matters dealing with patient involvement in health.

To show their support for patient involvement in healthcare, the UK government published the first patients' charter in 1991. It mainly set out the patient's rights and the standards of service they would expect (Department of Health, 1991). The patients' charter was recognized as an important step towards patient empowerment. However, it received criticism due to its failure to consult on the standards it established and for raising expectations of the patients before the delivery of services (Iliffe & Manthorpe, 2023). In 1992, the patient's charter was introduced through the publication of "Local Voices" that advocated for the involvement of local people in purchasing healthcare requirements. They were to participate in the provision of information, decision-making and provision of feedback. They were required to take part in varied stages of the purchasing cycle. This patients' charter was revised in 1995 (Limjoco *et al.*, 2023).

The rhetoric around public and patient involvement in their treatment increased in the 1990s and there is more effort involved in ensuring that the patient's voice is heard. Covey (2000) is of view that although the patient's agenda was the main interest in the process of development of the health policy, there was still so much more that needed to

be done before this was realized. Taking cue from the United Kingdom, many governments have called for greater involvement of patients in making their own health care decisions as well as involving them in strategic decisions about healthcare provision.

It is important to mention that gender plays a crucial role in the information that patients relay to their doctors. A study carried out by Vogel, Meyer and Harendza (2018) indicated that male and female patients have different issues to talk about with their doctors during consultation. The study found that men do not talk about psychological problems with their doctors. Women on the other hand, talk more about their psychological problems than their physical problems. On the contrary, for the doctors, their primary focus is biomedical consultation hence they may limit patient talk. The findings also indicate that the communication is usually directed one-way and the doctors take the lead in communication and decision-making often with the patient participating less.

Research has revealed that there are obstacles that hinder effective doctor-patient communication. This includes crowded environment which may in a way limit the time for consultation, lack of privacy, lack of health education and the use of medical terminology by doctors. This clearly indicates that communication is a complex process which can be influenced by culture and also determined by the individuals involved (Vogel, Meyer & Harendza, 2018).

In as much as communication is determined by the individuals involved, Newman (2019) observes that though there may be differences in communication, there is a great desire for information about diagnosis, prognosis and treatment among patients suffering

a life-threatening disease. Kunneman *et al.* (2019) are of view that in the cancer setting communication plays two main roles; it facilitates interpersonal communication and the exchange of information and decision-making. Effective communication is therefore important during oncology consultations and an important factor in determining patient outcomes. It is also emphasized as important in the delivery of services. According to Thorne *et al.* (2013), it is universally acknowledged that effective communication is a core value required in the professional health training and crucial in the delivery of services. They argue that patients prefer when they are communicated to by individuals who understand their needs. This view is supported by Nordfon *et al.* (2019) who aver that there is need to take care of the emotional aspects of patients in order to understand how they cope with their life experiences. When this is done, the patient becomes cooperative and is motivated. This is a key requirement in comprehending the patient's beliefs and attitudes towards their condition.

Thorne *et al.* (2013) conducted a study in two phases, covering the period 2005-2013, to determine patients' perspectives on the importance of communication especially in cancer treatment. The initial phase of the study was in 2005 to 2009, in which the researchers recruited 60 newly diagnosed cancer patients. In the second phase, covering 2009-2013, they expanded the cohort to include more patients with advanced stages of the disease. Their research mainly focused on an analysis of patients' accounts of communication from the patient's perspectives. They used verbal transcripts of the interview data which they coded using the NVivo qualitative data management software system. One of the categories of unhelpful communication that patients identified was occasional misses. This is a case where a physician/clinician forgets to communicate

something. When this occurred, the patients were able to forgive upon realization of these exceptions or errors as not intentional. Some patients deduced that “I am sure he does not mean to...” or “he is busy.” Other patients said they used discussions as a way of ensuring doctors gave them the required information. Patients also described poor communication as a result of doctors viewing cases with “professional lens” and not taking into consideration the patients’ perspective. For instance, some patients described some communicative encounters as being “brutally frank” in the sense that the decisional and emotional needs of the patients were neglected. According to the patients, the doctors were more concerned about professional liability. Patients were also of the view that receiving a lot of information about their condition and immediately being asked to make difficult treatment decisions after receiving the bad news was a poor communication technique. Some patients viewed this as a poor application of the shared decision-making philosophy since to them the doctors were more concerned about professional liability than supporting the patients emotionally and guiding them to make decisions. Some patients even argued that although the idea of informed consent was a good idea, they still found it difficult to decide on the best option since they had no medical background.

Another study on the issue of patient participation revealed that low literacy levels and health awareness of the patients has led them to be passive during medical consultation (Henselmans *et al.*, 2015). The study found that patients may be reluctant to ask their doctors questions or express their opinions for fear of asking the wrong questions or because of undermining “the decision-making role” of the doctor. There was evidence that doctors rarely encouraged partnership building and supportive talk to enhance

patient participation. In the study by Henselmans *et al.* (2015), patients considered poor communication as that in which the clinicians were unwilling or unable to convey basic courtesy, compassion or respect in their interactions. A patient described how in a dispassionate manner a physician had conveyed information to her about her diagnosis “Well you’ve got lung cancer and I suggest that you go home, get your life together since with lung cancer, the average is about 8 to 10 months.” From this excerpt, it is evident that the doctor did not take into account the psychological trauma that this information was likely to cause the patient. Some of the patients said the doctors rarely showed empathy as most of the physicians seemed detached from human feelings (Henselmans *et al.*, 2015). Such incidences, though rare, inspired the current research to explore the nature communication between doctors and chronically ill patients in the context of Kenya.

In another study conducted by Rogers *et al.* (2000) that included 30 patients with heart problems/heart failure, it was noted that patients believed that doctors did not tell them as much about their conditions as they expected. Some of the patients felt that doctors did not want to provide details which they considered too much or inappropriate information about their illness. In their findings, Rogers *et al.* indicate that some patients voiced concerns about their drugs and the possibilities of alternative intervention; others believed that they should not ask questions. Some patients reported confusion or short-term memory as the side effects of their illnesses. These side-effects may have contributed to their inability to ask questions to their clinicians (Rogers *et al.*, 2000).

Studies that have been carried out on patients with cancer have indicated that there is a positive effect on open communication on their likely prognosis. Hence, effective

communication could have similar results with heart failure. In addition to the indispensable information received from health professionals, patients need health professionals to help them make informed decisions and to actively participate in their own treatment (Hartzler & Pratt, 2011). This mainly occurs in cases where patients share information on the diseases from which they are ailing. Hartzler and Pratt define patient expertise as experiential knowledge gained from personally managing day-to-day experiences of an illness. Patient expertise is developed through one's everyday experience and self-care over time. This informational support is shared with other patients as they help one another cope with illness. Apart from sharing on a personal basis, patient expertise has gained visibility on web based social software (for example, social networking tools, forums, wikis, blogs, that help patients to readily exchange information with others who face similar health situations.

The support groups led by patients provide longstanding online resources for patient-generated guidance, provide advice on treatments, shared experiences and medication side effects. In their study, Hartzler and Pratt (2011) found that the medical topics discussed included the following categories: deciding on healthcare teams, treatments and procedures and on whether to enrol in research trial. Some of the issues the patients tackled included how to deal with competing recommendations from different doctors and making decisions such as between radiation and tamoxifen or chemo or determining whether to have a biopsy or if they are eligible to participate in genetic research.

From the work of Hartzler and Pratt (2011), patients were also keen on understanding bio-medical concepts, processes, clinical procedures and lists, side effects and biomedical research. Findings also indicated that patients were keen on managing

interactions with healthcare professionals. In addition, they were interested in knowing when to seek a second opinion, what to expect for their upcoming appointment and to understand the considerations doctors make when recommending treatment. According to Hatzler and Pratt, personal topics involved problems or concerns that were tied closely to one's personal life. These included: managing current responsibilities and the management of daily activities associated with the family, home, friends, work and health related issues especially those that occur outside the healthcare delivery system. For example, how to self-manage at home. They also found that both patient and clinician sources offered recommendations of four types (action strategies, knowledge, perspectives and information sources). The patient expertise was significantly different in topic, type of recommendations (action strategies, knowledge, perspectives and information sources) and the style of recommendation. Clinician expertise was predominantly medical in topic, knowledge oriented and prescriptive in style (Hatzler & Pratt, 2011).

Effective communication between patients and healthcare providers is important for quality care. The structure of conversations in patient-healthcare provider communication is multifaceted, involving initiation, information exchange, clarification, shared decision-making, conclusion, and follow-up

2.3 Communication and the Management of Chronic Conditions

2.3.1 Communication Strategies Employed by Healthcare Providers

Communication strategies are plans for communicating information related to a specific issue, situation or audience. They involve critically thinking about a communication problem or issue and determining the best approach for communicating the message or

the information (Daniels, 2022). Communication strategies are deliberate plans to help tackle emerging obstacles in the pursuit of particular communicative goals (Faerch & Kasper, 1983). They also involve the mutual attempts of two interlocutors to agree on meaning in situations where the requisite meaning seems elusive to either side (Tarone, 1980). From these two definitions, strategies are viewed as tools used to negotiate meaning between participants in the communication process.

In an effort to enhance mutual understanding with patients, health providers employ various communication strategies. Some of these strategies include assessing what the patient already knows about his/her condition before providing expert information. This helps to avoid confusion and allows doctors to tailor their messages accordingly. It is also necessary for doctors to understand the specific information the patient wants to know (Kee *et al.*, 2018). This is achieved by addressing the patient's concerns and answering their questions. In so doing, doctors can enhance patient satisfaction and engagement. Healthcare providers can use open-ended questions to gather relevant information and encourage patients to share their thoughts and feelings. Questions enable doctors to better understand the patient's perspective and make informed decisions. It is also essential that healthcare providers use clear and simple language when communicating medical information to patients. Avoiding jargon and using layman's terms can enhance understanding and prevent misinterpretation (Mohd Salim *et al.*, 2023).

Showing empathy towards patients fosters a supportive and understanding relationship. Acknowledging their emotions and demonstrating empathy can help patients feel heard and validated (Kuang, *et al.*, 2023). By implementing these communication strategies,

doctors can improve patient-physician communication consequently enhancing patient outcomes. According to Zhang *et al.* (2024), healthcare providers can improve communication with patients by setting the right tone. This can be done by the former initiating the conversation by welcoming and inviting the latter into the discussion, demonstrating a period of undivided attention. This helps the patient feel valued and establishes a foundation for effective communication. Powers *et al.* (2020) also suggest that doctors should employ active listening through showing concern and empathy to the patients. This involves paying attention to verbal and nonverbal cues, such as body language, tone of voice, and mannerisms. By acknowledging patients' concerns, doctors can foster a sense of trust and create a safe environment for open communication. Doctors need to adapt their communication style to different clinical settings and patient cultures without stereotyping. This includes being aware of potential gaps in communication related to gender, culture, and health literacy.

The communication strategies identified from various studies in this section helped the researcher to formulate a framework for examining how doctor-patient communication is undertaken at JOOTRH.

2.3.2 Healthcare Providers' Experiences in Communicating with Chronically Ill Patients

Chronically ill patients rely greatly on the expert information of physicians to better manage their conditions. They especially need professional information to make decisions concerning their conditions. In such scenarios', shared decision-making is important in patient-centred delivery of care. Studies have shown that shared decision-making improves health outcomes, patient adherence to treatment and patient

satisfaction with the decisions and the overall quality of care (Milly & Thomas, 2020). In spite of the advantages of shared decision-making, many healthcare providers are minimally engaging the patients in decisions related to their health. This is partly because it takes time to undertake effective negotiation and communication between the provider and the patient (Alameddine *et al.*, 2020). Shared decision-making is equally affected since some health providers do not support it in situations where less treatment options are available such as emergencies and or when the patient is unable and unwilling to participate in decision-making.

A study carried out in Dubai, which involved 50 health providers, explored the perceptions of physicians in relation to shared decision-making. The study identified some of the factors that affected shared decision-making including physician specific attitudes and behaviour. It revealed that some physicians were willing to engage the patients while others were reluctant. Others insisted on deciding for the patient. Additionally, health providers blamed failed shared decision making to the patients' attitude. In their opinion, some patients were reluctant to take responsibility for their health (Alameddine *et al.*, 2020).

In the United Arab Emirates, Hamann (2009) carried out a study which noted that culture and environmental factors affected shared decision-making. The study pointed out that there is a cultural norm where physicians are expected to take the lead and patients accept what is recommended. Hence, power relations affected shared decision-making in that physicians felt that they had the responsibility to make decisions for the patient. Some physicians had a fairly weak support for shared decision making and they

attributed their attitudes and behaviour to variables beyond their control such as patient stances, environmental and interpersonal dynamics.

In their study, Abdulah *et al.* (2020) found that healthcare providers faced challenges in disclosing diagnostic information to patients. At least 65% of the clinicians reported that breaking bad news was not easy task. More than half (56%) preferred to tell the truth to the family rather than directly to the patients. Clinicians revealed that they did not disclose information to patients due to various reasons such as: cultural beliefs (27.5%), 14.5% physiological impact and non-co-operation of patients in the therapeutic plan. Of the respondents, 60.2% mentioned that information disclosure might not necessarily be desired or helpful to the patients. This indicates that health providers experience unique challenges communicating difficult information to patients which underscores the importance of researching physicians' perspectives in doctor-patient communication.

The study further noted that most clinicians struggled to find the best ways to disclose difficult information without inflicting harm on the patient. This is an indication of the dilemma that physicians in healthcare find themselves in. Clinicians said they did not disclose information about serious illnesses since they felt that patients would not be cooperative in the therapeutic plan. On the other hand, without patients knowing the truth about their prognosis could lead to several negative outcomes, like mental distress, inconvenient prognostic awareness, receiving futile treatment at the end of life and lowered quality of life (Abdullah *et al.*, 2020).

According to Matlakala and Mokoena (2011), factors that affect disclosure include the fear of discrimination and stigmatization for the patient. This challenge relates to the disclosure of information about illnesses such as HIV/AIDs and cancer. The healthcare providers feared that the patient would be rejected or stigmatized by the family. In one study, student nurses indicated that they used to breach confidentiality by hiding information from the patient so as to accommodate the family which in most cases was against the idea of letting the patients know.

Health providers equally face challenges with interpersonal communication. In a study by Vimala and Omar (2016), cardiologists confessed to facing difficulties communicating with their patients due to time barriers. They had busy schedules and limited time due to the high number of patients. Language was equally a barrier to communication hence they were forced to use interpreters. In addition, medical jargon in some cases lacked equivalent terms during translations to local languages, leading to miscommunication. For example, terms like “Electricophysiology study” (EPS) were difficult to sufficiently explain to patients.

In a study undertaken to evaluate Chinese physicians’ performance in communicating with patients, it was found that physicians performed poorly in their interaction with patients and their communication style was determined by their personality and experience. From the findings of the study, several factors contributed to the poor performance of physicians in communication. High workload for the physicians led to limited time to interact with patients. Physicians, therefore, often failed to fully collect information from the patients, express friendly attitudes towards them or involve them in

decision-making. This led to heightened distrust and defensive behaviour among patients towards the physicians (Sun & Rau, 2017).

The study further revealed that physicians had low expectations of patients' medical literacy hence provided less education to them. Physicians also opined that they had little awareness on the importance of communication skills since some of these skills are innate. Findings indicate that physicians adopted defensive behaviours to protect themselves from disputes. They admitted to approving unnecessary examinations to reduce chances of misdiagnosis. Some confessed to having less interaction with patients to avoid questions or complaints (Sun & Rau, 2017).

In conclusion, healthcare providers face challenges when communicating with patients especially where a chronic illness is involved. Shared decision-making is challenging since some healthcare providers are reluctant to engage patients. Other factors that affect communication include time constraints, language barrier, cultural beliefs and difficulties in breaking bad news to the patient and family. These findings provided the units of analysis in the current study in examining how patients and doctors navigated the challenges of communication on the management of chronic conditions in JOOTRH.

2.3.3 Patients Views and Experiences on Barriers to Effective Communication in Management of Chronic Conditions

The improvement of the quality of care is an important global priority since it is the cornerstone to realizing better health outcomes and responding to changing population needs (WHO, 2018a). Quality of care is mainly intended to increase the probability of patient outcomes and reduce undesired outcomes. In essence, care should do better than harm to the patients leading to improved quality of health (Tunsi *et al.*, 2023). Currently,

scholars recognize that the inclusion of patients' views is what constitutes good quality of care (WHO, 2018b). The degree to which healthcare is responsive to their specific needs and desires can be provided by research that provides important insights to patients' perception of quality care. This may therefore result in higher satisfaction, increased confidence and willingness by patients to adhere to treatment plans (Members *et al.*, 2020).

Research conducted in Saudi Arabia on patients' perception of quality of care among the chronically-ill found that 50% of the participants were satisfied with accessibility and quality of care provided (Alshareef *et al.*, 2020). The level of satisfaction towards responsiveness and affordability was significantly low. At least 60% of the participants complained that doctors do not spend enough time with them. 30% were concerned with the financial burden due to the cost of medical care. In addition, some participants reported getting conflicting advice about pre-procedure instructions (Alshareef *et al.*, 2020). The study also indicated that healthcare quality is connected to the perceptions of healthcare providers skills and attitudes. Moreover, due to poor communication which negatively affects quality of health care, respondents in this study revealed that they did not get enough instructions and information before a procedure was conducted.

A study carried out in South Africa explored the experiences, challenges, barriers to and facilitators for chronic disease management (Mamiela *et al.*, 2015). The study looked at the viewpoints of both patients and healthcare providers. The study concluded that both patients and nurses faced similar challenges that included lack of knowledge, shortage of drugs and an acute shortage of nurses. This resulted in long waiting times for patients. Lack of knowledge about chronic illness among the patients and their carers led them to

attribute the diseases to witchcraft hence led to healer shopping. On the other hand, health workers reported that they lacked knowledge and were inadequately trained to manage chronic illnesses. The shortage of medication affected the continuity of care for patients.

Language is a key factor in the healthcare provider-patient communication. A study carried out in Rwanda that looked at patient preferences and perceptions indicated that language barriers affected communication (Cubaka *et al.*, 2018). Rwanda is predominantly rural and it is estimated that around 32% of Rwandans have limited literacy hence cannot read and write in English, Kinyarwanda and French which are the official languages of the country. Study findings indicate that due to language barriers there was miscommunication. These barriers increased the risks of inaccurate language interpretation, misdiagnosis and wrong treatment. Lack of an interpreter to mediate between the patient and the healthcare providers in some cases forced patients to use body language to explain themselves.

Time constraints were also another factor that impeded healthcare provider-patient communication. The study noted that patients felt that the health care providers did not pay attention to what they were being told. Moreover, patients did not get adequate time for consultation. They desired to be listened to by health providers in an environment free from distraction and interruptions (Cubaka *et al.*, 2018).

A study carried out in Malawi on patients' perspectives in medical decision-making among diabetic patients found that patients perceived implicit anger from health providers whenever they tried to engage them in a dialogue (Makwero *et al.*, 2018). Patients thus preferred to remain subservient and unknowledgeable so as to receive care.

This echoed the findings of an earlier study by Rogers *et al.* (2000), which found that some patients voiced concerns about their drugs and the possibilities of alternative intervention. Others believed that they should not ask questions because of the fear of how the healthcare providers would respond to their queries. For some, their inability to ask their clinicians questions was occasioned either by confusion or short-term memory which were side effects of their illnesses.

From their findings, Makwero *et al.*, (2018) noted that patients perceived providers as superior and unchallenged authority as such, the patient's role should be inferior. The desire of the patients is to get clear and precise information about their health. They want to know the health providers' thoughts and findings while some want to know the purpose of the various examinations requested. Nevertheless, a healthcare provider has limited time to provide sufficient information to meet patients' needs. Besides, socio-cultural tendencies perpetuate passivity among patients thereby subduing them into rarely voicing their concerns. The study further observed that patients were keen on understanding bio-medical concepts, processes, clinical procedures and lists, side effects and biomedical research. Additionally, patients were keen on managing interactions with healthcare professionals. They were interested in knowing when to seek a second opinion, what to expect for their upcoming appointment and to understand the considerations doctors make when recommending treatment. In addition to the indispensable information received from health professionals, patients needed the doctors to help them make informed decisions and to actively participate in their own treatment.

According to Makwero *et al.* (2018) shared decision-making between health provider and patient is equally affected by patient literacy. Patients with limited literacy expected providers to repeat or paraphrase their problems so that they are sure that they understood. The study noted that patients realized they had low health knowledge therefore, they desired to get more information regarding their conditions. They realized that low health knowledge minimized their choices and affected their ability to explain to the health providers their problem. Literate patients on the other hand, experienced a few challenges as compared to the illiterate ones. One of these challenges was lack of comprehension which prompted them to seek clarification before responding to queries posed by the health care providers.

There is increased awareness that patient-centred healthcare communication approaches are beneficial, especially to the patient. As such, it is essential for the health provider to have good interpersonal and communication skills to enable him/her establish a caring relationship with patients that would facilitate diagnosis, counselling and treatment. This would lead to patient satisfaction and effective delivery of healthcare. It is evident from the reviewed studies in this section that patient-centred communication is still a challenge due to a multiplicity of factors. These factors range from the relative positionality of the patient and doctor in the healthcare processes to the practical difficulties of communicating difficult information to patients. No studies were found focusing on patient-doctor communication in JOOTRH, Kenya, hence the current study sought to fill the gap. In so doing, the study would also provide insights on how contemporary referral hospitals in Kenya navigate the challenges inherent in doctor-patient communication.

2.4 Interpreter-Mediated Communication

Communication between the healthcare provider and patients is difficult even when everybody speaks the same language. Language barriers, when added to the mix of complex relationship between the patient and the provider, make it difficult to have an effective health encounter. This may be further complicated by the introduction of a third party in the form of an interpreter. Interpreters bridge the cultural communities of the provider and patient by coordinating talk and facilitating answers to both the provider and the patient (Angellelli, 2020; Sarangi, 2012).

Language barriers between physicians and patients are potential sources of frustrations, misunderstandings and miscommunication. In a study done in South Africa, Ellis (2004) noted that the most common causes of misinterpretation resulted from African languages, which utilize metaphors, allusions and euphemisms when explaining an illness. Subtle shifts in meanings and translations lead to confusion and miscommunication between a patient and a provider, especially when interpretations were not done appropriately.

Research has also shown that providers and patients have expectations about the interpreter's role. For health providers, the interpreter is the instrument that keeps the patient on track. For the patient, the interpreter is a conversationalist (David, 1998). According to Angellelli (2020), in a cross-linguistic medical encounter, healthcare interpreters are responsible for facilitating communication between patients and providers who do not share a language or culture. 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 overcome communication barriers

embedded in cultural norms (Pochhacker & Shlesinger, 2007). The interpreter works to sustain communication between the provider and patient, strives to maintain a neutral position and maintains information accuracy and completeness by ensuring there is mutual interpretation of messages being exchanged (Avery, 2001).

In as much as interpreters play crucial roles in doctor-patient communication, the task that they undertake is not an easy one. Using experience from a South African hospital, Ellis (2004) poses these crucial questions: can I negotiate my patient from the 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? These questions underscore the importance of shared language and references for meaning.

Interpreters are mainly categorized into two namely: professional or trained (with specific education on medical interpreting) and ad-hoc or informal interpreters consisting of friends, family and volunteers. Informal interpreters do not possess any special training but can interpret because of their proficiency in multiple languages (Angelelli, 2004). Interpreters constitute an important component in the physician-patient interaction (Garcia *et al.*, 2004). However, literature leaves many unanswered questions and there are inconsistencies surrounding the functions of the interpreter within the health communication triad (patient, interpreter and the physician). First, at what point does an interpreter draw the boundary; should an interpreter speak for the patient or provider when required by a situation? Further, literature does not clearly address the concept of accuracy. How accurate must a translation be for a physician to know he/she made an informed diagnosis and for a patient to feel he/she received proper

care? It is thus evident that the actual role of the interpreter in patient communication is not well-defined.

Patient and provider communication, especially physicians' ability to listen to the patients and support them in making difficult lifestyle changes, is an essential component of chronic condition management. A study was carried out to explore how physicians communicate in interpreter-mediated consultations with diabetic patients and determine how their communication behaviours may impact diabetes communication and care (Huddleston *et al.*, 2013). The findings indicated that, in health communication, physicians used mainly closed-ended rather than open-ended techniques. They made directive utterances and this rarely elicited the patients' feelings, opinions or difficulties. There was little collaborative problem-solving discussion. Patients tended to provide mainly short answers of one or two words. Patients rarely asked questions of their own or spontaneously offered information.

The study by Huddleston *et al.*, (2013) also noted that clinicians spoke in short turns when asking questions about the patients' symptoms (e.g., where does it hurt?). However, they spoke in long turns when providing explanations or instructions to patients. This may indicate that clinicians overestimated the patients' language skills or were simply unaware of the difficulty of the interpreters' task.

Mediated communication is faulted for ignoring patients' understanding of medical information (Huddleston *et al.*, 2013). In some cases, family members or caregivers, who act as interpreters, provide support and encouragement for patients and may offer additional information. However, there are accusations levelled against family members. For example, they impede patient-provider communication by failing to interpret all that

is said; they give incorrect interpretations; they directly respond to the queries posed by clinicians instead of giving the patients opportunities to respond and they engage the clinician and/or patient in side conversations.

Another study by Roter *et al.*, (2020) has also observed that mediated consultation communication tends to be one-sided that is, it is clinician centred with the clinicians doing most of the talking and controlling the conversation using closed-questions and directive speech. This situation leads to loss of patient-centred communication. The study further revealed that when family members interpreted health information, clinicians had difficulty managing the flow of the conversation and staying focused on the patients. A different scene was portrayed when clinicians were working with professional interpreters; they directed their speech towards the interpreters, spoke in long turns and asked several questions at once. This limited patient's participation in the conversation.

According to Waitiki (2010), interpreter-mediated communication denies the patient confidentiality. This can lead to miscommunication or misrepresentation of facts to either the patient or the doctor. It may also lead to the culture of silence if the patient shies away from discussing personal health information in the presence of a third party. In Kenya, English remains the language of interaction in health centres. As such, interpreters most of whom are not trained, have to grapple with the challenges of translating from a language that they may not have adequate competence in. Consequently, a lot is lost in the process of translation since some words or phrases may not capture fully what is uttered in English.

2.5 Theoretical Framework

This study is anchored on two theories of communication namely: Uncertainty Reduction Theory (URT) and Communication Accommodation Theory (CAT).

2.5.1 Uncertainty Reduction Theory

The theory of uncertainty reduction focuses on reducing the high level of cognitive uncertainty that exists in initial interactions between parties in a communication process. A distinction is also made between predictive and explanatory components. In formulating their uncertainty reduction theory, Berger and Calabrese (1975) sought to model the process by which communication is used to reduce uncertainty in the initial interactions of strangers. Uncertainty Reduction theory (URT) is a person-centred theory originally developed to explain the early communicative interactions of strangers. The main aim of individuals during initial communication is to increase predictability and reduce uncertainty about their own behaviour as well as that of others. Over time, the theorists began to expand the scope of URT to account for uncertainties not only in initial interactions, but also in interpersonal communication in general. One such application was medical communications. Scientists are aware of the uncertainties that patients face, such as the attribution of symptoms, medical conditions, treatment options and prognosis, social roles and predicting the impact of the disease on friends, family and individuals (Bylund *et al.*, 2012).

Sharing of information is a human function that ensures individuals provide, request and exchange information to reduce uncertainty. Uncertainty reduction theory (URT) is built on the premise that communication is motivated when uncertainty is reduced. This theory was designed to illustrate the interrelationships between the seven key elements

of a bilateral exchange namely: verbal communication, non-verbal expressiveness, information seeking behaviour, intimacy, reciprocity, similarity and empathy (Berger & Calabrese 1975).

Based on these central elements, researchers introduced a set of axioms supported by previous uncertainty studies. Each axiom represents a relationship between a communication concept and uncertainty and from the axiom foundation the theorist can use deductive logic to derive 21 theorems that form an uncertainty reduction theory. Uncertainty, an entity that is uncomfortable, increases the motivation to communicate and in so doing, it is reduced. Uncertainty reduction follows a pattern of developmental stages (entrance, personal and exit).

According to Berger and Calabrese (1975), there are three phases that characterise the uncertainty theory namely: entrance, personal, and exit. Much of the entry-level interaction is governed by communication rules and norms characterized by the provision of important demographic information (Berger & Calabrese 1975). In the personal phase, communicators are less bound by rules and norms, communicate more freely with each other and tend to reveal attitudes, beliefs and more personal information. In the termination phase, the communicator determines future interaction plans which are characterized by little information and no communication at all. However, certain calls may terminate at the end of the input phase.

Apart from the level of uncertainty reduction patterns, there are distinctions among his three basic ways in which people seek information about others (Berger, 1986). The interesting part is the area between the entry and exit phases. Here, trust is a knowledge-

based, passive, active and interactive strategy that reduces uncertainty and enables more productive relationships. Passive strategies involve discreetly observing a person, while active strategies may involve learning about a person from others. In a doctor-patient relationship, a doctor can read another doctor's medical history or ask another doctor to talk about the patient. Interactive strategies, on the other hand, are reciprocal and conversational in nature. This model hypothesizes that interactions, especially increased interaction frequency and passive and active strategies, form coalitions. The uncertainty reduction theory is helpful in predicting initial interaction among strangers based on their motives for communication.

Uncertainty reduction theory, however, fails to explain human interaction in cultures where people accept uncertainty as part of life or in a case where the people have no interest in others. To overcome this, communication accommodation theory will be used to complement URT.

2.5.2 Communication Accommodation Theory

Howard Giles in 1973 developed the Communication accommodation theory (CAT). The theory argues that "During interaction people adjust their speech, their vocal patterns and gestures to accommodate others". It examines the various reasons why people accentuate or minimize social differences between themselves and their interlocutors through verbal and nonverbal communication. The theory deals with the link between language, context, and identity. It focuses on both intergroup and interpersonal factors that lead to adaptation and how power, macro, and micro

contextual concerns affect communication behaviour (Gregory & Webster, 1996, Giles, 2016).

Convergence and divergence are the two main adaptation processes explained in this theory. Convergence refers to strategies by which individuals adapt to the communicative behaviour of others in order to reduce these social differences. Divergence refers to cases in which individuals emphasize verbal and nonverbal differences between themselves and their interlocutors (Gregory & Webster, 1996).

CAT aims to describe and explain aspects of how people adapt their communication depending on situational, individual, and even interactional variables. More importantly, the model offers a framework in which changes in communication behaviour can be viewed in relation to specific psychological processes that mitigate or exacerbate differences between interlocutors (Ryder & Garagounis, 2014). The process of convergence and divergence is important for the provider-patient relationship because it is crucial in the early stages when speakers try to improve the quality of the interaction in a process called “communicative attunement.” At this stage of the interaction, speakers choose communication strategies that consider and/or anticipate the communication needs and characteristics of the other party. This includes using simple words (rather than technical terms), providing nonverbal cues, asking open-ended questions, and mimicking the other party’s body language and verbal behaviour. Although the latter may sound offensive, it is surprisingly common for people to mimic the speech of others when they speak (Ryder & Garagounis, 2014).

Communication accommodation theory was incorporated into this study because it helps health practitioner better understand how to provide satisfactory care to patients by being active listeners as well as providers. CAT is a model for understanding interactions between two people. It states that communication is not just a matter of exchanging information about facts, ideas, and feelings (often referred to as referential communication), but that membership in important social categories is also often negotiated during interactions through a process of accommodation. An example of this would be a bilingual, say English-Dholuo, interpreter's decision to use Dholuo or English with the doctor or patient. The interpreter's language choice may depend on whether they want to emphasize a common identity (speaking their native language to show that they and the patient share a common language and culture) or a mismatched identity.

Convergent and divergent behaviours affect the doctor-patient relationship. Convergent speech indicates a desire to reach agreements, build bonds, form relationships, and communicate meaning effectively. Divergent speech, on the other hand, aims to separate the speech of the people involved in the interaction (Haidet, 2007).

Significant to this argument is the assumption that individuals' primary goal in initial communication is to increase predictability and reduce uncertainty about their own and others' behaviour.

2.6 Rationale for the Study based on Literature Review

For a long time, medical practice has placed emphasis on the doctor and not patient. The doctor had a final say and rarely would patients question his/her decisions. This scenario was also replicated in patient-physician interactions where physicians assumed active

roles while patients remained passive yet the focus should be on the patients who in most instances, had been relegated to the periphery. This situation is gradually changing since patients are increasingly becoming aware and have access to health information. Unlike before, more patients are willing to participate in making decisions on issues concerning their health.

Communication is an important component that determines the success or failure of the doctor-patient encounters. Literature review has indicated that effective communication leads to better health outcomes for the patient. Studies also emphasize the creation of partnerships between healthcare providers and patients. Such partnerships can enable patients with chronic conditions to be fully informed about and involved in their treatment, care and care decisions. Therefore, it was necessary to undertake a study in order to get an in-depth understanding of patients' perspectives on the role of communication with health providers in the management of chronic conditions.

Studies such as Makwero *et al.* (2018), Abdulah *et al.* (2019), Nordfon *et al.* (2019), Alshareef *et al.* (2020), Roter *et al.* (2020), Ocloo *et al.* (2021), Alanazi and Alharby (2022), Fernández-Ortega *et al.* (2023) and Zhang *et al.*, (2024) among others, have touched on aspects like the quality of communication, including emotional care, use of technical terms and information provision. However, there is a need for a more in-depth exploration into how communication barriers impact patient satisfaction and treatment adherence in the management of chronic diseases. Additionally, the existing literature emphasizes the importance of effective communication skills for healthcare providers. Nevertheless, further research is required to delve into the specific communication

obstacles faced by both patients and healthcare providers in the Kenyan context, particularly concerning chronic disease management from a cultural perspective.

2.7 Summary

The reviewed literature accentuates the importance of communication in healthcare. The studies reviewed show that for doctor-patient communication to be effective, it must be two-way meaning it should be interactive. Communication plays an important role in identifying health problems, diagnosis, exchanging health information and making healthcare decisions. The reviewed studies also underscore the fact that patients mainly prefer communication that is highly informative, sensitive to their personal needs and that which encourages collaboration with the doctor as opposed to one where patients are passive recipients of information and decisions regarding their health conditions.

Past research also underscored the need to ensure effective interpersonal communication between the health provider and patient since it is evident that effective communication influences the quality and outcomes of healthcare services. Additionally, Uncertainty Reduction Theory explains how individuals reduce the high level of cognitive uncertainty that exists in initial interactions. On the other hand, Communication Accommodation Theory places emphasis on the way an individual's communication is influenced by the situation, the participants' initial orientation and the social and historical contexts. In this study, CAT is used to explain the place of patient-centred communication in the management of chronic illnesses.

Initially, medical care placed more emphasis on the doctor. Doctors were expected to use their knowledge and experience to cure the patient. On their part, patients were

passive recipients of information and treatment. However, the reviewed studies showed that, over time, there has been a shift in doctor-patient interactions. Patients are increasingly aware and seeking involvement in decision-making concerning their health. Therefore, communication plays an important role in facilitating exchange of information between the doctor and patient. It is on this basis that the current study particularly explored doctor-patient communication in the management of chronic conditions.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter describes the research methodology of this study. It begins with a presentation of the research paradigm, followed by the research approach and methodology. It also describes the sampling techniques employed in the study. In addition, the techniques for data generation, processing and analysis are explained. The chapter further explains the trustworthiness of the research process and the ethical considerations made in the study.

3.2 Research Paradigm

A paradigm is a way of looking at and interpreting the world. It guides how the research is conducted, by whom and with what degrees of involvement (Rubin & Rubin, 2005). According to Creswell (2009), a research paradigm is a worldview and constitutes the basic set of beliefs that guide action. In his view, the factors that influence the worldviews include the student's area of study, the beliefs of advisers and the discipline of study, faculty of the student and his/her past experiences. Creswell further argues that worldviews are the general orientations about the world and nature of research that the researcher holds. Additionally, a good research inquiry makes philosophical assumptions about paradigms and the frameworks explicit in the writing of the study and that these two make the researcher aware of these influences when conducting an inquiry.

Creswell (2009) opines that there are two main philosophical assumptions that guide research namely: ontology and epistemology. Ontology is defined as the nature of reality or the assumptions people make about reality whereas epistemology is defined as how

knowledge is studied. In support of this, Mason (2002) holds that epistemology infers the rules and principles by which we decide whether and how social phenomena can be known and how knowledge can be demonstrated.

Ontological assumptions are viewed from the objective and subjective perspectives. Richards (2011) describes the two ontological paradigms as realism and relativism respectively. The realist perspective looks at the world as an objective entity with rules and regulations that govern behaviour, hence the existence of objective truth. The relativist perspective on the other hand, according to Cresswell (2009), individuals develop subjective meanings of their experiences. These meanings are socially and historically negotiated. The meanings are formed in the process of interaction with others and through cultural and historical norms that operate in their individual lives.

Epistemologies are concerned with knowledge and how people come to knowledge. Objectivism and constructionism are examples of epistemologies. Objectivists posit an objective world that is inherently meaningful. Within an objectivist framework, all things are independent of their ascriptions by human beings and their cultural systems. According to constructionism, meaning is not constituted or constructed in interaction with objective reality. Thus, there is a variety of meanings that might be attributed to any object or process; all of these meanings may be considered both reasonable and functional depending on the perspective from which they are viewed or known. The other assumption is that in the process of engaging their world, human beings do make sense of it based on their historical and social perspectives. Meaning is thus generated socially arising out of interaction with others.

Interpretivism, as an epistemological position, does prioritize the subjective interpretations of people and their understanding of social phenomena and their own actions. It can be linked to constructivism in which the nature of phenomenon is in the understanding and meanings ascribed to the social phenomenon by social actions. According to the interpretivist approach, the knowledge gathered includes the people's interpretations and understanding. This approach focuses mainly on the way people interpret their social world and social phenomena which enables the exploration of different perspectives.

The relativist philosophical paradigm guided this study. This paradigm was deemed appropriate since it gave the researcher the opportunity to gain deep insight into patients' perspectives on doctor-patient communication. It facilitated the exploration of how patients communicate with their doctors in relation to the management of chronic illnesses. Relativists take the subjective position that there is no single viewpoint of the world as such, reality is dependent on an individual's perceptions and experiences (Richards, 2003). Therefore, in this study, the relativist interpretivist paradigm enabled the researcher to understand the communication between the patient and healthcare provider in relation to the management of chronic conditions from the perspectives of both the patients and the healthcare providers.

3.3 Research Approach

According to Creswell (2012), there are three approaches employed in research namely: qualitative, quantitative and mixed methods. Creswell argues that the nature of the research problem, questions and the reviewed literature help to steer the research and determine the approach to be used. This study adopted the qualitative approach.

Qualitative research produces descriptions or explanations as such, this study used the qualitative approach because it aimed at drawing links in communication processes between the healthcare provider and chronically ill patients. This approach was deemed instrumental in capturing the subjective feelings of patients with chronic conditions and identifying recurring patterns of experience among individuals with chronic conditions. The information gathered consisted of the patients' views, feelings and opinions on their interactions with doctors on the management of chronic conditions. In essence, qualitative approach aims at "giving voice" to those whose accounts tend to be marginalized or discounted (Alcoff, 2009).

Qualitative researches are concerned with meaning. In other words, they are interested in how people make sense of the world and how they experience events. Their aim is to understand 'what it is like' to experience particular illnesses. This study was interested in the communication between healthcare providers and patients suffering from chronic illnesses. Qualitative researches are therefore concerned more with the quality and texture of experience rather than with the identification of cause-effect relationship. Qualitative researches are interested in meanings given to events by the research participants. They do not predict but seek to explain events, experiences and describe them (Willig, 2008).

Qualitative researchers study people in their own natural settings such as hospitals, homes or schools. Willig (2008) further argues that the use of preconceived variables is likely to lead to the imposition of the researcher's meanings and would exclude the identification of the respondents' way of making sense of the phenomenon being investigated. In qualitative research, data is collected so that the researcher learns from

the participants in the study (Creswell, 2012). The participants and researcher's interpretation of events contribute to this process. Qualitative researchers do not aim at predicting outcomes; they instead ask questions about the process, such as "How do people live with chronic pain?" This study adopted the case study method as discussed in the next sub-section.

3.4 Case Study Method

For this study, instrumental case study was used. The study examined communication between healthcare providers and patients at Jaramogi Oginga Odinga Teaching and Referral Hospital (JOOTRH), which was the health facility selected for the case study. Of interest to this study, were patients with chronic illnesses and how they communicated with their healthcare providers. This involved an in-depth analysis of patient-healthcare provider communication in the hospital.

A case-study was considered appropriate because it allowed me to get a deep understanding of the content of the study. The research mainly used interviews to collect data. It sought to gain deeper insight into the interaction between patients and healthcare providers with regards to the management of chronic conditions. As such, a case study was deemed appropriate since it facilitated the researcher to engage with the patients and report the complexities of chronic conditions and present the meanings that individual actors bring to those settings (Stake & Horace, 2005).

As a research strategy, a case study is based on in-depth empirical investigation of a small number of phenomena so as to explore the configuration of each case thus elucidating features of the larger group. A case study therefore, presents an opportunity to view the case from inside out and to analyse it from the various perspectives of those

involved. It is a form of qualitative analysis that involves a careful and complete observation of a social unit, be it a family, institution, a cultural group or even an entire community (Kothari, 2004).

According to Kadzin (2003), case studies are broad in their inclusion of several primary characteristics. This includes the fact that they must involve the study of an individual person, group or classroom. Kadzin further argues that data collected in case studies is detailed, qualitative and anecdotal, but is rarely systematically or qualitatively measured. A case study thus allows for an in-depth examination of events, phenomena or other observations within a real-life context for purposes of investigation. The current study's interest was to gain an in-depth understanding of the communication between patients and healthcare providers and to particularly get the patients perspectives on the role this plays in managing their conditions. Hence, the study took advantage of the fact that case studies allow for the examination of phenomena at deeper levels within real-life contexts.

Social reality is created through social interaction situated within particular contexts and histories; hence, case studies seek to identify and describe before trying to analyse and theorize. Since this study intended to understand the complexities involved in the communication between patients and healthcare providers with regard to managing chronic conditions, case study was appropriate. Case study method has several advantages. First, it enables the researcher to obtain a real and live recording of personal experiences. The researcher can thus understand the participants at a deeper level in terms of their feelings, tensions, strivings and the motivations behind their action (Kothari, 2009). Secondly, through a case study, a researcher can use one or more data

collection techniques such as in-depth interviews, questionnaires and document analysis. This study thus used two different data generation techniques: namely interviews and focus group discussion to enrich the data collected.

3.5 Sampling Techniques

Sampling is the procedure a researcher uses to select the people, places or things to study (Kombo & Tromp, 2006). It is the process by which one selects a sample that is representative of the population for purposes of determining parameters or finding characteristics of the whole population. A sample is a finite part of statistical population whose properties are studied to gain information about the whole group (Mujere,2016).

The study employed non-probability sampling techniques. It used both purposive and snowball sampling to get the participants. Purposive sampling was used to select health providers (doctors, nurses and clinical officers). Snowballing was used to select patients with chronic conditions. The researcher identified patients with chronic conditions and who were members of the various support groups. Patients with chronic illnesses referred the researcher to others willing to participate in the study and it is through this method that the respondents with the desired attributes were selected. The number of participants was determined based on saturation level. Non-probability sampling procedure does not guarantee each individual in a population a chance of being included in the sample (Kothari, 2009).

The study was carried out in Jaramogi Oginga Odinga Teaching and Referral Hospital (JOOTRH). It mainly targeted patients in the Out-Patient Department which had around five hundred clients. This health facility was selected because it is a referral

hospital that serves populations from Western, Nyanza and part of the Rift Valley regions hence, the hospital was deemed suitable for generating rich data.

A research population refers to the total number of cases that can be included as research subjects (Matthews & Ross, 2010). It consists of target and accessible population. A target population includes all members of a population to which the investigation is related. On the other hand, the accessible population refers to the elements in the target population that are within the reach of the researcher (Pole & Lampard, 2002). In this study, the target population was all the patients suffering from chronic illnesses who visited JOOTRH in Kisumu County, which was estimated to be 500 people. Also targeted were all healthcare providers at JOOTRH who attended to patients suffering from chronic conditions.

The process of identifying the healthcare providers to be included in the study began with the researcher being introduced to the senior nurse in charge of the Specialists Clinic. The Specialists clinic section is found within JOOTRH and it deals mainly with patients with chronic illnesses. The senior nurse then introduced the researcher to the medical personnel who worked at the Specialists Clinic in particular, those who regularly attended to the patients during the consultation clinics which were undertaken every Monday and Wednesday. Among the 20 staff, those who had dealt with chronically ill patients for more than two years were included in the study. Inclusion in the study was also based on their willingness to participate in the study. Based on this, 10 healthcare providers were sampled for the study.

3.6 Data Generation

To generate data for the study, interviews and focus group discussions were used.

3.6.1 Interviews

By virtue of its interactionist nature, interviewing is considered a naturalistic tool for data collection. It involves a face-to-face interaction in which the interviewer asks the interviewee questions designed to obtain answers that are pertinent to the research problem (Kerlinger, 1979). To obtain data through this method, a researcher makes use of an interview schedule. Cresswell (2009) defines an interview schedule as a protocol form that is used for recording and writing down information obtained during interview by qualitative research. The main objective of an interview is to investigate characteristics that cannot be observed directly. These may include thoughts and feelings. The researcher formulated an interview schedule that was designed to solicit the views of chronically ill patients and healthcare providers concerning the role of healthcare provider-patient communication in management of chronic conditions. Each interview session lasted for a period of 30 to 45 minutes. The researcher had a research assistant to help with interviewing patients who only understood Dholuo.

3.6.2 Focus Group Discussions

A focus group discussion (FGD) enables participants to provide comprehensive information on the research objectives. In an FGD, participants are facilitated to speak freely. Focus groups, which are considered naturalistic, give the researcher a chance to not only listen to what the respondents say but to also observe or notice their emotions, ironies, contradictions and tensions (Krueger & Casey, 2003).

Ferns (2001) avers that focus groups provide trustworthy naturalistic data that can also lead to important insights about human behaviour. In this study, a pre-determined list of open-ended questions was mainly used for the discussions with the patients. Focus group discussions were mainly held after the various clinics and support group meetings that were held in the hospital. Three focus group discussion sessions were held with groups each comprising five members. Every session lasted for approximately 30 minutes. The sessions were held in one of the offices or any other discreet locations within the hospital where respondents felt free and safe to hold discussions. Tape-recording and note-taking were used to capture the discussions.

3.7 Data Processing and Analysis

Kothari (2009) defines data processing as editing, coding, classification and tabulation of collected data so that they are amenable to analysis. This is an intermediary stage between data collection and data analysis. It is a process that prepares collected raw data and paves way for analysis of data. Yongsheng (1989) states that qualitative research mostly uses participant observation and in-depth interviews to enter into the world of subjects, systematically record what they see and hear and then analyse what they have recorded and supplement it with other materials. This makes it a flexible research method. According to Jwan and Ong'ondo (2011), data analysis in qualitative research is a systematic process of transcribing, collating, editing, coding and reporting the data in a manner that makes it sensible and accessible to the reader and researcher for the purposes of interpretation and discussion. They further suggest that qualitative data analysis should begin with transcribing the data.

This study used thematic analysis on the collected data. Thematic analysis usually moves beyond counting explicit words or phrases to identifying and describing both implicit and explicit ideas within the data that is, themes. From this analysis, codes were then developed to represent the identified themes and applied or linked to raw data as summary markers for further processing (Denzin & Lincoln, 2005).

3.7.1 Transcribing the Data

The researcher personally transcribed all the data from the interviews. Inscribe version 2.2 software was used to transcribe the data. The software enabled the researcher to adjust the speed at which the recordings were played and type the recordings word for word. Thereafter, the researcher listened to the recordings and compared them with the transcribed version to eliminate errors or address deletions. This process ensured that the data collected was not only accurate but was also true representations of what the respondents stated.

Although transcribing is a tedious and time-consuming process, it enabled the researcher to engage with and internalize the data thoroughly. Jwan and Ong'ondo (2011) emphasize that it is important for the researcher to ensure that transcription is accurately done before proceeding with further analysis of the data. The researcher was assisted by a trained research assistant to translate interviews that had been conducted in Dholuo language since two of the participants had preferred to be interviewed in their mother tongue and in Kiswahili. After transcription, the researcher read the data closely and repeatedly to be familiar with the perspectives of the interviewees. A folder was designated for keeping the transcribed data of each participant. In presenting data, the

researcher provided some of the verbatim quotations to enhance data originality and validity.

3.7.2 Refamiliarization with the Data (Pre-coding)

Coding involves highlighting the extracts of the transcribed data and labelling them in a way they can easily be grouped and retrieved (Dornyei, 2007). According to Creswell (2007), coding is the process of organizing material into segments of texts before interpreting it. To begin with, the transcribed data were read several times. This helped the researcher to internalize and gain a deeper understanding of the data. Each of the participants' transcripts were then summarized in readiness for analysis. At the pre-coding stage, general views were captured. At this stage, unnecessary or meaningless data, such as repetitions and false starts, were removed. Also noted were some of the emerging and useful issues from the data that were not directly related to the study objectives. For this study, categories were identified and grouped into themes. The collected data was coded manually and discussed.

3.7.3 First Phase Coding (Open Coding)

Open coding involves the creation of categories from the transcribed data (Mugenda & Mugenda, 2012). In this case, the transcribed data comprised interviews and focus group discussions. The researcher reread the transcripts word for word and assigned codes. The codes, which were in the form of a word or phrase, were guided by the objectives of the study. Phrases were grouped based on how they addressed the subject of patient-healthcare providers communication in relation to the management of chronic conditions. The researcher read through the transcripts and designated the chunks that

were relevant to the study. The data that could not fit into established codes or categories were labelled 'other' and stored for future use.

3.7.4 Second Phase Coding

According to Creswell (2007), in axial coding, the researcher groups together similar codes that have been generated during the first phase in order to avoid repetitions. The second phase coding mainly enabled the researcher to eradicate redundancies and overlaps. The categories that were relevant in relation to the research questions were identified as well as the codes. Thereafter, the researcher looked for codes that were similar and grouped them together. In addition, categories considered similar or related were put under a newly created broader category. Later, these codes were put together or merged and identified as categories and then used to develop themes. In some cases, certain codes became categories while in others categories were lowered into codes. It was ensured that the coded data retained the original meanings communicated by the respondents during data generation.

3.7.5 Third Phase Coding (Selective Coding)

Third phase coding is also referred to as selective coding. During this process, categories are grouped into themes. In Jwan's and Ong'ondo's (2011) view, it is essential for the researcher to re-read the data since they are under new themes and ensure that categories and codes have appropriate labels of chunks and data under them. They also advice researchers to 'bank' or put aside data that does not fit into the new themes, categories and codes. In this study, the themes were reviewed and sorted out. Some were

combined; others separated while some eliminated. The process of refining themes continued for presentation of the analysis. In the final step, the themes were labelled.

3.8 Trustworthiness

Trustworthiness involves ensuring the research process is truthful, careful and rigorous enough to qualify to make valid claims (Bassey, 1999). Lincoln and Guba (1985, as cited in Cresswell & Poth, 2016) define four criteria for determining the trustworthiness of a study. These are: credibility/internal validity, transferability/external validity, conformability/objectivity and dependability/ reliability. These are discussed in the sub-sections below.

3.8.1 Credibility

The main concern in achieving credibility is determining the extent to which the study can be trusted. According to Merriam (1995), credibility deals with the question of how congruent the findings are with reality. In this study, one of the concerns was to find out whether the study could be trusted or considered credible. Credibility was addressed in various ways. First, the researcher involved the two academic supervisors throughout the study. Their input was considered and integrated into the process of defining the methodology of the study. Second, different methods of data generation were used to enhance triangulation and corroboration of data from multiple angles.

Yin (2003, as cited by Jwan & Ong'ondo, 2010) avers that any finding or conclusion in a case study is likely to be much more convincing and accurate if it is based on several different sources of information. This view is supported by Cresswell (2009) who observes that the triangulation of different data or sources of information is one way of

ensuring validity. He further argues that a study is considered substantially credible if themes are established based on a convergence of several sources of data or perspectives from participants. Hence, in this study, various participants, namely patients with chronic illnesses, their caregivers and health providers were engaged. The researcher also informally observed the daily communication and interactions between chronically ill patients and healthcare providers. This enabled verification of the responses given during interviews.

Cresswell and Poth (2018) posit that prolonged engagement and persistent observation in the field is also encouraged as a strategy for enhancing credibility. They aver that prolonged engagement enables the researcher to make field-based decisions that are salient and relevant for the purpose of the study. Moreover, it helps the researcher to create rapport with participants and gatekeepers learn the culture and context and check for misinformation that stems from distortions introduced by themselves or informants. In this study, the researcher took time to get familiarized with the daily care routines for chronically ill patients at JOOTRH. Permission of hospital management was also obtained before embarking on the research. Also observed were the operations of the special clinics, which dealt with patients with chronic conditions. It was not possible to have very lengthy engagements with the participants. However, the interactions were adequate to enable the researcher access and generate data required for the study.

According to Lincoln and Guba (1985), member checking is also another important way to reinforce the credibility of a study. For this study, the accuracy of the data collected was confirmed during collection. The researcher confirmed the information from the

participants at the end of data generation. The study also involved pilot testing of the research instruments to determine and enhance credibility. Through the pilot testing, the weaknesses of the research instruments were noted and readjusted. A standard interview guide was used to collect data. The researcher ensured that the interviews were conversational and the respondents were given a chance to give their views freely. They were also probed based on the answers they gave and guided to remain relevant to the topics being discussed. This enhanced the respondents' freedom to contribute to the conversation as well as to the study. Non-coercion of participants was also observed in the study. Their participation in the study was based on their willingness.

3.8.2 Confirmability/Objectivity

Jwan and Ong'ondo (2011) define confirmability as how objective or neutral the researcher is and to what extent he/she influences the findings. The researcher explained in detail the logic followed in arriving at particular conclusions from the collected data, which in this case was systematic, coherent and explicit. An audit trail detailing the steps undertaken in the research and decisions made has been provided. Also provided, are the procedures from data collection to theme generation, analysis and interpretation and eventually recommendations given at the end of the study. To enhance objectivity, the researcher remained emotionally detached from the participants as much as possible to limit the influence of her positionality on the findings.

3.9 Ethical Considerations

In research, it is essential to observe ethical considerations. This view is emphasized by Hammersley and Atkinson (2007, as cited in Jwan & Ong'ondo, 2011) who argue that

researchers should tell the truth and there is need for all participants to be given accurate information about the research. In addition, the consent of the respondents should be sought before commencement of the study. They should be assured of confidentiality and anonymity moreover; the respondents should not be exposed to any sort of harm. The researcher may need to show appreciation to the participants in an appropriate manner.

This study was set in a hospital environment. As such, ethical considerations were of paramount importance. In the first place, the researcher obtained a letter of introduction from Moi University. The introductory letter outlined the purpose of the study and the type of access required by the researcher. It enabled the researcher to gain access to the gatekeepers and the various sections of the hospital. Permission was also sought from JOOTRH management to enable the researcher to collect data from the hospital. To obtain this permission, the researcher submitted the study proposal to the Ethics Review Committee of JOOTRH for review. Some adjustments were also made on the proposal and the consent form as recommended by the Ethics Review Committee. Upon satisfactorily fulfilling the requirements of the board, permission to collect data was granted.

The introductory letter from the management of JOOTRH was attached to the introductory letter earlier obtained from Moi University together with other required documents to facilitate application for a research permit from National Council of Science and Technology (NACOSTI). The research permit enabled the researcher to visit JOOTRH to collect data. At JOOTRH, the head nurse in-charge of the specialists' section was the main contact, who then introduced the researcher to the nurses, clinical

officers, doctors and other members in his section. The researcher was also introduced to the various sections of the hospital by one member of staff. For two weeks, the researcher undertook reconnaissance at the hospital, in which she learned the hospital's daily operations and interacted with members at the specialists' clinics section. During these interactions, the researcher informed the respondents of the study and its main purpose. They were generally co-operative and were willing to give the necessary assistance. The head nurse further introduced the researcher to the patients with chronic illnesses who then helped in identifying other participants for the study.

Informed consent was upheld in the study. According to Amiger (1997), informed consent means that a person knowingly, voluntarily and intelligently and in a manifest way, gives their personal consent. Informed consent entails giving all research participants accurate and detailed information about the research and getting their individual consent before engaging them in the research. The participants were informed about the objectives of research in the language they best understood and they were given a chance to make informed decisions to partake in the study. Before engaging them, the authority of the participants was sought; those who accepted to participate in the study individually signed informed consent forms. They were informed that their participation was voluntary and that they were free to withdraw from the study at any stage. Participants were also informed that they should feel free to respond to questions and give any opinions they deemed relevant to the study objectives. However, if they felt uncomfortable with some of the questions, they were free to decline to answer.

Anonymity and confidentiality for the participants were also upheld in this study. The findings were treated with anonymity and confidentiality by ensuring that responses

were not linked directly to specific participants. The information they gave was kept confidential and could only be accessed by those authorized. The identities of participants were protected by using pseudonyms and codes instead of their real names or other identifying information. The descriptions of data were done in such a way that prevented easy identification of the participants.

During interviews, the principle of non-maleficence was also observed. This entailed considering a patient's health condition before seeking for his/her informed consent for interview. Those participants in visibly poor health conditions were not interviewed. This is because in research, it is considered unethical to interview critically ill patients. Those interviewed were patients in stable health conditions who could also speak fluently. In seeking informed consent, the researcher clearly explained to the patients her positionality as a student seeking their opinions concerning chronic conditions. This was necessary as some thought the research was intended to evaluate the doctors and nurses' performance as they attended to chronically ill patients. Therefore, the researcher avoided getting involved in those issues between patients and the healthcare providers that were not relevant to the research objectives. The study also respected the hospital's norms and regulations to ensure harmonious relationship with the authorities. The study was planned to minimize, as much as possible, disruptions to the hospital's established routines. Upon completion of data collection, the recorder and written materials were stored safely to ensure limited access to only those authorized and thus maintain the privacy and confidentiality of all participants.

3.10 Summary

In this chapter, the research methodology of this study has been discussed. The chapter began by defining the study paradigm. This research was guided by the relativist interpretivist philosophical paradigm. Relativists believe that there is no single viewpoint of the world and that reality depends on the individual's experiences and perceptions. The interpretivism epistemology is subjective and assumes that knowledge is created and understood from the individual's perspective. This study sought to gain a deeper understanding of the patient's views on healthcare providers-patient communication in the management of chronic illnesses.

The study adopted a qualitative approach which seeks to describe and explain events and experiences but never to predict. In this study, the qualitative approach captured the experiences of patients with chronic conditions in relation to their interaction with doctors. The case study method was used because it allows for an in-depth examination of phenomena within real life contexts. Instrumental case study was used to gain deeper understanding of the patients' perceptions.

Purposive sampling was used to select the health providers (doctors, nurses and clinical officers) to take part in the study. Snowball sampling was used to select patients with chronic illnesses. The chapter has also described the data generation techniques, that is, interviews and focused group discussions. Interviews were used to get the views of healthcare providers as well as the patients. Focus group discussions were used to get information from the patients with chronic conditions.

Finally, to ensure credibility, the researcher involved the two academic supervisors. Ethical considerations of the study have also been captured in this chapter. Necessary permissions from JOTRH and NACOSTI were sought and obtained prior to data collection. Also discussed in this chapter is how informed consent, anonymity and confidentiality for the participants, among other ethical concerns, were observed during the study.

CHAPTER FOUR

PRESENTATION OF FINDINGS

4.1 Introduction

This chapter presents the findings of the study based on the four research questions namely: What are the healthcare providers' perceptions on communication with chronically ill patients? How do healthcare providers communicate with patients on management of chronic illnesses? How do caregivers influence communication between healthcare providers and patients on the management of chronic illnesses? How do patients and their caregivers perceive the communication approaches used by healthcare providers in the management of their illnesses? For ease of presentation of the findings, each research question was broken down into sub-themes.

The first objective of the study was to investigate healthcare providers' perceptions on the provision of messages to patients with chronic conditions and their caregivers. The data on this objective is discussed under the following areas: demographic characteristics of healthcare providers; healthcare providers' knowledge on provision of messages to patients and care givers on chronic illnesses; healthcare providers' perceptions of provision of messages to patients and caregivers.

4.2 Demographic Characteristics of Respondents

The researcher deemed it necessary to document the socio-demographic characteristics of the respondents. These characteristics would provide insight into the thoughts, feelings and experiences of the participants. The socio-demographic characteristics of healthcare providers which were interrogated in the study included age, gender, marital

status, level of education, religion, area of specialization and length of time worked at JOORTH at the specialists' clinic, which mainly focuses on chronic conditions. The socio-demographic characteristics of health providers who participated in the study were as presented in Table 4.1.

Table 4.1: Socio-Demographic Characteristics of the Healthcare Providers

Health provider No.	Age	Gender	Marital Status	Level of Education	Religion Denomination	Specialization	Length of Period Worked at JOORTH in the Chronic Illnesses Section
1	36	Male	Married	Higher Diploma	Christian	Clinical Officer	5
2	32	Female	Married	Diploma	Christian	Nursing Officer	3
3	39	Male	Single	Diploma	Christian	Clinical Officer	3
4	45	Female	Divorced	Diploma	Muslim	Nursing Officer	6
5	55	Male	Married	Diploma	Christian	Nursing Officer	11
6	44	Male	Married	Bachelors	Christian	Medical Officer	7
7	46	Male	Separated	Bachelors	Muslim	Medical Officer	6
8	27	Female	Single	Diploma	Christian	Nutritionist	2
9	32	Male	Single	Diploma	Christian	Counselling Psychologist	3
10	45	Female	Married	Diploma	Christian	Nutritionist	7

Source: Field Data (2019)

The study engaged 10 healthcare providers aged between 27 years and 55 years. Of these, four were female and six were male. The 10 healthcare providers had different areas of specialization as follows: 2 were clinical officers, 1 counselling psychologist, 2 medical officers, 3 nursing officers and 2 nutritionists. There was need to ensure healthcare providers who offered diverse services to patients at the specialists' clinic at JOOTRH were included in the study to enhance representativeness and richness of data collected. In terms of the duration worked at JOOTRH, 9 out of 10 had worked for a period 4 to 15 years. This length of time served as an indicator of their experience, which signalled that they had adequate knowledge of their work environment and the various aspects of patients-healthcare providers' communication that were pertinent to this study. Only one health care provider had worked for less than two years.

The study also sought to document the demographic characteristics of chronically ill patients and their caregivers. Table 4.2 presents the profiles of patients and their caregivers.

Table 4.2: Chronically ill Patients and their Caregivers Profile

Sample	Category of other Respondents	Age	Gender	Level of Education	County of Origin	Condition of Patient as Reported by Patient or Care Givers	Duration Attending the Chronically Ill patients Clinic at JOORTH(Years)
1	Care Giver 1	48	Male	Graduate	Vihiga	Diabetic & Hypertensive	6
2	Care Giver 2	37	Female	Primary	Homabay	Throat Cancer	3
3	Care Giver 3	39	Female	Primary	Kisii	Heart Condition/ Asthmatic	4
4	Care Giver 4	45	Female	Primary	Homabay	Heart Condition.	3
5	Care Giver 5	28	Female	Primary	Kisumu	Breast Cancer Patient	2
6	Patient 1	50	Male	Graduate	Kisii	Diabetic & HIV	Over 12
7	Patient 2	30	Male	Secondary	Kisumu	Arthritis	2
8	Patient3	60	Male	Primary	Siaya	Diabetic & Hypertensive	10
9	Patient 4	50	Male	Primary	Kisumu	Diabetic & Hypertensive	4
10	Patient 5	44	Female	Secondary	Kisumu	Breast cancer	3
11	Patient 6	64	Male	Graduate	Kisumu	Diabetic & Hypertensive	5
12	Patient 7	48	Female	Diploma	Vihiga	Breast Cancer	2
13	Patient 8	34	Female	Secondary	Kisumu	Diabetic	2
14	Patient 9	49	Male	Primary	Siaya	Diabetic	5
15	Patient 10	45	Male	Graduate	Kakamega	Diabetic/ Kidney Failure	2

Source: Field Data (2019)

As shown in Table 4.2, the study engaged 10 chronically ill patients and 5 caregivers. The 10 patients were interviewed. The five caregivers were aged between 28 and 48 years. Caregivers were interviewed when the patient did not understand English or Kiswahili but the caregiver could comfortably speak in English or Kiswahili. Of the five caregivers, one was male while 4 were female. All the patients had been treated at JOOTRH for a period of between 2 years to 12 years. In terms of the county of residence, 6 out of the 15 participants were from Kisumu County while the rest came from Vihiga, Kakamega, Homabay, Kisii and Siaya Counties. The patients suffered from various chronic illnesses as indicated in the table above. Some of them suffered from more than one chronic illness.

4.2.1 Healthcare Providers' Perception on Provision of Messages to Patients with Chronic Conditions

4.2.1.1 Knowledgeability of Health Providers on Provision of Information

This study sought to establish whether the healthcare providers were knowledgeable on provision of messages to patients and their caregivers. Information is important in the management of chronic conditions as it empowers the patients and their caregivers to make the right decisions for the good health of the patient. As such, healthcare providers need to be knowledgeable and offer this information in a suitable way to patients and their caregivers. The healthcare providers were thus asked to state whether patients with chronic conditions were entitled to information. Healthcare Provider 4 stated thus:

“As a nursing officer, for effective communication, I need to explain to my chronically ill patients the reason why I often do triage to them. If I am unable to explain myself, they might think I am bothering them every time they come for clinic... Based on my many years of practice, I have learnt the importance of

empowering the patient through giving them information. Information enables them effectively manage their conditions. It ensures that they live quality lives in spite of the medical conditions they have...”

Healthcare Provider 5 also had this to say:

“...most cancer patients have their expectations. I understand cancer is mysterious and patients want to know more about the condition. At times, they don't get the information...Some believe that if you have cancer you are going to die. We always tell them... that it depends with the time the cancer is diagnosed, the affected part ...in the early stages one can be treated.”

Most cancer patients have their expectations..... we tell them the investigations done... after that we then start talking about the journey of treatment... we help them understand what cancer is, inform them of the part of the body that is affected and how it is likely to be treated. We inform them of the side effects of treatment.

Healthcare Provider 8 further stated thus:

“For most of the chronic illness, management is done from the nutritional aspect. My role as a nutritionist is to provide adequate information on the nutritional aspects that chronically ill patients need to adhere to so as to prolong their lives.....I guide the patient on how they can feed so as to control the disease and relieve the symptoms...we counsel diabetics to eat foods with low sugars and low fats so as to control the hyperglycaemia and hypoglycaemia...”

From the sentiments of Health Providers 4, 5 and 8, it is evident that most patients lack adequate knowledge on the risk factors of chronic illnesses. Therefore, healthcare providers considered it important to inform patients about the maintenance of good health practices, such as nutrition, exercise and adherence to treatment, to remain healthy. According to Health Provider 2, they gave diabetics detailed information regarding their illness, maintenance of sugar levels through dieting, drugs and exercise. The healthcare providers also emphasized on the need to ensure patients understood the importance of regular monitoring of blood sugar levels with a glucometer and adjusting the diet based on their needs. They also encouraged regular self-monitoring and discussed foot care, eye and dental check-ups. The healthcare providers further

communicated with patients about treatment goals and ways of reducing risks of complications and improving the overall quality of life.

From the perspective of healthcare providers, most chronically ill patients lack the requisite knowledge on the causes, signs and symptoms of their illnesses. As such, they cannot put in place measures to prevent these conditions. Additionally, with this lack of information, they are equally unable to manage these conditions. For example, Healthcare Provider 5 argued that most patients considered cancer a mysterious disease.

4.2.1.2 Healthcare Providers' Perception on Provision of Information to Chronically Ill Patients

The Collins Dictionary (1995) defines perception as the ability to understand inner qualities or relationships; the knowledge gained from the process of coming to know or understanding something. In this study, the researcher sought the healthcare providers' views about provision of messages to patients with chronic illnesses. Healthcare providers were asked whether they disclosed information to patients, if and why they withheld any information from the patients. From the findings, some stated that patients with chronic illnesses needed to be provided with sufficient information to enable them manage their conditions. Others they were of the opinion that, even though patients had the right to be provided with information, healthcare providers should exercise caution when providing certain information. A few of the healthcare providers held the view that patients and caregivers should not be provided with information. These viewpoints are discussed in detail in the next section.

4..2.1.3 Knowledgeable Patients can manage their Conditions hence Live

Productive Lives

The research sought the healthcare providers' perspectives about provision of information to chronically ill patients. Healthcare providers were asked whether they disclosed information to patients. They unanimously agreed that information was key in the management of chronic conditions and that informed patients were empowered to make important life choices once diagnosed. In the words of Healthcare Provider 2:

Based on my experience as a health provider, providing information has enabled many of them (patients) especially those suffering from diabetics and hypertension to manage their conditions and live a fairly productive life.

Healthcare Provider 4 also stated thus:

In my opinion, both the caregiver and the client need to know about the client's condition. From the time when diagnosis is made, we usually talk to them about it so that they understand what it entails. We tell them about some of the investigations that have been done till now and when the condition is confirmed. After that, we then start talking about the journey of treatment. Like in oncology we deal with chemotherapy treatment which is a journey. So, we tell them that we shall walk with them through the journey, and they have to adhere to the appointment dates...With such sharing of information, my patients are able to manage their health conditions. ... so it eases the anxiety...

In the view of Healthcare Provider 6:

I subscribe to the navigator approach which means I have to provide the patient with detailed information regarding his/her health... communicating with the patient and informing them about all the available treatment options is crucial to enable them make truly informed decisions and contain the spread of diseases such as cancer in early stages... also helps in the management of conditions such as diabetes and hypertension.

Healthcare Provider 6 argued that he used the navigator approach which involves providing detailed information to the patient regarding his/her health. This involves informing the patients about the nature of ailment, the various tests that were performed, the available treatment options for the disease and the likely side effects so that they

make informed choices. This idea was reinforced by Healthcare Provider 4 who argued that both the caregiver and the patient needed to be given full information with regard to the illness that the patient was suffering from. For him, apart from diagnosis, cancer patients need to be informed about the treatment journey. They also need to understand and be informed about chemotherapy and radiotherapy, adhering to treatment and the recommended nutrition. The healthcare providers believed that information empowers patients in various ways. For instance, patients are made to understand the nature of their illnesses as well as how to treat and manage the health conditions.

In the view of these healthcare providers (healthcare providers 4 and 6), informed patients can live productive lives. To further support the assertion that patients need to be given adequate information regarding their illnesses to be able to lead product lives, another healthcare provider argued that cancer patients who have been given drugs and informed on the management of pain can live fairly independent lives. Moreover, diabetics who are also taught on sugar control through diets and drugs can successfully manage their conditions. Healthcare providers averred that patients needed to understand that complications could be detected and treated as early as possible. This in turn helps patients maintain healthy and quality lifestyles. From the discussions conducted above, the need for provision of sufficient information to chronically ill patients as well as their caregivers needs to be underscored for effective treatment and management of such conditions.

4.2.1.4 Information Enables Patients Plan their Lives

Information is an essential service in its own right and it enables patients understand their own health, adopt healthier lifestyles and choose treatment options that are suitable.

Healthcare Provider 4 says:

Treatment and management of chronic illnesses is quite costly. For instance, procedures like chemotherapy and radiation are quite expensive and require that we give the patient full information on both of them in relation to the cost as well as the side effects of the procedures. By giving them information early enough on the cost incurred when these procedures are carried out, patients and their care givers have adequate time to plan for the treatment.

Healthcare Provider 8 argues:

Most of patients who visit our clinic are not economically well endowed and it is fairly right for us to provide them with adequate information on the cost of their treatment and management of their illnesses. This will enable them make financial arrangements so as to deal with their illness.

The remark “patients who visit our clinic are not economically well endowed” uttered by healthcare Provider 8, indicates that by sharing information with patients and their caregivers on the cost implications of the procedures undertaken in the treatment of cancer, healthcare providers give them a road map that will help them make financial plans for the all required procedures and medication. Information thus enables patients and caregivers to plan adequately for the care and management of patients since medicines, treatment plans, diets and medical tests are expensive.

4.2.1.5 Knowledgeable Patients Pose a Risk to Healthcare Providers

In the earlier sections, it is indicated that information is crucial for the planning of the management of chronic illness. On the contrary, some health providers suggested the need to be cautious when providing information to patients. They gave various reasons for suggesting caution in providing information as shown below:

Healthcare Provider 7 lamented:

Nowadays it is not easy when treating patients. Most of the patients and their care givers who come to us are well informed of the chronic illnesses that their

kin are suffering from. In case we give much information to the patients and it ends up to be a case of misdiagnosis then we are in trouble. Around two years ago, one of my colleagues was sued by a patient due to misdiagnosis and from that day I avoid giving too much information to the patient or their care givers. I only give as little as possible and also gauge the patient's enthusiasm to know more about his or her condition. Once I am certain they don't have an ill motive, I can disclose much information but in a friendly manner and in a shared discussion approach.

Healthcare Provider 9 stated:

Internet has made life difficult for doctors. Everyone is a 'doctor' nowadays. As a doctor struggles to explain to a patient or a caregiver the situation at hand, one finds a myriad of questions being bombarded to him or her as the healthcare provider. Most patients and care givers mostly visit websites such as Mayo clinic for more information and even challenge us on the treatment plan, we are suggesting to them. Due to internet, I would rather be safe by providing as little information as possible especially when dealing with well-informed patients or caregivers.

Healthcare Provider 6 explained thus:

As a medical doctor for the last 7 years in this facility, I inform a patient on his or her diagnosis and even map out a treatment plan. Then, after the first meeting the patient vanishes and attends another clinic to verify the information, I gave whether it's true or not. If they realize it is true, some come back to our clinic.

Healthcare providers also withheld information based on what they thought the patients knew from their own experiences or from discussions with fellow patients.

Healthcare Provider 7 had this to say:

... "Around two years ago one of my colleagues was sued by a patient due to misdiagnosis and from that day I avoid giving too much information to the patient or his/her care giver."

Healthcare has made life difficult for doctors. Everyone is a 'doctor' nowadays."

Healthcare Provider 7 further added:

Provider 9 also commented as follows:

"Internet

Personally, I don't accord my patients and their care givers so much trust. Modern world has changed and most of patients and their families are exposed and can easily embarrass you when it comes to providing them with information.

One of the reasons for being cautious with information according to one healthcare provider was that patients and caregivers are quite educated. Some of them have a wealth of medical experience that makes it easy for them to dispute the provided information. Some patients visit other hospitals for further consultation so as to compare notes and confirm or refute previous diagnosis. In some cases, if they get the same results from the hospital, they had gone to for second opinion they would go back to JOOTRH and receive treatment. It was further revealed that, in other cases, if the results are different, they use the new information to sue the first hospital for misdiagnosis. Other patients use information obtained from the internet to dispute what is provided by healthcare officers. In some instances, it was reported that patients have sued doctors for negligence once they know the doctor's fault contributed to the error, misdiagnosis or to their deteriorating health condition. As such, healthcare providers said they were often cautious in releasing information to patients since they believe that contemporary patients are well-informed and are often prone to raise critical questions about the type of care received.

4.2.1.6 Provision of Information can negatively affect Patients Health

Ideally, provision of information is intended to adequately prepare patients for their treatment, to enhance adherence to therapy and promote recovery. Information is also expected to enable patients adequately cope with their conditions. In this study, all the healthcare providers affirmed that patients have rights to be fully informed of their health and treatment. However, some of the health providers warned that certain

information should be withheld from patients. In their view, patients should not be provided with information that is likely to interfere with their rights.

Affirming the above, Healthcare Provider 1 said:

As a health provider I just don't give much information to patients or their caregivers. I give information based on the stage of chronic illness. If I notice the chronic illness is at initial stages, I provide as much information as possible making it a learning process for the patient and care giver. I don't stop at explaining the sickness in general but I also give the patients and their care givers all the available options for them to make sound decisions on the best treatment plan for their patients. ...For a chronically ill patient that I encounter for the first time or at later stages of his or her illness, I am not able to provide much information hence most of the times I limit what I say to the patient or caregiver since I might provide information which might land me into legal battles.

Healthcare Provider 3 also had this to say:

If one has cervical cancer stage four for instance, this is somebody with advanced cancer disease you cannot...the only.... this is someone undergoing palliative care and death is the end result of this condition so you need to encourage this person and the information you give especially to such clients will either take him/her down or add him/her some days. So, for such clients, we encourage them and tell them there is still life ... This happens not just with cancer but even with HIV. We have counsellors around but even we doctors counsel them. I personally say that giving up is not a solution. This is somebody who needs to be talked to.

Healthcare Provider 5 similarly stated as follows:

In my experience of many years, I prefer not to disclose much information to patients if I see that the information might actually hinder his or her treatment progress.... It is equally difficult informing them that they came to hospital when it is late and nothing much can be done.

The study findings thus indicated that health providers were willing to give information to patients or their caregivers based on their own assessments of the patient's health condition or stage of health status. Health Providers 1, 3 and 5 insisted on following therapeutic privilege, which entails withholding information from a patient when there is

justified belief that disclosure may cause serious mental or physical harm to them. The moral basis of invoking the therapeutic privilege was for doctors to do what is beneficial for the patients and to avoid inflicting harm on them. If disclosure of certain information is deemed harmful to patients, the doctor may be justified in withholding such information. This enables doctors to uphold rather than violate the ethical principles of beneficence and non-maleficence. Beneficence entails promotion of others' well-being while non-maleficence entails avoiding harming or injuring others.

4.2.1.7 Patients do not have a Right to Decide

The study observed that some of the healthcare providers totally believed that chronically ill patients or their caregivers did not need to be provided with information.

These health providers argued that patients are not experts at treating their illnesses.

This view point is supported by Healthcare Provider 2 who gave the following account:

They come to us because they want us to help them. I believe that I should decide for the patient.” In this case, the healthcare provider takes on his/her role as the expert who should make decisions based on his/her expertise or consult with fellow medics.

Similarly, Health Provider 3 argued thus:

After many years in school, I have specialized in chronic conditions and therefore patients are to be given treatment. At times, giving patients and their caregivers information does not yield much since they do not even understand.

Echoing the above sentiments, Healthcare Provider 6 added:

Being a medic, any information concerning patients with chronic conditions can only be discussed by me together with other medical specialists who can bring in their expertise on the medical issue at hand and offer a solution. Consequently, I don't need to discuss medical issues afflicting my chronically ill patients with them or their care givers.

The above data justifies why healthcare providers are at times reluctant to provide information to patients or caregivers. Healthcare providers 2, 3 and 6 believed that by virtue of being healthcare providers with expertise in chronic illnesses, their main role was to treat the patient not to give information to the patients and his/her caregiver. Therefore, to them healthcare provider-patient communication is one-way.

The findings in this section have shown that there is at times mistrust pitting patients and caregivers on one hand and the healthcare providers on the other. This mistrust is often compounded by the fact that healthcare providers think that patients and their caregivers are well-informed and could embarrass them. To avoid such scenarios, the healthcare providers approach their clients with caution thus opting not to disclose any information to them or their caregivers. Overall, the data presented in this section has revealed the following:

Some healthcare providers emphasize that patients need to be empowered and provided with all the available information regarding their condition, including details about the condition, available treatment options and financial costs.

Information enables patients to live productive lives.

Information enables patients to plan their lives.

Healthcare providers need to be cautious about the kind of information they provide to patients since it could affect the treatment process.

4.3 Healthcare Providers Communication on Management of Chronic Conditions to Patients and Caregivers

The second objective of the study set out to examine how healthcare providers communicated with patients on management of chronic illnesses. This question sought

to generate information on the communication strategies that healthcare providers used in providing information to patients. It also sought to identify the linguistic and non-linguistic barriers to communication and to determine the strategies used by both the healthcare providers and patients or caregivers to overcome communication barriers. This section also presents the challenges that the healthcare providers face during their communication with patients and caregivers. Patient-related barriers and health system/organizational barriers are also discussed in detail. The section begins with the communication challenges that healthcare providers face and ends with the strategies they employ to overcome these challenges.

4.4 Challenges faced in Communication

Challenges are inevitable in the field of patient communication. This study identified challenges encountered in healthcare providers-patient communication. The section presents data on patient-related barriers, barriers related to the health facilities and the general factors that hinder effective communication between healthcare providers and patients with chronic illnesses.

4.4.1 Patient-Related Barriers

4.4.1.1 Language Barrier

JOOTRH, being a referral hospital, treats patients from various socio-economic backgrounds. Some of the patients are well educated while a majority are either illiterate or semi-illiterate. Patients and caregivers cited language as a barrier in their attempt to seek treatment. Some of the participants came from the neighbouring counties where they neither spoke nor understood Dholuo, which is the dominant language in Kisumu County, the location of JOOTRH. In some cases, healthcare providers used interpreters

to facilitate communication with patients. Some of the responses cited below capture the different dimensions to the challenge of language barrier.

Patient 2 argued thus:

“We are quite a number of patients who do not understand English or Kiswahili. Most of them just like me, speak and understand Dholuo. It therefore becomes hard communicating with the doctor.”

In support of the same view, Patient 3 had this to say:

“In some cases, I understand the little that the doctor translates to Dholuo. There are times that I don’t understand much.... How I wish they talked to us in a language that we understand.”

Health Provider 3 expressed his frustration with these sentiments:

Illiteracy is also another thing. You are...like you find the patient does not know anything at all. Therefore, as you offer services you are supposed to offer, you find that you are teaching the patient like in class.... For some, you are talking to them in a language they speak but still they do not understand.

In support of the above remarks, Healthcare Provider 5 stated that:

Quite a number of patients who visit come from the village. Some have very low literacy levels. You struggle to explain something but this person does not get it. I have to repeat and repeat. I find this quite frustrating.

In the words of patient 8:

Most of them assume that we understand English. I always let them know that I understand Kiswahili. In some cases, there are things that they say and I find it hard to understand. So, at that point, I always ask the doctor if he can say it in Dholuo since I am more fluent in Dholuo. At that point if there is someone who understands he/she can help out... I have difficulties at times.... You know at times you may have a question but then you get confused and the question disappears... it is quite difficult and in most cases the doctor calls someone else to attend to me.

Patient 3 also had this to say:

“I understand the little that the doctor translates to Dholuo. There are times that I don’t understand much....”

Some of the patients faced language barriers in their communication with health providers. It was evident that most healthcare providers preferred English as the main language of communication. This preference could be attributed to the fact that it is the language of instruction in medical colleges in Kenya. Although, English and Kiswahili are national languages most healthcare professionals are more proficient in English. Healthcare providers found it easier to communicate medical information in English as compared to Kiswahili or vernacular languages yet this did not augur well with most of the patients.

4.4.1.2 Barriers Related to Health Facility

For patients and their caregivers to feel satisfied with the services provided, the health facility they visit must function effectively. In this study, it was observed that there were communication barriers related to the facilities. These barriers included heavy workload, unsuitable environment, time constraints, lack of required facilities or specialized equipment for certain tests and procedures and lack of continuity of care. These barriers are discussed in the subsequent sections.

4.4.2 Heavy Workload

Workload refers to amount of relevant work to be done by a person within an organization. According to World Health Organization, the universally accepted doctor to patient ratio is 1:1000. The reality in Kenya however, is 1:16000 for doctor-patient ratio. The study found that health providers faced the challenge of high workload. It indicated that there was a low number of health providers against the high number of chronically ill patients received at JOOTRH.

As Healthcare Provider 3 revealed:

“...this is a referral hospital very many patients come here in large numbers. Sometimes patients are queuing at your service area and you can only see one at a time unless it is a couple...”

In support of this argument, Healthcare Provider 6 stated as follows:

As a doctor, my work schedule is very tight since everything has to be done on time. I have to do ward rounds to see those admitted, I have to be around to attend to patients on the queue who need consultation, seek treatment and referrals. In addition, I attend to emergencies that come up often. I am forced to be very brief when giving information to patients.

Healthcare Provider 9 also added this:

To ensure we serve our patients well and give them adequate information to manage their illnesses, we don't mix duties nowadays. If it is the day of clinic, you won't find me rushing to emergency or wards every time. I only go to such places if it is serious. We try as much as possible to reschedule activities at our clinic not to coincide with other duties expected of us.

From the sentiments of healthcare providers 3 and 9, the medical practitioners are faced with large numbers of patients to attend to in addition to performing other duties. In relation to the issue of numbers, patient 2 had this to say:

I have been a frequent visitor to this clinic and most of these healthcare providers always lament they should be seeing 30 patients in a day but they usually see around 60 patients per day. They cannot see them all..... so they will only treat a few and the rest are treated the following day. There are days we have been on the queue for two or more days and when they see you within a few minutes, they dismiss you without providing the much-needed information.

The sentiments of patient 2 above clearly shows that communication delivery between healthcare providers and their patients as well as caregivers was hampered by high workload experienced by healthcare providers in the facility. In addition, one of the respondents in a focus group discussion stated the following:

With advent of mobile phones, everything is easier. Some of the healthcare providers have shared their numbers and patients can seek clarification on any

information they need from them even after office hours. Some of the healthcare providers are very cooperative and enthusiastic when clarifications are sought. For some, we book to see them in their private clinics.

The healthcare providers noted that in order to deal with the large numbers of patients and the workload problem, they were at times forced to shorten the consultation time allocated to each patient.

4.4.3 Time Constraints

The health management of people with chronic illness is a time-consuming exercise for the healthcare providers, patients and their caregivers. As has been indicated in the previous section, there is a shortage of healthcare providers at JOOTRH. It was thus observed that time constraints played a big role in curtailing the provision of health-related information to patients with chronic conditions and their caregivers. Healthcare Provider 6 affirmed thus:

... According to clinic schedules, we are expected to conduct the main clinic thrice a week and it should end latest 3pm. However, that isn't possible due to the number of patients attending our clinic. We are forced to either see patients in the least time possible or request those unattended to, to come to the clinic on the next day which is in itself inhumane....

Patient 6 lamenting on the situation, added as follows:

Most of the doctors here are very busy people. They don't have much time for us so, they hurriedly give us information on our sicknesses. If you complain to them to demanding elaborations on what they have said, they say you are not considerate of others queuing outside and the line is long.

Healthcare Provider 4 also stated thus:

To save time and deal with the large numbers of patients at our clinic, we start our clinics at 7am rather than the official time of 8am set up by the hospital administration. Previously, we used to start our clinics at the prescribed time but we were not able to finish our tasks early and the quality of information we shared with our patients was poor as opposed to now. We give a general talk on management of their health conditions, something that was not possible previously.

The above sentiments show that at JOOTRH, healthcare providers dealing with chronically ill patients work under immense pressure. It was noted that most of the patients who visit the hospital do not make appointments in advance; they simply arrive, queue and wait for their turn to be seen by the healthcare providers. This led to inefficiencies in management of time on the part of healthcare providers. It was indeed observed that the queues were often very long so some patients took several hours before meeting the healthcare provider.

4.4.4 Lack of Requisite Facilities

In the past three decades, technical advancement has transformed the health industry. With dynamic and emerging technologies across the globe, healthcare providers have embraced electronic recordkeeping (Okolo *et al.*, 2024). With the help of computers, healthcare providers are able to store patients' information before communicating tests results. This increases accessibility to patients' data and improves efficiency in communication. In this study, some of the healthcare providers said that the lack of machines essential for carrying out certain tests and procedures in the health facility hindered effective and timely treatment. Healthcare Provider 5 highlighted this point as follows:

We do not have enough facilities and machines for carrying out diagnosis for cancer and kidney diseases. Sometimes, we admit patients for two to three days as we wait for their results taken to hospitals, we have partnered with that have better machines and facilities. Waiting for results from other hospitals led to communication breakdown with the patients and their caregivers. In other cases, we refer them to Eldoret or Nairobi since we do not have a machine for radiotherapy.

FG1 had this to say:

I have challenges whenever I am expected to undergo the echo-test. It is expensive and most of the times we are told that the machine is not functioning

or it is unavailable here at Russia Hospital. I have to get the test done in town or in other hospitals.

According to FG2:

Most of the tests are usually done in town. They only do basic tests here. For tests like MRI and x-rays we have to go to town. This greatly affects patients especially when there is an emergency and the patient is in bad shape.

One of the respondents in focus group discussions corroborated that lack of better facilities and machines causes tension to physicians, especially where a patient is in critical condition and urgent treatment is needed. The healthcare providers noted that the installation of modern equipment for various tests in health facilities would enhance the patients' satisfaction with health services and reduce complaints from the patients.

As indicated in this section, the findings showed that some of the challenges faced in the healthcare provider-patient communication include language barriers. In addition, healthcare providers had heavy workloads as they had to attend to a high number of patients as well as perform other duties. Time was equally a limiting factor. In addition, the hospital lacked equipment for some critical tests and procedures, which caused delays in the treatment processes. To overcome these challenges, the healthcare providers made attempts to communicate with their patients using interpreters and they ensured they attended to as many patients as possible by reducing the time spent on every patient. In the next section, the various strategies used by healthcare providers in communicating with chronically ill patients are discussed.

4.5 Communication Strategies used by healthcare providers

4.5.1 Clarification Strategy

These are strategies that are used by health providers to ensure that the patients clearly understand what is being communicated to them. From the study findings, the following strategies were employed by healthcare providers: explanation, use of questions, demonstration, use of simplified language and provision of reading materials.

4.5.2 Explanation

In the healthcare provider-patient communication, healthcare providers said they used the explanation approach to pass a variety of information to patients in relation to the management of chronic conditions. Below are samples of the responses regarding the dissemination of information through explanation:

Creating awareness is essential in this field. If the patient is exposed to risk, we have to iron out all the details to the patient or the next of kin before proceeding with a clinical decision. It is worth noting that some scenarios call for a benefit risk assessment whereby the interdisciplinary health team assess whether a patient should undergo a specific therapy or not.... (Healthcare Provider 1).

Health provider 9 says:

For my diabetic patients, I always emphasize to them the importance of adhering to diet and avoiding fluctuation of sugars. I also explain to them the importance of taking their drugs at the required time and in the right doses. Management of the sugars is essential to avoid further complications like nerve or kidney damage. In my practice, I have met patients who have developed complications due to negligence and carelessness. With the right information, this could be avoided..... We encourage them to eat right, stay physically active and make good food choices. (Healthcare Provider 9).

According to healthcare providers, patients with chronic conditions need to be continuously provided with information and guidance for them to better handle the various conditions and the challenges that come with them.

4.5.3 Use of Questions

A question asks for information either for clarification, understanding, evaluation or for confirmation. Questions normally arise because some information is lacking or because the stimulus conflicts with existing information and the person is trying to re-establish equilibrium (Cardiello, 2003). Questions are intended to engage the information seeker intellectually and emotionally cause them to think (Loertscher & Woolls, 2003). In this study, it was revealed that healthcare providers used questions for purposes of verification and to address concerns raised by the patients and caregivers. The healthcare providers used questions especially during consultations. This was indicated in the excerpts below:

...there are those who do not care; it is upon you to decide whether it is a case of management or mismanagement. After you have done your part, they walk away but there are those clients who after each and everything you do they want to know..... Some even ask about the classes of medicine that you prescribe, the mode of action, how they work in the body the side effect so patients vary (Healthcare Provider 1).

Healthcare provider 3 said:

...I feel so. Because when I ask the patient, for instance, a patient came last month and I asked, "When you came last month what was the problem?" Some will tell you...I do not know. I was sent to the lab, I came back and the doctor prescribed drugs, I took the drugs but I am not feeling well. I do not know what was being treated. So, at the point you will know that the patient was sent to the lab and they came back with the result without knowing what is happening. The results have been interpreted; the drugs have been prescribed ...but it is only the doctor who understands. (Healthcare Provider 3).

In support healthcare provider 9 said:

Based on the question, you then guide the patient as required. You have to tell the patients that you will experience this and this because of that drug. I ensure that the patient knows this. It is easy to tell when the client is not satisfied and this is mainly done by digging deeper and based on the responses you can tell if a client is satisfied or not. Through this, I can tell (Healthcare Provider 9).

The healthcare providers said they used questions to create an environment that is friendly, private and assure patients of confidentiality. Questions were also used to request for action or to call for an agreement.

So, after talking to the patient, I will ensure that I tell the patient everything that he/she needs to know.....I will ask the patient, is there anything that you would still like to inquire? ... So, you have to tell the patient that you will experience this and this and it is because of that drug. I ensure that the patient knows... (Health Provider 9).

According to Healthcare Provider 3, questions were used to check patients' understanding of health information. Patients also used questions to seek further information on matters concerning their health. The providers also used questions to inquire and document the medical history of the patients and based on the answers given, they diagnosed and eventually administered suitable treatment.

4.5.4 Demonstration

Healthcare providers also used demonstrations when communicating with patients. Demonstration mainly involves exhibiting or showing. Concerning this approach, healthcare providers gave the following statements:

We use a plate to show them the portions of food they should take. We tell them to increase vegetables to six portions so that half the plate should be vegetables, a quarter carbohydrate and a quarter protein ... We also have food models we use to show them the right portions. We encourage them to eat nitrogen rich diet comprising of foods such as celery, beetroot, carrots and onions. (Healthcare Provider 1).

We demonstrate to patients how to take care of themselves. We show diabetics how to take care of their wounds. We demonstrate to them how to wash their wounds, care for their feet We show them where to inject... (Healthcare Provider 4).

This is equally done for patients undergoing chemotherapy and radiotherapy we show them how to handle the vomitus, the pain relievers (analgesics), how to give medication and how to handle them. Some prefer homecare to reduce on medical bills. (Healthcare Provider 5).

Demonstration approach was mainly used by healthcare providers to show the patients how to manage their conditions.

4.5.5 Teach-back Strategy

This approach involves the patient repeating information using their own words to the healthcare provider about a diagnosis or a treatment plan so that the healthcare provider can verify the patient fully understood the medical information. Any misunderstanding is clarified by the healthcare provider. In relation to this strategy, healthcare providers gave the following accounts:

At times, I make the patient tell me in their own words what they have understood from the consultation. Where necessary, I correct or repeat the information until I am sure he/she has understood. (Healthcare Provider 2).

When I provide medication, I insist on them repeating the dosage to avoid over or under dosage. (Healthcare Provider 5).

4.5.6 Use of Simplified Language

Simplification is a strategy in which a speaker or writer modifies language to facilitate second language learners' comprehension. These simplifications include phonological (on oral input), morphological, syntactic, lexical, and discourse modifications (Leow, 1993). Simplification is intended to make the text more comprehensible and more suited to the needs, knowledge and proficiency level of the reader or listener without rendering it childish or simplistic. This can be achieved by a variety of means such as use of a familiar vocabulary or everyday words. Healthcare provider 1 had this to say:

I would say that I try to use the simplest language; a layman's language. I try to avoid using jargon so that they do not feel that I am superior to them. I try to talk to them in the simplest way and in a language that they understand. For example, if someone has cancer and you have the diagnosis, for the psychological well-being of the patient, you need to take them through psychological counselling. This is because just telling one that he/she has cancer may lead to depression. (Healthcare Provider 1).

...we first talk about cancer so that they understand it as well as its stages. We also try to simplify the language that we use... for example instead of talking about taking a sample for histology ... we tell them that we will take 'some meat' from the part that is affected to the laboratory for testing.....We avoid the use of technical terms though for some words it is hard to translate or get an equivalent in Kiswahili and mother tongue. We just tell them that the meat that was taken to the laboratory indicates the following... and then we break it down for them. (Healthcare Provider 4).

When I explain that cancer occurs as a result of spontaneous mutation of cells in the body I translate this in Kiswahili as follows: zile celli za mwili zinabadilika na mutation tunasema zinazaana tu. Radiation- miale ya radiation au ule moto unaenda kuchoma zile celli (Healthcare Provider 4).

Healthcare providers indicated that in an effort to enhance communication with their patients they used simplified language. Healthcare Provider 2 said they used vernacular if it was the only language that the patient could understand. Healthcare Provider 8 similarly averred that he spoke slowly to enhance patient's or their caregivers' understanding of information.

One of the healthcare providers however, pointed out that there were challenges experienced when the simplification strategy was employed. He mentioned that simplification led to the omission or exclusion of some ideas or information in the communication process. He said that some medical terms lacked an equivalent in the layman's language or vernacular. In addition, medical language was considered complex even to the educated patients; as such, it was difficult to select what to omit to realize

simplification.

4.5.7 Provision of Reading Materials

Healthcare providers also indicated that they provided reading materials to patients to enable them get more insights on chronic conditions. The excerpts below reveal some insights on how health providers adopted this communication strategy.

There are patients who find it hard to understand Body Mass Index (BMI) hence we use a chart to illustrate to them about normal weight, overweight and underweight. The chart clearly shows them their normal BMI weight and what is considered obese. We give them brochures on what constitutes a balanced diet. We try to give them material suitable for their condition. (Healthcare Provider 9).

We provide reading materials but then I am not sure if they are helpful since there is such a poor reading culture. (Healthcare Provider 6).

4.6 Effect of the Caregiver Role on healthcare Providers-Patient Communication

The third research question looked at the extent to which the healthcare provider and patient communication was impacted by the role of the caregiver. The study findings revealed that caregivers mainly acted as interpreters in the healthcare provider-patient communication process. Interpretation refers to the process by which a spoken or signed message in one language is relayed, with the same meaning, into another language. Health or medical interpretation refers to interpretation that is done for issues that are health related or for those within the health system. Often language barriers occurred during the healthcare provider-patient encounter which necessitated the involvement of an interpreter. Doctors revealed that whenever they found a patient who struggled to communicate, they would ask the accompanying relative or caregiver to provide the translation services. If the patient was unaccompanied, the healthcare providers would seek a trusted interpreter for the patient.

As observed in this study, most healthcare providers at JOOTRH were not native speakers of Dholuo. A good number spoke and understood basic Kiswahili and therefore found it hard to communicate with patients. Similarly, although most of the patients were drawn from the neighbouring Dholuo-dominant communities, a good number of cases referred to JOOTRH were from regions with different native languages. Asked to explain their experiences as a result of language problems and the role of caregivers as interpreters, the healthcare providers made the remarks as cited below:

I have noticed that when an interpreter is present, rarely is the conversation the same as a one-on-one encounter. At times, the patient gives a detailed answer but the interpreter only passes the information in a sentence or two or using a few words and phrases ...in other cases, I would ask the interpreter a question so that they translate it to the patient. Some give me an answer without talking to the patient. If I insist on them seeking the answers from the patient, they say they have the best interest of the patient at heart. (Healthcare Provider 4).

I struggle to communicate with patients who are not fluent in either English or Swahili. The language barrier is a challenge I have to face every day since I do not speak the local language. I see a lot of patients in this rural setup who come to the doctors' offices and are unable to explain their conditions. ... (Healthcare Provider 5).

I once came across an elderly diabetic man who had been accompanied by the daughter when they came to seek treatment. I suspected the man could be having kidney failure and to ascertain I had to ask questions. The daughter acted as the interpreter since the father only spoke Dholuo and a few basic words in Kiswahili. Given the nature of the conversation, the daughter tried and then in the course of discussion she declined and asked if I could get a male interpreter who spoke Dholuo well. She later confessed to me that she found it rather hard and disrespectful to ask her father some of the personal questions I asked and did not feel free to interpret. (Healthcare Provider 6).

Healthcare Providers 4, 5 and 6 confirmed that they encountered patients with difficulties in communication due to language barrier. In such cases, the healthcare providers asked the guardians or caregivers to act as interpreters to facilitate communication. Although some of the patients and caregivers could speak English or Kiswahili, they had varying levels of proficiency in these languages. Some of the

participants confessed to being fluent yet not proficient in a language. This was supported by one patient who said that he understood simple Swahili but had difficulties when deeper or complex Swahili vocabulary were used.

The caregivers also gave various views concerning mediated communication when they acted as interpreters. Patient 1 made the following comment:

I am usually accompanied by my son who helps in the translation when I communicate with the doctor..... I prefer it when I get a doctor or nurse who can speak my mother-tongue. When I talk to a doctor who understands my mother tongue, I find it easier to express myself and understand the instructions he/she provides. I feel free to ask questions and seek clarifications. I find it easier to discuss with them and follow instructions. When my son interprets, I think he does not translate the whole conversation. There are things he hides from me. I think he fears that I will not respond well to the information. (Patient 1).

To corroborate the difficulties in health communication as a result of language barrier, Caregiver 3 gave the following account:

...for example, there a number of people who do not understand English or Kiswahili and they only know Dholuo language. ... these people experience difficulties in communicating with the doctor; they are unable to explain the patient's condition. Because of such language barriers, the doctor just resorts to writing. In some cases, I understand the little that the doctor translates to Dholuo. There are sometimes I don't understand much...they can sometimes talk to you in Kiswahili but you still don't understand much. (Caregiver 3).

Caregiver 5 said:

Like a year ago I was busy and requested my niece to accompany my mother to hospital. During that visit, the doctor adjusted mum's medication regimen. The medication was changed and so was the dosage. She was told not to use her other medicine for a month so that the doctor can monitor the progress. My niece who was the caregiver and acted as the interpreter at this time misunderstood the new instructions. Mum continued to take the old dosage and I suspect even mixed the medications. As a result, her health was affected and she had to be admitted for three days. (Caregiver 5)

After her diabetes diagnosis, my sister did not fully understand my mother's specific dietary needs. Like the need for low calorie foods, high-protein meals or

avoiding certain foods that could interfere her general wellbeing. She equally did not understand the importance of administering the medication in the correct dosage at the right time. This affected her body organs including the kidney. The doctor informed me it was due to the constant high blood sugars in her body. (Caregiver 1)

The study revealed that due to language barriers, some of the patients could only communicate to the healthcare provider through their caregivers or a third party. The interpreter performed at least functions namely: comprehending the meaning of the information relayed in the source language and reconstructing it then relaying it to the patient in the target language. The interpreter not only applies his or her knowledge of the rules (grammar) of the source language, but must also consider the context in which the source language is used.

4.7 Patients and Caregivers' Evaluation of the Healthcare Providers Communication Approaches

This section presents findings on patients and caregivers' evaluation of messages given by healthcare providers in relation to the management of chronic conditions. It covers patients and caregivers' views on how bad news was broken to them, healthcare providers unilateral decision-making, inadequate provision of information, lack of privacy and lack of continuity of treatment.

4.7.1 Patients' Views on Bad News Communication

Bad news is defined as any information that has a huge emotional valence and which adversely and seriously affects an individual's view of his or her future (Buckman, 2005; Camargo, 2019). In the context of health, bad news communication includes relaying messages to patients on disease diagnosis, disease recurrence, failure of treatment, prognostication of outcomes, presence of side effects of treatment, results of

genetic tests or raising the issue of palliative care and resuscitation (Ishaque *et al.*, 2010).

The patients and their caregivers were asked to give their opinion on the ways in which bad news was broken to them. Two varying groups emerged based on their responses. The first group was of the opinion that the healthcare providers should have broken the bad news to the caregiver or to the husband/wife of the patient if they were present at the hospital. Some patients believed that relaying bad news directly to them might worsen their illness. Some of the views were as cited below:

Let us say for example I have come with my wife or child to the hospital; I think that she should be the first person who should know it. You find the doctor saying that the medical report is between him and the patient alone. I believe that the caregiver needs to be informed regardless of the nature of the disease that the patient is suffering from. This would help him/her support the patient. In my opinion, it is important that the person who brought the patient to hospital know what is going on. (Patient 9).

They should just let you know that; you are not the only one who suffers from this condition and let you know you have hypertension. They can also call one of your family members who is present so that we discuss the way forward. (Patient 5).

In my opinion, the way I see it, they should ensure you are accompanied by someone because there are many people who when told something that hurts them, they faint. When you break news to someone that he/she is suffering from cancer ...like when I was diagnosed with diabetes mellitus, I was there with my sister and I did not feel so bad because I had someone to support me. When the news was shared with me, it did not hurt me so much. Yes, I was not shocked. (Caregiver 3).

Bad news brings a lot of mixed feelings. In some cases, it shortens life. For example, if you tell me I have throat cancer and you want to tell it to me directly I may not take it well. Just like in the recent past if someone said you have HIV, then you knew you were just about to die. The breaking of news for cancer patients should be done in a way that is tactical. This is because in Africa, cancer is equated to a death sentence. (Caregiver 4).

From the above data, a few patients were pleased with the way bad news was broken to them. In their opinion, the doctors delivered the news with tact and consideration. For example, for some patients, the presence of a family member made it easier to receive the news.

On the contrary, there were respondents who believed that the bad news should be relayed to the patients directly after assessing the patients' physical and mental capacity to receive and handle such news. Nevertheless, there were patients who were not satisfied with the way bad news had been communicated to them by the healthcare providers. Some patients said that healthcare providers lacked sympathy when delivering bad news, as indicated in the excerpts below:

When I handed him the report, he curiously looked at the results then looked at me for a few seconds. He then checked the results again and without mincing words he informed me I had breast cancer and that I should check in to see the pathologist and visit the hospice ...he insisted that I needed to begin treatment immediately... (Patient 7).

The doctor simply asked me if in my family there is anyone else who suffers from diabetes. I answered and then he told me that he had done the tests and had confirmed that I was suffering from diabetes... Then, I did not know much about diabetes. I thought I would be treated and get well after a short while. (FG3).

...He initially had issues with swallowing food and had been treated for throat infections. We were later told that he is having a growth and therefore a pipe was to be inserted through the throat which would facilitate the passage of food. It was at Tenwek Hospital where we had been referred that I learnt he had cancer that was spreading to the oesophagus. The doctor just mentioned it in his conversation. He assumed that we had earlier been informed before being referred there for the surgery. (Caregiver 2).

The doctors mentioned that everything was fine and that I would get better. Later, I realized that my condition was getting worse with time. I think that doctors should just be honest and tell us the truth about our health. Hiding the truth only helps for a short while. (FG 3).

In the medical environment, the breaking of bad news is an inevitable task for medical professionals. Doctors must often deal with the delivery of bad news to a patient, caregiver or a family member. This calls for effective communication between the doctor and the patient since the receiving of bad news is an onerous task for patients as it may affect their options for the future. Therefore, doctors need to be sensitive to patients' feelings and responses when breaking bad news. The way information is delivered determines a patient's adherence to treatment as well as patient satisfaction for example, if bad news is not delivered well, it is likely to alienate or depress the patient making it difficult to administer treatment or manage illness.

From the study findings, it was evident that patients and caregivers were not adequately prepared before being given the bad news. Most of the patients were not psychologically prepared for the news. They felt that the healthcare providers did not create time to explain to them what exactly they suffered from and the likely long-term effects of the disease. Patient 9, for example, initially assumed that diabetes was a disease that can be cured within a short term. On her part, Caregiver 2 learned about her husband's illness through another party. The doctor just mentioned it in his conversation. He had assumed that she and her husband had earlier been informed about the disease before being referred to JOOTRH for surgery. Overall, the patients expressed distaste in the manner in which the bad news was broken to them. The study thus noted that healthcare providers dedicated little time to communicate diagnosis to the patients and their caregivers.

4.7.2 Health Providers' Unilateral Decision Making

Shared decision-making (SDM) is a process by which clinicians and patients (and/or their caregivers and families) come to a clinical decision regarding the next step to take in a patient's healthcare (Charles *et al.*, 1999; Stiggelbout *et al.*, 2012). It essentially involves a two-way exchange between the patient, who provides insight into goals, values and preferences and the clinician who outlines the benefits, risks and uncertainties of various care options based on the experiences and knowledge of the best research available. Through shared decision-making process, patients and clinicians make shared decisions about disease management (Eales & Smith, 2021).

All the ten healthcare providers interviewed agreed that there was need to involve the patients in their own treatment. They believed that it is essential for patients to take part in their own care. Three healthcare providers held the view that it is important to involve patients as a way of ensuring that they accept, own as well as adhere to the treatment. They emphasized on the importance of consultation. Four out of the ten interviewed supported the view of involving patients in shared decision making. On the contrary, there was a difference in opinion concerning the extent to which healthcare providers actually do it in practice. Some of the patients' and caregivers' views on shared decision making include:

Caregiver 1:

So my feeling is that doctors sometimes rush to conclusion. They make so many assumptions and at times they come up with wrong diagnosis. sometimes, they side line us and only pay attention to the patient yet we are also interested in knowing the course of action they intend to take with regard to treatment and management of the disease that our patient is suffering from. This information is important to us because we are the ones who take care of them at home. We give them medication, take care of their diet among other duties. The

COs (Clinical Officers) are the worst. They may think that you want to challenge or belittle them. Some are very cruel. Others see you as a bother while some prevent you from expressing your opinion on an issue or sharing your views. The interaction is limited and it is only based on what the problem is, when and how it began.

No, they rarely do that. Let us say I came for treatment the doctor will scribble something on a piece of paper and tell me to go with it to the laboratory. Once the result is out, I take it to the doctor who without saying a word to me, prescribes medication. He/she will not tell you what the results show. So, you just go home and you don't know what the problem is (Patient 3)

Patient 5:

The doctors always give their views. You cannot force the doctor to do what you want. They just tell you take this medication at this time and that is all. I have never been asked to participate in decision-making..... He tells me do this, do this but do not do that because I have this chronic disease (heart condition) and asthma, he also tells me when and how to take medicine. The doctor had instructed that I take the Echo test. After the test he does not tell me much about the results and the heart condition. All he tells me is the medicine and the next review. He has never sought my opinion.

FG 2:

Doctors demand we do as instructed. Whenever a patient asks questions, they ignore or they assume that you are being stubborn. I can't argue with them since I am the one in need.

CG1, PT1 and PT5 are of the opinion that the healthcare providers do not encourage shared decision making with the patients and their families. PT5 says that they are not allowed to share their views with healthcare providers. All that the healthcare providers seem interested in with regard to the patient is the problem and after the consultation, without much discussion the prescription is provided. Patient 5 and PT10 argue that when tests are done the results are hardly communicated to the patients instead, the

healthcare provider makes a decision singlehandedly. The patient is given a prescription or asked to undertake further tests. The doctor rarely seeks the patient's opinion.

4.7.3 Inadequate provision of Information by Healthcare Providers

Patients and caregivers were of the opinion that healthcare providers rarely provide them with information that is timely and adequate to enable them participate actively in the management of their chronic conditions. The responses below capture the voices of some of the participants:

Caregiver 2

We were informed that our mother had lung cancer stage three progressing to stage fourinitially she suffered from ulcers and a lung infection which was treated for a long time before the cancer was diagnosed.....I would like to know what caused it because she neither smokes nor drinks. When they say stage four what exactly do they mean? Is it curable? When they send us home for palliative care do they mean we should give up? Can anything be done? There is so much about cancer that I would wish to be told. Is there an alternative to chemo? The chemo seems to be doing more harm than good to her.

Patient 8:

When I was diagnosed with diabetes, I thought I would get cured after a short while. ... the disease has progressed and now I have issues with my kidneys so that I need to undergo dialysis at least twice a month.The doctor insists on putting me on insulin though he has not explained to me in detail what the likely side effects are..... I fear that I will become dependent on it. I have been given but I stopped using it..... Though I find it hard to tell the doctor. Rarely are explanations given, ...

Patient 7:

I was curious to know what I was suffering from for a long time and I believe it would be easier if it had been detected earlier..... I wanted to know to what extent my body "was eaten" and the chances for survival or relapse. I wanted to know more about cancer, what causes it and its general effects on the Body..... I wish he explained to me the real effects of chemotherapy on my

body system. It was worse than I expected. The nausea, the diarrhoea, weight loss, when my body turned black, I thought I was going to die. I was shocked by the side effects.

FIG1:

Doctors do not say much about our health conditions. They give little information, give you a prescription and tell you about the next visit.

A number of patients and caregivers noted that health providers do not provide sufficient information about chronic conditions to them. Patients gave their own experiences based on the fact that healthcare providers did not fully disclose to them the details of their chronic conditions. The health providers only prescribed drugs but did not take time to explain the disease. Patients were of the opinion that healthcare providers need to provide information regarding the investigations and tests done, treatment and the likely side effects.

4.7.4 Lack of privacy

The consultation process is expected to be handled in a private and discreet way since it involves the patients opening up to healthcare providers about their health which is a personal matter. There is need for consultation rooms that are private. This was necessitated by the experience that most patients went through at JOOTRH where consultations were done in rooms that lacked privacy. Some of the consultation rooms at the hospital are shared by two or more doctors, nurses and their patients. Reliving their encounters, some of the patients had this to say:

Patient 2:

... Someone just pops into the room during consultation time when you are discussing personal issues with the doctor. Such incidences interfere with private talk. We need privacy...interruption should be reduced.

At times you find that the doctors are forced to share a consultation room. While you are talking to your doctor, there is another one who is also attending to his/her patient. ,,,,, you cannot openly discuss with the doctor. First, you assume the other party is listening. you feel uncomfortable and it becomes hard to talk freely...

Patient 8 says:

Due to diabetes. I kept getting infections and was on treatment. During one of the reviews the doctor asked me to lie on one of the beds in the room so that he examines me. While I was lying there being examined, the door suddenly opened and another doctor came into the room. He came and stood next to the bed. The doctor carried on with the examination. When he completed and left, I dressed up. I left the room feeling very embarrassed.

The patients also felt the need for the general wards to have more privacy.

There is need for more privacy in the wards too. In the general ward the beds are arranged too close to each other that it is so hard to have a private conversation with the doctors and nurses without the other patients following the conversation. It is hard to say some things in public.....

Patients also expressed the need for more doctors both male and female so that one has an option of choosing the doctor to see. Some patients preferred to see a doctor of their own gender. For example, some female patients felt that they would be comfortable expressing themselves to a female healthcare provider. On the issue of the gender of healthcare provider the following was said:

Patient 8:

You see as a woman I may have a problem. When I get into the room and get a male doctor, there are some details that I would find it hard to say as compared to if I had gotten a female doctor. The presence of a male doctor complicates my situation because I feel uncomfortable and shy in his presence. I may gather courage and explain some things but withhold others..... How are they likely to take it? It is hard to open up on such issues.

Patient 6:

I may not be comfortable, especially when I consider the gender of the doctor. Sometimes there are some things you cannot tell a lady so you just keep quiet.

Age was also a variable that was taken into consideration in healthcare provider-patient communication as noted below:

Patient 6:

Yeah....there are things you don't If I meet a young lady... it feels like you are opening up to your daughter and it is quite embarrassing.

From the data, the age of the doctor is important with regards to matters of privacy. Some of the patients expressed reservations about being treated by a doctor they considered young.

Patient 2:

Yes, there are circumstances I do not feel comfortable. Sometimes it matters because when you meet someone who is your daughter's age and you want to open up to her you find there are some things that you withhold.

However, some of the patients felt free to open up to both male and female health providers whether young or old as stated in the following account:

Patient 4:

I always feel free with every doctor. Personally, I don't choose. I don't care whether the doctor is my child's age mate. I usually hear some people saying that they have been attended to by trainees.....

Patients expressed need for privacy in the consultation rooms as well as in the wards. They preferred middle aged and older healthcare providers as compared to the young. The elderly patients said that they felt embarrassed explaining their condition to the young inexperienced doctors who in some cases were the age mates of their sons and daughters. Some of the females expressed a desire to be treated by female healthcare

providers instead of males. They were of the opinion that they find it easier opening up to fellow women.

4.7.5 Lack of continuity of treatment.

Patients felt that the regular change of doctors affected the continuity of treatment. They complained that rarely do they find the same doctor who attended to them the last time they visited the clinic. They argued that this change affected the quality and continuity of treatment. One patient made the following comment:

At one time you find a doctor who gives you this instruction. The next time you find a different doctor who gives totally different instructions.....

In terms of the doctors who handled them, the patients preferred consultants to clinical officers. This preference was attributed to the fact that consultants were keener at their work and gave patients more time during consultation as compared to clinicians. A patient gave the following comment to show his preference for consultants”

If you have been handled by consultants, they are good. They listen to you, they carry out tests and you feel that these tests are important and necessarythey give detailed descriptions of illnesses or procedures. When you visit them in private hospitals, they will give you more time. This may be because of the money factor now that you have paid a higher consultation fee as compared to when you visit the public one which is far cheaper.

4.7.6 Patients Views about the language used by healthcare providers during treatment.

4.7.6.1 Complicated Medical Language/medical jargon

Kenya is a multi-lingual society that uses both English and Kiswahili as the official languages. However, the knowledge of English is a preserve of the educated minority. According to Waitiki (2010) one can argue that Kiswahili is understood by more people than those who understand English although this is to varying degrees of competence

and intelligibility. This underscores the importance of language in the management and treatment of chronic conditions. Language can be a facilitator or a barrier that affects the treatment process. Most of the patients confessed that they found the language used by healthcare providers quite difficult to understand. In the first place, most doctors prefer to use English in their communication during consultation. The patients were of view that most of the doctors made the assumption that they understood English. The following comments were made by patients on the issue of language barriers during interaction:

Patient 2:

Most of them assume that we understand English. I always let them know that I understand Kiswahili. In some cases, there are things that they say that I find hard to understand. So, at that point, I always ask the doctor if he can say it in Dholuo since I am more fluent in it. At that point if there is someone who understands, he/she can help out. Whenever I find a doctor who does not understand Dholuo, our communication is hampered so in most cases, the doctor calls someone else to attend to me.

From the data, the patient does not understand English but to some extent understands Kiswahili though he is fluent in his mother-tongue which is Dholuo.

Patient 3:

If possible, doctors should have translators to speak to us in the local languages.

In the scenarios presented above, there was need for the services of translators and interpreters.

Language is a challenge for patient 2 who does not communicate in English and is not very proficient in Swahili. He confessed that although he spoke and understood simple Swahili he gets lost when complicated Swahili is used. He preferred to get a doctor who

spoke Dholuo since this would make communication easier and he would easily express himself. It was evident in the hospital that healthcare providers found it necessary to send a patient to another doctor who spoke / understood his/her mother tongue.

This therefore implies that certain patients cannot be treated by some healthcare providers due to language barrier. These patients found it difficult or almost impossible to communicate with certain doctors or nurses who do not understand their mother-tongue. Some patients expressed apprehension that they may not be getting appropriate treatment or prescription for their conditions because of the challenge posed by language barriers.

At JOOTRH the translators used were either nurses who spoke a similar language to the patient or the caregiver who was used as translator and interpreter for both the patient and doctor. The practice of translation is a challenging one. If a patient only speaks and understands mother tongue for example, Dholuo or Ekegusii, then the doctor would be forced to carry out consultation with the help of a relative who understood English or Kiswahili. and carry out the treatment. In this way, consultation would be facilitated to enable the doctor carry out diagnosis, treatment and management of the chronic condition

Medical jargon and medical terms also proved to be a challenge to most of the patients. Most of them do not understand the medical terms or short forms that are commonly used by doctors and nurses in their conversations. Most patients did not understand prescriptions in terms of the drugs, the composition and the side effects. Some patients expressed the difficulties they had with the prescriptions given as captured in the following accounts:

Patient 2:

Doctors need to tell us the drug, its composition and how we need to take it. For me, the prescription given plays a pivotal role in the health of the patient the reason why the doctor should explain its contents. The other details are fairly difficult to understand. Most of the time, I just go and do not seek clarification.

Patient 10:

It is difficult to understand some of the medical tests undertaken. The results are equally complicated. One is not aware of some of the drugs and whether they are likely to complicate or affect one's health.

The language they use is fairly difficult. At times, I feel frustrated but just take it as normal because it is their language..... When I came in the morning, the healthcare provider who registered me wrote D.M at the back of the file....was forced to ask what that meant and he informed me that is the short form of diabetes mellitus. Some of the terms that they use are also confusing for example, the terms hypoglycemia and hyperglycaemia.

Patient 7:

Sometimes doctors use very complicated language comprising medical terms that cannot be easily understood. Like the first time I was diagnosed with breast cancer the doctor said I should do an MRI. Initially I had visited the hospital and was being treated for chest problems. It was after several visits that the doctor ordered for MRI. I went did the test and brought the results to the doctor..... that I should check in to see the pathologist and visit the hospice. I guess I was too shocked to think clearly. The first thing that came to my mind was that I was going to die. The doctor did not clarify this issue to me. The explanations given by the doctors do vary.all I could understand on the report was the word tumour. The rest seemed so strange that I could barely grasp what it was all about. I could hardly understand what was stated in my medical report.

Patient 7 says, “that I should check in to see the pathologist and visit the hospice. I guess I was too shocked to think clearly. The first thing I thought was that I was going to die, pathologists are doctors who deal with the dead and he is already sending me to a hospice (silence) ...” In addition, Patient 10 says, “The language they use is fairly

difficult. At times I feel frustrated but just take it as normal because it is their language.....” these expressions are indications that healthcare providers in their communication, use medical jargon assuming that the patients have understood yet in essence they have miscommunicated. Patient 7 assumes that she is about to die when she is asked to see a pathologist. This underscores the importance of healthcare providers ensuring that the patients understand the message communicated to them. Patients equally found it difficult to understand some of the medical tests that were performed on them and some healthcare providers were reluctant to discuss the results.

4.8 Discussion of Findings

This section discusses the findings of the study in relation to the research questions. The study is anchored on the Communication Accommodation Theory, which explains how individuals adjust their communication styles to manage social dynamics. CAT principles apply in the healthcare contexts. Communication Accommodation theory has three principles of convergence, maintenance and divergence. Convergence refers to strategies individuals use to adapt to the communicative behaviour of others they are communicating with. In this study, healthcare providers used the convergence principle to simplify medical jargon, repeated phrases and created a friendly environment so as to create trust and understanding.

Divergence strategies refer to instances where healthcare providers intentionally or unintentionally create distance in their communication style, often differing from the patient's expectations or norms. This mainly occurred when the healthcare providers used medical jargon or technical terms hence exacerbating power imbalance. On the

contrary, patients diverge by withholding information if they don't feel free with the healthcare provider.

Uncertainty reduction theory equally emphasizes that communication is motivated when uncertainty is reduced. URT emphasizes information seeking behaviours that mitigate ambiguity. In the management of chronic illnesses this calls for explicit explanations of diagnoses, treatment plans and prognosis to help patients understand their illnesses.

The first research question deals with the healthcare providers perception on the need for provision of information to patients with chronic conditions. There are three findings in relation to the first question. The findings are that some healthcare providers emphasize the need for patients to be empowered and provided with all the available information regarding their conditions including details about the illness, available treatment options and financial costs. They argue that information enables patients live productive lives and to plan. On the other hand, some of the healthcare providers held the opinion that there is need to be conservative and cautious about the kind of information they provide to patients since it could affect the treatment process. Some of the healthcare providers also argued that patients do not need to be provided with medical related information since most of them do not understand it because they are not medical professionals.

For the first finding, healthcare providers believed that patients need to be provided with detailed information concerning their chronic illnesses. Healthcare provider 6 emphasized on navigator's approach which involves providing detailed and complete information to patients with chronic conditions. He opined that patients with chronic illnesses have a right to information that will enable them seek treatment and effectively

manage their conditions. He based his argument on the training he had received in medical school and on work experience gained. In addition, he had observed that most patients with chronic illnesses lack adequate information. This indicates that healthcare providers are willing to provide information to the patients.

Healthcare Provider 6 emphasized that patients should be educated on the importance of a healthy diet and nutrition. As healthcare providers, they guided patients on diet to enable them maintain normal weight and relieve symptoms of various diseases like diabetes, hypertension, arthritis and heart conditions. Diabetics in particular were informed on how to control hyperglycemia and hypoglycemia to ensure sugar levels were between normal ranges. They were also informed about maintaining normal body mass index through diet, exercise and lifestyle adjustments. Healthcare providers therefore provided information that would enable patients to manage their conditions.

In addition, patients were informed about medication and the need to adhere to treatment. Consistency was also stressed since it was common for patients to abandon treatment when they felt better. The study revealed that most of the patients sought medical treatment when the disease had advanced or when it was quite late. Healthcare providers took it upon themselves to enlighten the patients about their chronic conditions. For instance, Healthcare Provider 5 argued that cancer is viewed as a mysterious disease whose actual cause cannot be explained. Due to the episodes of pain and suffering, patients found it hard to understand the disease. Healthcare providers found it necessary to demystify the disease and assure the patients that having cancer was not a death sentence. This indicates that healthcare providers reassure the patients as a way of developing trust during the treatment period.

Healthcare providers highlighted the need to sensitize patients on chronic conditions they suffer from and the available treatment options. They emphasized that information provision empowers patients to make informed choices on diet, treatment options, continuous screening, testing and early detection. In essence, information enables the patients to cope with chronic illnesses and live fairly independent lives. Thus, effective interpersonal communication between the healthcare provider and patient ensures the latter receives medical information regarding his/her condition.

Náfrádi et al., (2018) emphasize that effective communication is a cardinal aspect of medical practice. Patients' adherence to the information given by the healthcare provider plays a role in the overall outcome of the treatment process. The study found that when doctors provide psychological support and promote patients' health literacy, patients feel empowered and are more cooperative in finding the right treatment (Náfrádi et al., 2018). Information is expected to empower the patient.

Emmanuelle (2015) also found that the interaction between a healthcare provider and patient can significantly influence the way the patient reacts to diagnosis, manages reactions and negotiates treatment. For most patients, their interpersonal interaction with healthcare providers is therapeutic. For cancer and diabetic patients for instance, the communication given by healthcare providers plays a significant role in their course of treatment and in their general outlook towards life.

Beach and Inui (2006) are of the opinion that communication is essential since through relational communication, patients and healthcare providers share information, provide the resources, determine diagnosis and develop treatment plans. When the patient and physician work together, they identify common ground, resolve differences in opinion

and negotiate so as to come to an agreement on the treatment plans. A successful interaction between patients and healthcare providers thus enables patients to take a more active role in medical interactions; they feel valued and view themselves as equal participants in their medical care. This ensures the relationship is based on mutual trust, respect and commitment (Epstein & Street, 2007). To corroborate the need for successful healthcare provider-patient interaction, Engel et al., (2008) argue that when there is shared understanding, a humanized healing can occur. When providers are more informative, patients tend to have less emotional distress and improved resolution of symptoms. Doctors' responsiveness to patients' emotional state reduces levels of patients' distress and improve symptom resolution.

Findings indicated that healthcare providers believed that patients needed to be made aware of available treatment options. Healthcare providers tried to create a friendly and open environment for the patients to ensure the patients felt free to express themselves. Based on the diagnosis, for example in the case of diabetes, they explained to the patient the various types of diabetes (type1, type 2 or gestational) and how it affects the body's ability to regulate blood sugar. According to the healthcare providers, this was done based on the severity of the disease before medication was prescribed. CAT theory emphasizes adaptive interpersonal communication that meets the unique needs of patients. This calls for tailored disease specific information suitable for each patient.

Friedman et al., (2008) concluded that doctor-patient communication contributed to patient adherence. In their study, they found that patient learning styles that were associated with less concern about future effects of glaucoma and likely side effects of not taking the prescribed medication were associated with less adherence. This finding

highlights the need for healthcare providers to properly educate the patients on the need to adhere to the recommended treatment for positive therapeutic outcome. This applies to the study as healthcare providers emphasised on the need for empowering patients to enhance independence and quality lives.

In essence, the healthcare providers support patient-centred care that addresses the relational, affective and structural aspects of the patients (Tates & Meeuwen, 2001). There was emphasis on creating a friendly environment for patients to make inquiries and be informed in a manner that they understood. Patients with chronic illnesses should be given a chance to explain their symptoms, preferences and concerns. The patients also expressed their desire for the doctor, based on his/her expertise, to provide them with sufficient information on the disease and the course of treatment. Patients with chronic illnesses need to be given a chance to explain their symptoms, preferences and concerns. They expressed their desire to be provided with information regarding the disease and side effects they are likely to suffer from in the course of treatment (Irwin *et al.*, 1989). There is emphasis on the need for healthcare providers to provide information in a simple and clear way that would encourage shared decision making. Holmen *et al.*, (2020) emphasize the need for patients to access information relevant to their situations so as to take an active role in their disease management. They further noted that there is need for clinicians and patients to work together to yield good results. This would enhance individualized care that would lead to better management of the condition.

On the contrary, Pooley *et al.*, (2019) found that patient-centred care was hard to achieve since it entailed the healthcare providers getting to know the patient as a person. The researchers posited that healthcare providers faced several challenges in the provision of

individualized care. For example, their attempt to establish and build relationships with their patients were marred with incidences of insincerity perpetuated by the patients, leading to the provision of inaccurate information. This implies that in as much as healthcare providers work towards achieving patient centred care, various factors such as the high number of patients that they have to attend to within limited time and non-adherence to treatment hinder this. This finding is similar to the findings of the current study in the sense that the healthcare providers felt they had a very heavy work load with equally limited time. Patients also confessed that if they thought the healthcare provider would reprimand them, they would not tell him/her the truth. Language was equally a barrier to the communication between healthcare providers and patients. There is need to ensure the language used is appropriate for the delivery of the message.

The study highlighted the importance of communication regarding costs of healthcare to patients. Healthcare providers raised concerns regarding provision of information about costs of medication early enough to enable patients plan their treatment since chronic health conditions have a significant financial impact on families. Some of the patients had financial challenges which were barriers to care access. Meluch and Oglesby (2015) established that patients and physicians perceived healthcare costs to be crucial and can influence financial and health outcomes however, discussions on actual costs were rare. Agarwal *et al.*, (2021) corroborated the findings indicating clinician gaps in provision of information about treatment costs and financial burden recognition. Further, Kuang *et al.*, (2023) indicated that most patients were willing to engage in discussions surrounding costs of care because the benefits of such discussions outweighed the drawbacks.

Most chronically ill patients wanted to engage their physicians in talks about costs but most physicians failed to initiate these discussions due to inadequate skills and confidence to facilitate such discussions. Kuang *et al.*, (2023) point out that barriers and shortcomings of cost discussions during care include: extra requirements such as personnel, content, timing, further training, standardized processes, tools and protocols. In as much as the discussion about the cost of treatment is central in healthcare provider-patient communication, the framework upon which such discussions should be grounded is not clearly spelt out. Agarwal *et al.*, (2021) and Kuang *et al.*, (2023) highlighted lack of guidelines, lack of organizational support and policies addressing how clinicians should approach cost discussions as some barriers that hinder such discussions. Effective communication between patients and providers should capture financial issues to facilitate patients to make informed decisions about care and choice of medications.

Some of the reasons for healthcare providers reluctance to discuss the cost of treatment and procedures could be that they are ill equipped with counselling skills to pass the information to patients. In some cases, patients come expecting that the healthcare providers will help them pay part of the bill or waive the treatment costs. For the patient, failure by healthcare providers to disclose of the cost of treatment delays the treatment process in that they realize that they cannot undertake certain surgeries and treatments without undergoing tests. Some postpone the treatment and come back when their health has deteriorated. Others opt for local herbalists in an attempt to find a cheaper solution.

The study established that some of the healthcare providers exercised caution when providing information to patients and their caregivers. Healthcare Provider 3 argued that

modern patients should not be given too much information so that in case of a misdiagnosis the doctor does not land into trouble. He noted that patients or their caregivers tend to seek second opinion from other doctors and hospitals as a result, some of their colleagues have been sued for negligence or misdiagnosis. The search for second opinion leaves healthcare providers in limbo. Some of them felt that patients do not trust them hence were reluctant to provide information. They feared the possibility of liability of exposure. Therefore, he argued that the doctor should only give the patient what they thought the patient needed to know.

Healthcare Providers 4 and 5 argued that they were reluctant to disclose advanced cancer diagnosis when it was at stage 3 or four or when the patient's health had deteriorated. Some of the healthcare providers expressed reluctance to provide information to patients for fear that it might negatively affect their cognitive and emotional states hence affect treatment. They feared patients might have extreme reaction to the news. Healthcare Provider 7 also argued that in cases where the patient's illness had not been fully confirmed they avoided giving too much information just in case there was a misdiagnosis. Healthcare Providers 1, 5 and 7 insisted on following the therapeutic privilege which allows the withholding of information from a patient when there is justified belief that disclosure may cause serious mental or physical harm to them. The moral basis of invoking therapeutic privilege was for the doctors to do what is beneficial to the patients and avoid inflicting harm. Doctors justified the withholding of information by arguing that they did it for the welfare of the patient.

Ngene *et al.*, (2022) opined that doctors believed that the patient's emotions affected their disclosure. As such, they were reluctant or did not disclose vital information if

they found the patient too emotional or agitated. The patient's behaviour determined how much information would be disclosed in relation to their health. This finding supports Wei, Xu and Wu (2020) who posited that doctors found it necessary to be mindful of what they say, how they say it and ensure that the body language reflects the message. This is in tandem with Swain *et al.*, (2015) who emphasize on the need for quality communication founded on trust and shared meaning between the doctor and the patient.

Thurman (2001) cited the ethical and legal perspectives of medical mistakes that are barriers to informing patients about medical errors. This included the providers difficulty in confessing mistakes or the fear of implicating other providers. Healthcare providers also feared the possibility of liability of exposure. He argues that many providers do not like to confess error since it is usually accompanied by shame, the fear of potential punishment or the feeling that power has been lost. This explains the cautious approach some healthcare providers take when passing information to patients. For fear of liability, they only gave what they thought the patient needed to know. Hence, they avoid providing too much information to the patient so as to avoid legal battles. They either delayed providing information or withheld if it was considered serious or if it would be detrimental to the patients' health.

Culture equally affected healthcare providers' provision of information to patients based on their perceptions of the patients and the severity of the disease. Providers withheld information from patients for fear that they would be stigmatized. Traditional beliefs about the causes and treatment of some chronic illnesses conflicted with biomedical explanations. For instance, some patients attributed like diabetes or cancer to spiritual

causes or curses. Some, consulted traditional herbalists over medical professionals hence came to hospital when their conditions had deteriorated. Superstitions and stigma surrounding certain conditions also led patients to withhold information. Some patients feared asking questions expressing concerns out of respect or fear of being seen as challenging the doctor's expertise.

Findings of this study indicate that healthcare providers were reluctant to disclose difficult information to patients but preferred to give the information to the caregiver or the person responsible for the patient. Organ *et al.*, (2021) investigated non-disclosure of health information among physicians in Jordan. Of the total 164 physicians who participated in the study, 10% (17) said that they were always truthful, while the remaining 90% (144) said they were not. A minority of the physicians indicated that they were always truthful and were of the opinion that nondisclosure is unethical and unbeneficial for both the physical and psychological health of patients. Most of the physicians who participated in the study indicated that all patients have a right to know their diagnosis. Azam and Watson (2017) revealed that a physician is less likely to disclose sensitive health information if the patient has poor prognosis such as end stage cancer or limited life expectancy. Ewuoso *et al.*,(2021) validated these findings indicating that healthcare professionals employed several strategies to manage delivering difficult information including: centering communication, decision-making, confidentiality and professional duty. Some of the highlighted communication challenges included quantity of information to disclose and the persons to disclose to in the event of clinically significant information. The study argued that healthcare providers face difficulty deciding how much to disclose with worries of lawsuit and

malpractice if the information is shared to unauthorized sources or disclosed without the consent of the patient. Hahne *et al.*, (2020) indicated that Chinese doctors perceived withholding of information from cancer patients as sometimes necessary but it was non-ideal and compromised the rights of patients.

A review of the code of ethics highlights the need for open and truthful communication between patients and providers to fulfil the principles of autonomy. Withholding patient information can create an ethical dilemma and conflict between the obligations of beneficence/non-maleficence and autonomy. Withholding vital patient information is deemed unacceptable unless when a patient lacks decision-making capacity and providers should relay the vital information as soon as the patient has regained optimal capacity for making own decisions (American Nurses Association, 2021; Petersen *et al.*, 2018).

Providers are obligated to ensure veracity and communicate honestly to patients immediately and at once. However, in their quest to fulfil their communication mandate, the health providers got frustrated due to lack of guidelines and adequate training on assessing decision-making capacity of patients. Besides, clinicians also cited lack of guidance for ethical challenges related to information (Ewuoso, Hall, & Dierickx, 2021). Clinicians have an option to suit their communication on the patients' preferences and their ability to comprehend information. The communication must be respectful and done in a sensitive fashion.

Providing information to patients about a diagnosis such as cancer can be stressful to doctors. However, patients perceive this discussion as a tenet of enhanced quality care. Clinicians face challenges when breaking bad news due to sociocultural factors that

shape patient's understanding of end-of-life decisions, preferences for communication and decision-making within the family. While clinicians may be willing to involve family in such decisions, some of the cultural values of Africans can oppose their decisions. Medical information can extend to the nuclear family unintentionally when doctors provide care decisions unquestionably. Physicians should allow patients to list their preferences regarding communication of medical information and choose to honour the request of patients and families. Providers can assess whether the patient's health literacy levels can support the communication of vital data and determine whether healthcare providers instructions match with the needs and expectations of the patient. A consultation with the patient's family and caregivers can assist in assessing the merits and demerits of withholding information. Disclosure should not be permanently delayed but be delivered in a planned manner.

Another opinion held by healthcare providers in regard to provision of information was that patients should not be given information since in the first place, they do not understand medical information and they don't have a right to decide. Another doctor supported this view by asserting that giving patients information does not yield much since they do not understand. To further corroborate their stand on not giving information to patients, some healthcare providers argued that since they are the experts in the medical field, they had all the solutions to the challenges that patients face the reason why patients sought their help. Therefore, they should be left to do their work in consultation with other medical experts.

According to one healthcare provider, they prefer to keep conversations professional by consulting other medical professionals so as to get the best treatment for the patient.

They find it difficult breaking down medical related information to semi-illiterate or illiterate patients. Moreover, medical language is complicated to an extent that even the educated have difficulties understanding it. Healthcare providers reported having difficulties with patients who do not understand and do not follow medical instructions. In some cases, it was difficult to gauge the health literacy level of the patient hence, healthcare providers were forced to do what they considered was in the best interest of the patient. By this the healthcare providers increase the power imbalances between the healthcare providers and the patients.

A study conducted on the challenges that healthcare providers encountered in serving patients with low health literacy found that patients had difficulties in understanding and applying the health information provided and communicating effectively. Approximately, a third of the doctors met patients who did not convey their preferences prompting the provider to make decisions on their behalf (Murugesu, 2022). Patients also did not show up for follow up sessions/appointments, had difficulties articulating their symptoms and preferences. Medical staff could not gauge the health literacy levels of patients and were not sure if the instructions had been understood. Patients with low health literacy are equally vulnerable to low digital health literacy skills (Smith *et al.*, 2019).

A study conducted by Graham & Brookey (2008) showed that low literacy affects patients understanding of medical instructions, appointment reminders, informed consent procedures, hospital discharge instructions and health education materials. Another study carried out by Storms *et al.*, (2019) has shown that healthcare providers often missed cues that would reveal the patients' health literacy level and that at times

patients conceal their low health literacy levels. This study thus concluded that general health practitioners were often unable to estimate their patients' health literacy levels.

Healthcare providers are aware of the need to provide patients with sufficient health information. The prerogative of providing this information, when and how do it lie with the healthcare provider. As a result, patients are left with a lot of uncertainty. Effective communication between the healthcare provider and the patient has been shown to be crucial in ensuring adherence to treatment and overall health outcomes. Hence, patients who experience uncertainty about their illnesses may benefit from clear and informative communication from healthcare providers, which can help reduce anxiety, improve treatment adherence, and enhance overall well-being.

This section examined how healthcare providers communicate with patients on the management of chronic conditions. Data indicates that healthcare providers make effort to ensure that they communicate with the patients. Some of the strategies employed included the use of explanations, questions, simplification and interpreters (especially in instances where language barriers were encountered). Some of the challenges encountered during communication included: low literacy levels which affected understanding among patients; stigmatization by family members due to the chronic conditions the patients suffered from; time constraints which prevented healthcare providers from adequately attending to their patients and lack of required facilities which delayed the treatment process.

4.8.1 Challenges Faced by Healthcare providers in Communication with patients

Language barriers affected the ability of the patients and caregivers to understand medical information. Some of the patients had difficulty in expressing themselves and in

understanding what was communicated by the physicians. Although Kiswahili was used as the alternative language for patients who did not speak English, the communication process still faced difficulties since some patients confessed that they only knew basic Kiswahili and that whenever “deep” Kiswahili was spoken they did not understand. The predicament that such patients found themselves in made it hard for them to engage the doctor one on one and they had to rely on interpreters to facilitate the communication. This finding agrees with the finding of a study conducted on the linguistic challenges in the fight against HIV/AIDS in Kenya. The findings indicate that Kenya is multilingual country in which the knowledge of English is a preserve of the educated minority. Kiswahili on the other hand, is understood by more people than those who understand English but at varying degrees of competence and intelligibility. Even though a majority of Kenyans are not competent in these two languages, they are the ones used in educating the citizens about HIV/AIDS. Language hindered patients from obtaining treatment when they could not speak English or Swahili or speak to the nurse/ doctor in the local language. This forced them to find untrained interpreters to facilitate the communication (Waitiki, 2010)

Findings also indicate that a patient’s educational level and socio-economic status affected his/her level of participation in shared decision making. Patients from a lower socio-economic class who are semi-illiterate tended to unquestioningly accept what was relayed to them by the healthcare providers. On the contrary, patients who had achieved higher academic statuses for example, diploma holders or a graduates asked more questions in relation to their health as compared to those who had acquired basic

education only. Rarely did the uneducated engage in shared decision making with the healthcare providers. This could be attributed to lower literacy levels.

According to one healthcare provider, whenever they came across patients with low literacy levels, the healthcare providers would check through the files or treatment records of the patients and find a way of treating them rather than waste a lot of time explaining things to them. He argued that most of these patients would neither understand nor recall what they were told. In addition, such patients were only interested in having their problem solved. So that if a patient was in pain, all he/she wanted was a solution to the pain. This finding is in line with that of Sun and Rau (2017) which concluded that physicians' low expectation of patients' medical literacy led to less education for the patients. That health providers prefer to educate those who are eager but also understand the information conveyed. The management of uncertainty through effective communication between doctors and patients is crucial in diabetes management. Patients who experience uncertainty about their illness may benefit from clear and informative communication from healthcare providers which can help reduce anxiety, improve adherence to treatment and enhance overall well-being.

In a study conducted on the challenges that healthcare providers encountered in serving low health literate patients, it was found that patients who had difficulties in understanding and applying health information provided and faced difficulty in communicating effectively with providers. Approximately a third of the respondents met patients who did not convey their preferences hence left the onus of making decisions to the provider (Murugesu, 2020). Healthcare professionals also came across patients who

did not show up for follow up sessions/appointments and had difficulties articulating their symptoms and preferences.

Medical staff also had difficulty in gauging the health literacy of patients and were not sure if the instructions were understood. Healthcare providers acknowledged that lack of knowledge about healthy lifestyle and inability to appraise non-validated information especially from the internet as problematic to patients. They failed to make appointments at hospitals since they relied on own online searches. This highlights the need for structured follow-ups. Low health literate patients are equally vulnerable to low digital health literacy skills (Smith et al., 2019). Findings reveal that low literacy affects patients understanding of medical instructions, appointment reminders, informed consent procedures, hospital discharge instructions and health education materials (Graham & Brookey, 2008). Storms *et al.*, (2019) concluded that general health practitioners were often unable to estimate their patients' health literacy levels.

In a study carried out in Botswana on the communication of cancer diagnosis, findings indicate that multiple misconceptions about cancer were identified as factors that interfered with successful communication of the disease and the recommended treatment. For instance, patients attributed cancer to consumption of sugar, mercury and exposure to plastic materials; patients struggled to reconcile their traditional ways of making sense of cancer with modern medicine. Due to vocabulary inadequacies patients and physicians maintained different levels of understanding of diagnosis. Healthcare providers would assume they had given a thorough explanation only to realize a gross misunderstanding had occurred on the part of the patient (Henry *et al.*, 2021).

Schouten and Meeuwesen (2009) carried out a study which showed that language affects the participation of minorities /migrants in treatment. The study noted that ethnic minority patients tend to participate less actively during medical consultations as compared to patients who belong to majority population. Minority patients ask less questions, are less verbally dominant and display fewer initiatives. Ethnic minority who are less proficient in the physician's language had lower participation levels than ethnic minority who are more proficient. Turkish-Dutch participants discussed difficulties of understanding information and expressing themselves due to language problems. Low proficiency of Dutch became a barrier to their participation since they could not communicate effectively. There is therefore need for healthcare providers to adjust their communication to meet the needs of their patients if effective communication is to be achieved. According to Communication Accommodation theory, providers can use strategies like linguistic convergence which include matching vocabulary, accent and cadence to bridge communication gaps effectively.

In this study it was observed that most of the healthcare providers had a heavy work load within the Specialists Clinic. Coupled with time constraints, the doctors were forced to limit the time allocated for consultations. These findings are in tandem with a study done by Mirzaei *et al.*, (2013) on a patient-centred approach to health service delivery. Findings indicated that chronically ill patients are affected by level of work load experienced by health providers. In addition, the findings are similar to a study done by Vedanthan *et al.*, (2016) on barriers and facilitators to nurse management of hypertension carried out in Western Kenya. The findings indicated that health providers lessen time for each patient to ensure all the patients at the hospital receive their services

equally. A study carried out in Tanzania concluded that limited consultation time affected shared decision making (Juma & Manongi, 2009).

Time constraints was also a challenge at JOOTRH. The sentiments of Healthcare Provider 6 and Patient 6 are a testimony that time constraints played a very big role in curtailing provision of health-related information to chronic ill patients and their caregivers. This resonates with a study done by Sun & Rau (2017) who found that physicians failed to communicate patients results because of time constraints. The hospital also lacked facilities and machines to carry out various tests a situation which led to the delay in treatment since patients had to be referred to other facilities for the tests and x-rays. In some cases, due to financial constraints, patients took too long to bring the results back. A study to investigate communication barriers faced by cardiology doctors in Malaysia found that healthcare providers are overwhelmed. They were expected to attend to between 30-40 patients, provide detailed reports of each patient treated, make plans for surgeries and organize referrals. Hence, patient consultation time was shortened to ensure they attend to as many as possible (Vimala, 2016). A study carried out in China also found that heavy workload limited doctors' consultation time (Sun & Rau, 2017).

The second research question dealt with how healthcare providers communicate with patients on management of chronic conditions. This mainly looked at the communication strategies healthcare providers employ in their communication with patients. Explanation is one of the strategies used by healthcare providers. They used it to continuously guide the patient on how to handle the condition. Healthcare providers explained to the patients the risks, the details of the disease and how to handle

themselves. For instance, for patients suffering from diabetes and hypertension the importance of adherence to drugs for the purposes of stabilizing the sugars and pressure were emphasized. They also provided individualized care that attended to patient specific needs. Self-management of chronic conditions demands that patients make daily decisions to manage symptoms and alleviate them. In one study, Gance-Cleveland (2007) observed that the use of prescriptive and authoritative instructions such as “You have to improve your breakfast.....you have to walk or to ensure that you take your medication at the right time...” may harm patient adherence. Even though diet, medication and exercise are decisive factors, the way such behaviours were recommended may not encourage dialogue and active participation of the patient.

Findings of the study indicate that at JOOTRH questions were also used by healthcare providers to provide information and for clarification purposes. Healthcare Provider 3 is of view that questions are used to check patients understanding and to provide further information to them on matters concerning their health. Through the use of questions, the healthcare providers expected to take the history of the patient, diagnose and eventually administer treatment. Healthcare Provider 1 argues that questions are used for clarification especially for patients who show interest in wanting to get more information concerning their health and treatment. On the contrary, there are patients who are disinterested and accept the little that is offered without question.

According to healthcare providers 3 and 9, they made attempts to gauge the patients’ level of understanding through questions. They noted that this strategy was important in determining what the patient already understood thereby aiding them in crafting suitable messages. Through the use of questions, health providers are able to check the progress

the patients are making regarding their health conditions. From an account previously given by healthcare provider 3, some patients see a doctor, are tested, and given prescriptions without them understanding what exactly they are being treated for. It is only when they do not improve that some go for review. This shows that some doctors are not keen when communicating to patients and they do not take the initiative to help the patients understand the consultation process. What counts for them is the diagnosis and the giving of a prescription to the patient. It takes a keen doctor who is willing to engage the patients to realize such gaps. Questions also play a role in confirming the patient's satisfaction with the information provided. The questions that a patient asks may act as a guide to the healthcare provider on whether the patient has understood the information or not and what can be done to improve comprehension.

Questions play an important role in establishing interpersonal relationships and in facilitating dialogue. Through the use of questions, the healthcare providers were able to get relevant information; they were able to clarify information as well as pass it to patients and care givers. According to a study done by Damasceno *et al.*, (2012), the use of questions is controversial since the manner in which one asks questions may impede obtaining results expected from the communicative process. In their view, they emphasize that there is need to ask questions using vocabulary that is appropriate to the patient's age, educational background and current context of life. In addition, they posit that there is need to apply wisdom during interrogations so that the patient does not think that the provider's aim is just to probe him/her because when this happens, the patient may decide to be passive. Questions should encourage patients to be active and ensure that they participate in self-care and management.

The role of questions in the management of chronic diseases has been given attention in various studies. These studies highlight the importance of asking specific types of questions to improve patient understanding, self-management and overall care. By asking targeted questions, healthcare providers are in a better position to address the challenges patients with chronic diseases face and tailor management plans to suit their personal needs. Additionally, questions play an important role in assessing patient knowledge, facilitating education and empowering patients to take an active role in the effective management of chronic conditions. Studies have shown that patient education, understanding of the condition and lifestyle modifications are important aspects influenced by questions asked during healthcare interactions (Fasulo *et al.*, 2016).

The use of simple language in healthcare provider-patient communication has been given precedence. In a study conducted by Vandebosch *et al.*, (2018) which examined the impact of health literacy interventions on diabetes management, it was noted that interventions using simplified language and clear communication strategies led to improved self-management behaviours and glycaemic control. As such, healthcare providers have resorted to the use of simple language in effort to enhance communication with their patients. This resolution is reinforced by healthcare provider 8 who is of the opinion that to enhance understanding, healthcare providers speak slowly, repeat and even clarify concerns raised by patients or their caregivers. Simplification is faced by challenges in that in as much as the healthcare providers are able to communicate with the patient, there are ideas that will not be fully comprehended. This is because some of the medical terms lack equivalents in the layman's language or

vernacular. In addition, medical language is considered complex even to the educated people.

Henry *et al.*, (2021) conducted a study on barriers to communicating cancer diagnosis. The study revealed that health workers were unable to translate English medical terms into their equivalents in the local language. They also noted that some of the cancer medical terminologies did not exist in the local language and they concluded that language is a barrier to communication. The findings of the study by Henry *et al.*, (2021) are corroborated by those of the current study which also reveal that cancer terminologies do not exist in the local vernacular. Medical terms like histology, chemotherapy and radiotherapy do not have equivalents in Dholuo language thus healthcare providers resorted to using words that they thought would help the patient understand.

Healthcare providers also advocated for the use of teach back method in enhancing patients understanding. Research shows that teach-back method is more effective than general education in terms of knowledge scores of patients with chronic diseases (Dinh, *et al.*, 2019; Nas, Cayir, & Bilen, 2020). These results are consistent with previous findings which revealed that patients' knowledge retention was improved after the teach-back method intervention (Awuah-Asamoah, 2019; Yee *et al.*, 2016). A contrary view, brought forth by Samuels-Kalow *et al.*, (2016), pointed out that the teach back method is not an appropriate approach for some people with chronic illnesses who are themselves highly health literate.

The third question looked at the extent to which the healthcare provider and patient communication is impacted by the caregiver's role. In the study, some of the patients could only communicate to the healthcare provider through their caregivers or a third party due to language barriers. The interpreter carried out at least two activities namely: understanding the meaning of the source language and reconstructing the meaning understood into the target language. The interpreter not only applies his or her knowledge of the rules (grammar) of the source language, but must also consider the context in which the source language is used. Interpretation is essentially, means an extempore oral reproduction. It involves correctly translating a spoken or signed message into another spoken or signed language after processing, comprehending, and evaluating it (Masduki, 2020). Interpreted communication gives the patient the opportunity to express himself/herself in a language he/she understands and is comfortable with. For patients who did not have a caregiver, the nurses played the role of the interpreter.

The healthcare providers were of the opinion that even though interpreters play an essential role in facilitating communication, interpretation was faced with challenges. Some of the concerns included the cases of extended turns, the un-interpreted and the ignored turns during consultations. According to Healthcare Provider 4, the challenge with interpreter-mediated encounters is that providers are not in a position to control the flow of the conversation as effectively as those carried out in the English language hence, they rely on the interpreter to control or limit the patient's narrative. Healthcare providers rely on the information given by interpreters to make clinical decisions which may not actually reflect the patient's actual position.

While it was essential to provide an interpreter for the patient, it is necessary to consider how interpretation affects privacy and disclosure. In some cases, healthcare providers had to rely on relatives or friends present to translate information to the patient. Some of the interpreters would freely ask the questions to the patients and convey the same information to the doctor/nurse. On the contrary, some conversations were difficult based on the age and relationship of the patient and caregiver. For example, in the case of the diabetic father and his daughter, the latter found it difficult to ask her father personal and medical related information as required by the health care provider. Culture played a significant role in the father-daughter interaction. In the African culture, in this case the Luo culture, there are matters considered private that a daughter cannot freely discuss with the father. According to one healthcare provider, interpretation affected the level of disclosure and also contributed to withholding of information. He said that he had observed that women were not willing to disclose some issues to a male interpreter. It was also difficult for a patient to open up to a total stranger. In some cases, patients had no choice but make use of anyone who was available and willing to interpret. This affected confidentiality. Some patients were also not comfortable with having relatives as interpreters as they feared that they would discuss their conditions with family and friends.

Healthcare providers also raised concerns regarding the interpretation of medical terminology and some of the English words to Kiswahili and mother tongue. They felt that a lot of meaning was likely to be lost in the process of simplification as well as translation. The task of interpretation was also not an easy one. It was clear that most of the interpreters are not trained as a result, they do not give the exact translation as

required. This, in some instances, led to miscommunication while in others it lengthened the consultation time making healthcare providers not to attend to other patients on the queue.

According to Nord (1997), it is expected that translation should produce a text that is meaningful to the target culture receivers. This means that patients should be able to effectively understand the message in the communicative situation, context and culture in which it is received. However, we find that translation is not as simple and as direct as expected since the source or original text and meaning are always interfered with. This is due to the fact that translation not only deals with the words, but also the ideas, world views, cultural norms and moral values that the words convey.

In an attempt to reach the patient, caregivers simplify texts. This process entails simplifying problematic medical terms and expressions. The process of translation is not devoid of challenges. Sometimes, there are words that do not have equivalents in the target language hence affecting comprehension. At other times, the translated message retains the non-translated scientific term for example, cancer. Despite the difficulties encountered, translation is crucial in healthcare provider-patient communication because the use of medical jargon without detailed explanation and translation constitutes a challenge to the patient.

This study noted that the use of medical jargon affected patients understanding and discouraged their participation in the conversations. Patients felt that most of the medical information provided to them were either unfamiliar or complicated terms making it hard to understand details of the disease. In some cases, the translation process failed in its purpose in the sense that the patients' needs were not fully addressed. When the

translators found difficult terms, they at times skipped them yet this could be the word which was key to understanding the message. Healthcare providers equally found it hard to explain certain terms to the patient like hypoglycemia, echo-test, artery, chemotherapy and radiotherapy in the local languages. Interpreted communication denied patients a chance to fully tell their side of the story since it does not encourage dialogue and active participation of the patient. A previous study on vocabulary and medical terms found that patients' limited vocabulary compounded by the physician's overuse of medical terms is the main source of inadequate communication between the patients and healthcare provider (Davis *et al.*, 2000). A study carried out in South Africa revealed that while medical staff spoke English or Afrikaans, many patients spoke Xhosa. Patients had a culture of specific labelling of disease that was quite different from that of healthcare providers. This resulted in misunderstanding and misdiagnosis. Findings from the study indicate that due to limited vocabularies and assumed meanings, patients care was not only affected but could also be compromised. Illiterate patients felt they did not have adequate knowledge about their conditions and were reluctant to ask questions or take active roles in the conversations relating to their treatment (Van den Berg, 2016).

A study carried out in England which was aimed at finding out the nurses' perspective on language barriers noted that language barriers led to missed appointments and/or difficulty in arranging appointments. Nurses felt that patients might not comprehend the reason for appointment and did not understand instructions during care procedures. The study further revealed that language difficulties affected patient's ability to comprehend the treatment regimen and the side effects. Nurses were concerned about provision of

quality care to patients from linguistically diverse backgrounds such as Asia, Europe and non- western countries. These findings are consistent with previous research that explored the influence of language barriers on care provision to patients (Savio & George, 2013, Tay *et al.*, 2012).

Previous research findings suggest that using interpreters to provide language concordant care is not free from limitations as the interpreters are not always aware of medical terminology and may find it difficult to offer explanations to the patients (Bischoff & Hudelson, 2010, Green *et al.*, 2005). Other factors such as the costs involved as well as the state of a patient play a significant role in the failure or success of the interpretation exercise. Ali and Watson (2017) found that communication through an interpreter is not always feasible especially when the patient is under stress, in pain, under medication or anaesthesia. Interpretation is equally time consuming and expensive hence most hospitals in African countries have very few interpreters. This finding is contrary to previous research which suggests that the use of interpreters can reduce the cost of care (Carter-Pokras *et al.*, 2004, Jacobs *et al.*, 2007).

4.8.2 Patients and caregivers' perception on the effectiveness of communication

Patients noted that the hospital visits were beneficial. Through such visits, they were diagnosed and informed about their health conditions and ways of managing the illnesses. Patients were however, dissatisfied with the way some of the healthcare providers broke news about their health conditions to them. Data indicates that caregivers felt that they should be informed about the health conditions of their patients before the news is delivered to the patients. They argued that they were in a better position to deliver the news in a friendly way to the patients so as not to endanger their

health. Some argued that they were the ones to be the first recipients of such news especially in instances where the disease was serious and it would negatively affect the patients. The caregivers mentioned that the patients need to be prepared psychologically to receive the bad news. This finding contradicts the views of Baile and Buckman (2003) who opine that the idea that receiving unfavourable medical information will invariably cause harm is unsubstantiated. They argue that although many patients desire information to enable them make important decisions on the quality of life, others find it quite threatening and may employ forms of denial, shunning or minimizing the significance of the information while participating in the treatment.

Patients had negative feelings due to what they considered improper ways of delivering bad news. They felt that the healthcare providers were not considerate of their feelings and reactions upon receiving information about their health. In the first place, healthcare providers failed to give detailed explanations about the disease and the possible consequences due to the diagnosis.

Patients were of the view that doctors make so many assumptions with regard to the knowledge that patients have about the diseases they are suffering from. According to patient 7, after being diagnosed with cancer, she was told that she needed to undergo a mastectomy without being informed the reason for the procedure, what it entailed and its side effects. The fact that healthcare providers regularly use medical jargon, makes it equally hard for the patients and their caregivers to understand and take part in the conversations.

Based on their experiences (present and past), patients felt that doctors tend to be dismissive of their views or opinions. Some healthcare providers took the queries posed

by patients in bad faith. To them, such queries meant that the patients had doubts about their experiences as well as the treatment they prescribed. The healthcare providers were not willing to share sufficient information. This indicates that the information provided is hardly enough to facilitate effective exchange between healthcare providers and patients hence affecting their relationship and communication. The Uncertainty Reduction theory advocates that healthcare providers should engage patients in open and empathetic communication, actively listening to their concerns and addressing them. There is need to provide patients with accurate and timely information about their conditions, treatment options and management strategies to reduce uncertainty and improve understanding. Patients had the perception that healthcare providers rarely provide a chance for informational exchange.

The patients were of the opinion that there was no conducive environment for shared decision making. Moreover, healthcare providers rarely engaged the illiterate patients in shared decision making. Some patients found it hard to speak up and voice their concerns hence making it difficult to participate in shared decision making. Others were of the opinion that doctors were best suited to make decisions therefore, that role was solely bestowed upon them. They also believed that doctors were better placed to make decisions on their behalf since they are educated, knowledgeable and experienced. Another reason that the patients gave for wanting the doctors to make decisions was the fear of taking responsibility in case something went wrong. It was also evident from the data that patients tended to undervalue their ability to play a role in shared decision making.

Some of the patients believe in the paternalistic role of the doctor. The doctors are held in high regard in the society; they are viewed as having high statuses the reason why they should make decisions which should not be questioned. This finding is similar to a study done in Tanzania which concluded that patients engage in little or no decision making in hospitals (Vedasto et al., 2021). Some doctors held the belief they are the ones who have the authority to make decisions after consulting with fellow doctors and consultants.

The study also noted that patients were hardly involved in the treatment process. One of the reasons advanced for the passive role of patients is that they lacked enough information to make the right choices. Some of the patients and their caregivers reported little or no participation in decision making during the patients' treatment. The patients also revealed that some healthcare providers were reluctant to address the questions raised in relation to treatment. Patients also feared that healthcare providers would get angry when they asked many questions. Some argued that asking many questions would make doctors feel that they do not appreciate their expertise. There is thus the need for patients and their caregivers to be educated on their roles and their rights to decision making. Shared decision making helps in reducing uncertainty in communication hence empowering patients to participate more actively leading to more informed choices and better adherence to treatment plans. It can equally boost patients' confidence in their healthcare providers, promoting a sense of security and reassurance in the care they receive.

Time is also a barrier to decision making. This was mainly due to the high patient ratio as compared to the low doctor ratio. Patients felt that the doctors do not provide adequate information due to time constraints. These findings are similar to those of Vedasto *et al.*, (2021) who concluded that limited consultation time is a barrier in decision making. According to the study findings, patients participated minimally in shared decision making due to time constraints and the doctors heavy work load.

Low literacy levels also affected decision making. According to the doctors, low literacy levels affected the patient's role in decision making. They argued that patients with low literacy levels were reluctant to be involved in the process hence the doctors were forced to decide for them. These findings were similar to a study carried out in Rwanda which indicated that people with limited literacy depended on providers for decision making (Cubaka *et al.*, 2018).

Healthcare providers also found that some patients lacked interest in learning about their health conditions and relied on them to make all the decisions and offer solutions for all their problems. The study findings indicate that shared decision making was not embraced by patients with low educational qualifications/ low literacy levels. Other studies done indicate that regardless of their educational levels, some patients prefer to have physicians guide them in the course of the treatment (King *et al.*, 2011). Some patients preferred that the doctors fully make decisions with regard to their health issues while others opted for the doctors to provide explanations so that they can make informed decisions. This therefore calls for the healthcare provider to make conscious effort to listen to patients concerns (Smith, 2011).

Patients also complained of lack of continuity of care in that they encountered different healthcare providers each time they visited the clinic. This affected the quality of care they received. Regular change of healthcare providers also affected the development of close relationship between the patient and their providers. Patients expressed confusion whenever the instructions provided contradicted those that they had been given earlier.

Patients felt that they needed more information than what was provided. Data also indicates that most of the patients felt that healthcare providers needed to give them details concerning their conditions that is, the cause of the illness, the treatment options and disease management so that they know whether the condition is treatable or chronic hence manageable with the aid of drugs and good nutrition. Patient 8 explained that when he was diagnosed with diabetes, he thought that he would be treated and get well only to learn later that it is a chronic condition. Patients expressed desire for detailed explanations concerning their conditions.

Patients expressed their frustrations due to lack of information or inability to find the information they were looking for. Long waiting periods for appointments and very brief consultations left little time for questions and acquisition of information thereby limiting opportunities for more patient participation and co-production. While patients with chronic conditions have a strong desire for detailed information, doctors often lack the time, knowledge of guidelines, and communication skills to provide it during the limited consultation time available. Improving physician competencies and consultation time are key if the information needs of the patient population is to be met.

CHAPTER FIVE

SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter presents the findings of this research and their implications on healthcare provider-patient communication and the management of chronic illnesses. It presents a summary of the findings, the conclusions and recommendations that were arrived at. It also presents the contributions of the study to the field of communication and implications for policy. In this section, I present summary of findings based on the research questions. The study sought to answer the following research questions: The first question sought to find out the healthcare providers knowledge and attitude towards provision of messages to patients with chronic illnesses. The second question sought to find out how healthcare providers communicate with patients on management of chronic illnesses. The third question sought to find to what extent the healthcare provider-patient communication impacted by the caregiver role. The fourth question sought to find out how patients and their caregivers perceive the communication by healthcare providers in the management of the patients' chronic illness.

5.2 Summary of findings

Based on the first question which sought to find out the healthcare providers knowledge on the provision of information to patients with chronic illnesses, the study established that healthcare providers are knowledgeable based on their training and work experience. They believe that patients need to be provided with information on chronic illnesses to enable them live productive lives.

Reasons advanced by the healthcare providers for providing information to patients include that patients need adequate information to enable them live productive lives. Secondly, provision of comprehensive and understandable information is essential for the promotion of self-management skills e.g. medication management, healthy diet, glucose monitoring and exercise. This prevents complications and improves overall health and well-being of the patients.

In relation to provision of information to patients, some healthcare providers held a contrary opinion. They were reluctant to provide information. Their reluctance is influenced by a combination of factors including the paternalistic model of healthcare. Some healthcare providers argued that decisions need to be made by healthcare providers since they have the knowledge and the medical expertise. Some hold the view that consultations should be done with other consultants. Some providers resist the shift to more patient centred where patients are encouraged to take an active role in their care. They are unwilling to support patient autonomy. Some argue that this affects confidentiality and may negatively affect the patient's health leading to non-compliance. They argued that this was done in the best interest of the patient. For this reason, healthcare providers invoked the therapeutic privilege which gives doctors authority to decide what to disclose or withhold based on whether they think it is useful or harmful to the patient.

Healthcare providers also revealed that although they provided information to patients regarding their health, certain situations determined the kind and amount of information they gave to patients and caregivers. Healthcare providers expressed challenges when communicating with patients and caregivers who are illiterate or semi-illiterate and it

was equally hard confirming that they had understood the message conveyed. The level of development of the disease determined the healthcare providers level of disclosure. If the, they withheld the information if the disease was quite advanced and were more open if the disease was at initial stages.

The second question investigated how healthcare providers communicate with patients and caregivers on the management of chronic conditions. Healthcare providers make efforts to pass messages to the patients and caregivers. Some of the strategies that are employed by healthcare providers in this exercise include the use of explanations, questions, simple language and by making reference to the file. Through explanations, healthcare providers were able to pass information to patients in relation to the management of their chronic conditions. They explained to patients the treatment of the conditions, the expected or modifiable diets, the recommended portions and the complications of the diseases.

Simplified language was also used to ensure that healthcare providers communicate with patients and their care givers. Despite the application of this strategy, some patients were still unable to comprehend what they were being told. Due to language barriers, healthcare providers were forced to make use of interpreters. Interpreters were mainly family members, caregivers or healthcare providers who were willing to play the role of an interpreter. Interpreters facilitated communication thus enabling healthcare providers to make diagnosis and clinical decisions for the patient. The patients on the other hand, got a chance to express themselves.

The third finding is that the interpretation process is usually faced with challenges. In the first place, most of the interpreters are not trained but are picked on the basis of their

willingness and ability to translate from one language to another. Healthcare providers noted that when there is an interpreter, a lot of time is wasted because the consultation process takes longer. Moreover, the exercise affects privacy and confidentiality since healthcare providers are forced to disclose their medical conditions through a third party who could either be a relative or a stranger. Due to lack of mother tongue equivalents for some medical jargon used, there was a difference in the level of understanding of the patients which was contrary to the expectations of the healthcare providers.

Patients found it difficult to follow discussions due to various reasons. One of the reasons was that some of the discussions were held between the caregiver and the healthcare provider with little involvement of the patient. Another reason was because of time constraints; due to time limitations, doctors preferred to be very brief in their discussion. The use of medical terminology was another reason that made it difficult for the patient to understand and be involved in the treatment plan. Patients therefore took a passive role and relegated all authority to the healthcare providers and caregivers.

It was also noted that the translators at times did not fully translate what the patient said. They either summarized what the patient said or in some cases answered on behalf of the patients even before they sought the patient's permission. This affected patient inclusion. The lack of neutrality by caregivers who act as interpreters affects the communication process. Hence, there is a lot that is lost in translation. Language barriers contributed towards misdiagnosis, inappropriate follow up, poor comprehension of prescriptions and poor management of conditions which eventually led to deteriorating health and even death.

Some of the challenges that healthcare providers faced in their communication with patients included the following: heavy work load on the part of the healthcare provider. According to World Health Organization it is expected that the doctor to patient ratio should be 1:1000. However, in Kenya, the doctor patient ratio is estimated to be 1: 6500 this means that one doctor sees very many patients. They hardly have adequate time to attend to patients' needs and inquiries. In addition, the hospital lacks facilities for certain tests and treatments required by the patients. They are therefore forced to refer the patients to other facilities for tests and procedures like radiotherapy, x-ray and echo tests. When this happens, patients and their families incur extra costs and the treatment process is also delayed. Another challenge is the low literacy levels of some patients; Some of them are illiterate or semi-illiterate and the health providers find it difficult communicating with them.

The fourth question sought to investigate how patients and their caregivers evaluate the messages, attitudes and strategies used by healthcare providers. Patients were of the opinion that they lacked privacy especially during the consultation process, a situation that inhibited disclosure. Patients had a preference for doctors who were middle-aged or older as opposed to young doctors. Elderly patients were reluctant to see young doctors whom they likened to their sons or daughters hence did not feel free to disclose their issues to them. Female patients preferred being seen by female healthcare providers. Some patients did not like being treated by healthcare providers they knew so, they preferred those they were not familiar with.

Generally, healthcare providers agreed that there was need to involve the patients in their own care. The difference however, was in the way it was to be done. Patients and

caregivers felt that healthcare providers are dismissive of their views/opinions and did not actively involve them in shared decision making. When patients asked many questions about their health and the medical procedures, some of the healthcare providers viewed them as being too inquisitive or doubting their experience. Out of fear that they will not receive the best care from the healthcare providers, the patients preferred to remain silent rather than ask questions. Patients were also of the opinion that healthcare providers rarely created time for shared decision making. They always seemed to be in a hurry to complete the consultation process.

It was also noted that patients with lower education levels and the illiterate followed the doctors' instructions to the latter without asking questions. Some of the patients did not want to play a role in shared decision making since they believed that it is the healthcare providers who are best suited to make decisions since they are the experts. Some of the patients did not want to be involved in making decisions for fear of taking responsibility if something went wrong.

Low literacy levels are likely to widen power differences between patients and healthcare providers. Some of the patients viewed the power imbalance as legitimate and acceptable. In some cases, there was a high dependency on healthcare providers and patients unquestioningly accepted their ideas and decisions. This attribute was common among patients whose levels of literacy is low. These patients also indicated little or no interest in understanding their medical conditions and related issues. They depended on the healthcare providers or their caregivers for direction or management. Healthcare providers need to be made aware of power imbalance in the patient-healthcare provider communication so that they find an equilibrium which gives patients a chance to actively

participate in their care. There is need to create awareness among healthcare professionals about using language that is simple, familiar and easily understood by the patients.

Some patients were satisfied with the way healthcare providers broke news concerning their conditions to them. Patients were of the opinion that healthcare providers should let them know exactly what they are suffering from. This is because some had a vague idea of what they were suffering from; they lacked finer details of their conditions and did not fully understand. The patients noted that some of their caregivers did not reveal to them their conditions for fear that it would jeopardize their health. Patients and caregivers were of the opinion that healthcare providers did not adequately prepare them before breaking the bad news. They felt these providers lacked empathy when delivering bad news. In some cases, they were not given time to digest the information as the doctor indicated the need to plan for the next procedure.

Due to regular change of healthcare providers, the patients felt that their treatment lacked continuity. Some of the doctors gave contradicting opinions concerning treatment leaving the patient confused. There is therefore a need to ensure continuity of treatment for the patient. Healthcare providers gave inadequate information to patients despite the latter's apparent desire get details about their health conditions.

Healthcare providers should strive to engage their patients by actively involving them in making medical decisions and encouraging them to voice their concerns. Patient involvement would enhance therapeutic treatment. The healthcare providers would enhance patient satisfaction by giving them adequate time to express themselves and listening and addressing their concerns. Additionally, self-help and self-management

would be enhanced by allowing patients to contribute to the conversation about their health. Encouraging the participation of both the patient and care giver is crucial in the management of the patient's condition. The healthcare provider can communicate the goals of treatment to the patient as well as the caregiver. Working with patients and involving them in their own care is likely to lead to better health outcomes.

From the findings of the study, it can be concluded that healthcare providers are knowledgeable based on their training and experience gained. They are aware of the need to provide patients with regarding their chronic illnesses. Several factors determined the amount of information they disclosed or withheld. The doctor's personal decision to either disclose or withhold based on their own evaluation of the patient's condition, their literacy level and level of development of disease. Some healthcare providers held the opinion that they are the experts and should therefore make the decisions.

Findings indicate that healthcare providers used various strategies like simplification, use of questions, explanations and teach back to pass health related information to patients. In addition, caregivers also acted as interpreters. Interpretation faced challenges due to lack of trained interpreters. It lengthened the consultation process and affected privacy; confidentiality due to the presence of a third party. Healthcare providers faced challenges in their communication due to language barriers, heavy work load and limited time. Low literacy levels among the patients also affected the communication.

Patients and care givers were of the view that the consultation process lacked privacy and that they were not involved in shared decision making. They also felt that healthcare

providers did not adequately provide them with information to enable them manage their illnesses.

5.3 Main conclusion of the study

The study concludes that patients felt they did not get adequate information that would enable them to effectively manage their conditions hence there is need for patient-centred communication. There is need to encourage open dialogue and providing opportunities for patients to ask questions can build trust and address concerns, leading to better outcomes and satisfaction.

5.4 Recommendations

From the conclusions of the study, the following recommendations are made:

a) Need for the trainer of doctors to ensure that healthcare providers training and curriculum has the communication skills component. It is essential to train healthcare providers in communication skills that emphasize empathy, active listening and the use of plain language.

b) Need for the Ministry of Health in collaboration with partners to recruit and train medical interpreters. This would ensure every hospital has a pool of competent interpreters in the languages spoken by the majority of patients who visit the hospital. This would enhance patients' comprehension of their conditions hence improve the quality of care and patient satisfaction leading to better clinical outcomes.

c) Need for patient education to be conducted by the Ministry of Health to ensure that patients and caregivers are more informed on matters health. There is need to empower

them so that they can advocate for the rights of their patients. This would also enhance early screening and detection.

d)The Ministry of health should employ more healthcare workers to help reduce the doctor patient ratio hence improve services delivered.

e) There is need for hospital management in collaboration with the Ministry of Health to improve facilities at the hospital especially for tests and treatment. This would make the treatment more affordable to the patients and save time for patients.

f) Need to provide basic health education to caregivers so as to empower them so that they can advocate for the rights of their patients.

5.5 Recommendations for further Study

I would suggest that a comparative study be undertaken in a private and public hospital in order to find out if the findings can be replicated.

5.6 Thesis statement

Patient-cantered communication is crucial for effective management of chronic illness in Kenya. It addresses linguistic as well as cultural barriers ensuring patient satisfaction and improves treatment adherence by fostering trust, empathy and collaborative decision-making between healthcare providers and patients. There is need for healthcare providers to provide understandable information, offer empathy and psychological support. Need to recognize and address socio-economic barriers help patients navigate financial and other practical aspects of chronic illness management.

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APPENDICES

APPENDIX I: INFORMED CONSENT FORM

Dear Mrs, Mr, Miss.....,

I am a doctorate student from Moi University currently conducting research entitled:
Communication experiences of patients and healthcare providers in managing chronic illnesses at one referral hospital in Kenya.

You are requested to take part in the study. However, it is essential that before you decide to participate in this study to understand the reason why the research is being done and what it will involve. I request that you read the information below carefully and if you need any clarification, feel free to ask.

The main objective of the study is to identify healthcare providers' knowledge and attitude towards the provision of messages to patients with chronic conditions. It also seeks to investigate how patients and their caregivers evaluate the messages given and strategies used by healthcare providers in relation to management of the diseases.

Risks: There are no risks involved in participating in this study. If you are not comfortable with any question, you may decline to answer and may terminate your involvement in the study at any time.

Benefits: There is no direct benefit to you for participating in the study as an individual. However, I hope that the information that is obtained from this study will inform the healthcare providers hence improve services.

Compensation: There are no costs that will be incurred for participating in the study and there are no payments that will be made.

Confidentiality: Any information gathered in the duration of the research is confidential and no identifying information will be published without your written permission.

Audio recording: The researcher will use audio recording for the interviews and to ensure confidentiality, she will limit access to the tape.

Withdrawal: That you are free to withdraw from the study at any time.

Voluntary consent by the participant:

By signing this consent form you agree to the fact you have read or it has been read to you and you understand and are willing to take part in this study. The purpose of the research has been explained to you and you have been given an opportunity to ask questions. You also understand that you are free to withdraw your participation in the research at any time.

If you have further questions concerning the research please feel free to contact me through: Claris: Tel-0720839701 Email: clariska3@gmail.com OR the Ethics and Research Committee Jaramogi Oginga Odinga Hospital Tel:

Participant's Initials.

Signed:

Date:

APPENDIX II: INTERVIEW SCHEDULE FOR PATIENTS

INTERVIEW SCHEDULE

Interview Schedule for patients

A. General demographic information

1. How old are you?
2. Which County do you come from?
3. What is the highest level of education you have attained?
4. Which languages do you speak fluently?

Messages and attitudes

1. In which ways has the interaction with the health provider been helpful in managing your condition?
2. What are your views about the language used by the healthcare provider during your treatment? Do you ever seek clarification?
3. In your opinion, how does a doctor's personality or personal attributes affect the way you interact during consultation?
4. Are there instances when you do not feel comfortable communicating with the healthcare provider about some issues? Give examples
5. In what ways does the healthcare provider try to help you understand what he/she is saying in regard to management of your condition?
6. Does the healthcare provider encourage shared decision making with you? If yes, how?
7. Apart from the healthcare provider from which other sources do you depend on for information?

8. Do you find the interaction with your doctor useful with regard to the management of your condition?

9. How easy is it to understand the explanations given by the healthcare provider?

Explain.

10. How often are you given explanations about procedures carried out on you? Do you find the explanations adequate?

11. In your view, how should bad news be communicated to patients/caregivers?

12. How does the doctor or nurse ensure you understand what he/she is saying with regard to the management of your condition?

13. Under which conditions do you withhold information from your doctor?

14. Discuss some of the challenges encountered during your interactions with the doctors

15. In your opinion, do your caregivers understand your condition?

16. In your opinion, what are some of the factors that constrain the communication between patients and healthcare providers?

17. Which issues /topics do you talk about when you have your appointment? Is it different from what you expect?

18. Discuss some of the challenges you encounter during your communication with healthcare providers.

19. Are there instances when you need someone to act as an interpreter during your communication with the doctor or the nurses?

20. When an interpreter is involved, how does this affect your communication with the healthcare providers?

21. How easy is it to understand the explanations given by the healthcare provider?

Explain.

22. How often are you given explanations about procedures carried out on you? Do you find the explanation adequate?

23. In your view, how should bad news should be communicated to patients/caregivers?

24. How does the doctor or nurse ensure you understand what she is saying with regard to the management of your condition?

24. Under which conditions do you withhold information from your doctor?

25. Discuss some of the challenges encountered during your interaction with the doctors

APPENDIX III: INTERVIEW SCHEDULE FOR HEALTHCARE PROVIDERS

1. Please tell me what and how you communicate with your patients.
2. What are the general health information needs of your patients? In your opinion, are patients entitled to be given information concerning their conditions?
3. How do you ensure that the communication between you and the patient meets his/her expectation?
4. How much information do you disclose to the patients and why?
5. How do you ensure that patients are aware of every health risk involved during their treatment?
6. Explain some of the challenges that you face in an attempt to communicate with patients.

b) Questions on healthcare providers' attitude

1. In your view, what is your role during treatment? Does this match with the patient's expectation?
2. Which approaches do you use to encourage shared decision making with the patients you manage?
3. How do you handle patients who demand too much information about their condition? Does this affect the communication you have with them?
4. How do you manage patients who are so informed that they question every procedure undertaken on them?
5. How do you deal with patients who have given up on their condition?
6. In which ways would reliance on information from other sources among patients affect their communication with you?

2. How do healthcare providers communicate with patients on management of chronic diseases?

a) Communication strategies

1. Based on your interaction with patients, how would you describe the information seeking habits of patients?
2. Explain some of the factors that influence the communication style you adopt with a patient.
3. When do you find it necessary to withhold information from a patient?
4. Which kind of information do you withhold?
5. Which kind of information do you disclose to the patients?
6. How do you communicate what is considered to be difficult information to the patient?
7. Do you give reading materials to patients? Are they effective?
8. In your opinion, how should healthcare providers communicate bad news to patients?
9. Under which circumstances do you communicate to patients through their relatives? Is it effective?
10. Do you ever engage in telephone conversations with your patients? How effective is this mode of communication?
11. What is your view on the need for doctors to modify their communication to suit the needs of the patient?

iii) Strategies for overcoming

- a) How do you ensure there is effective communication with your patients with regard to management of their chronic conditions?
- b) How do you ensure that patients get adequate information even when interpreters are involved?
- c) In your view, how can the doctor-patient communication be improved?

Appendix 4: Questionnaire for Caregivers

a) Messages and attitudes

1. In which ways has the interaction with the healthcare provider been helpful in managing the condition?
2. What are your views about the language used by the healthcare providers during the treatment? Do you ever seek clarification?
3. How does a doctor's personality or personal attributes affect the way you interact during consultation?
4. In what ways does the healthcare provider encourage shared decision making with you?

5. Apart from the healthcare provider from which other sources do you depend on for information?

Strategies by healthcare providers

1. How easy do you find it comprehending the explanations given by the healthcare provider? Explain
2. How often are you given explanations about procedures carried out on the patient? Do you find the explanation adequate?
3. In your view, how should bad news be communicated to patients/caregivers?
4. How does the doctor or nurse ensure you understand what he/she is saying with regard to the management of your condition?
5. Under which conditions do you withhold information from your doctor?
6. Discuss some of the challenges encountered during your interaction with the doctors.

APPENDIX IV: A FOCUS GROUP DISCUSSION GUIDE
COMMUNICATION BETWEEN HEALTHCARE PROVIDERS AND
PATIENTS WITH CHRONIC CONDITIONS

Target participants: FGD – Patients with Chronic Conditions

COUNTY _____

INTERVIEWERS'S NAME _____

RESPONDENT'S NAME _____

DATE OF INTERVIEW _____

TIME STARTED _____ TIME ENDED _____

Patients' details

Name	Designation	Age	sex	Marital Status

1. What are the general health needs of patients with these conditions? What are your health information needs?
2. What has been your experience in the interactions held with healthcare providers on the management of your health conditions?

3. What kind of information from healthcare providers helps you manage your condition?
4. Please share your positive and negative experiences in interacting with healthcare providers.
5. What are your views on how you receive communication that helps you manage your health condition?
6. What would you say has been the contribution of effective communication by healthcare providers in management of chronic conditions?
7. Which factors can enhance effective communication during your interaction with doctors/nurses?

APPENDIX V RESEARCH PERMIT

**THE SCIENCE, TECHNOLOGY AND
INNOVATION ACT, 2013**

**The Grant of Research Licenses is guided by the Science,
Technology and Innovation (Research Licensing) Regulations, 2014.**



REPUBLIC OF KENYA

CONDITIONS

- 1. The License is valid for the proposed research, location and specified period.**
- 2. The License and any rights thereunder are non-transferable.**
- 3. The Licensee shall inform the County Governor before commencement of the research.**
- 4. Excavation, filming and collection of specimens are subject to further necessary clearance from relevant Government Agencies.**
- 5. The License does not give authority to transfer research materials.**
- 6. NACOSTI may monitor and evaluate the licensed research project.**
- 7. The Licensee shall submit one hard copy and upload a soft copy of their final report within one year of completion of the research.**
- 8. NACOSTI reserves the right to modify the conditions of the License including cancellation without prior notice.**



**National Commission for Science,
Technology and Innovation**

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CONDITIONS: see back page

APPENDIX VI: AUTHORIZATION I RESEARCH



NATIONAL COMMISSION FOR SCIENCE, TECHNOLOGY AND INNOVATION

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Email: dg@nacosti.go.ke
Website : www.nacosti.go.ke
When replying please quote

NACOSTI, Upper Kabete
Off Waiyaki Way
P.O. Box 30623-00100
NAIROBI-KENYA

Ref. No. **NACOSTI/P/19/16150/31640**

Date: **31st July, 2019.**

Kasamba Claris Kavulani
Moi University
P.O Box 3900-30100
ELDORET.

RE: RESEARCH AUTHORIZATION

Following your application for authority to carry out research on *“Communication intricacies between patients and healthcare personnel on management of chronic conditions: A study of one referral hospital in Kisumu County, Kenya.”* I am pleased to inform you that you have been authorized to undertake research in **Kisumu County** for the period ending **29th July, 2020.**

You are advised to report to **the County Commissioner, the County Director of Health Services, and the County Director of Education, Kisumu County** before embarking on the research project.

Kindly note that, as an applicant who has been licensed under the Science, Technology and Innovation Act, 2013 to conduct research in Kenya, you shall deposit **a copy** of the final research report to the Commission within **one year** of completion. The soft copy of the same should be submitted through the Online Research Information System.

DR. STEPHEN K. KIBIRU., PhD.
FOR: DIRECTOR-GENERAL/CEO

Copy to:

The County Commissioner
Kisumu County.

The County Director of Education
Kisumu County.

APPENDIX VII: RESEARCH AUTHORIZATION II



CS CamScanner

COUNTY GOVERNMENT OF KISUMU
DEPARTMENT OF HEALTH

Telephone: 057-2020801/2020803/2020321
Fax: 057-202433*
E-mail: medsuptrnggh@yahoo.com
ceo@jaramogi-referral.go.ke
Website: www.jaramogireferral.go.ke
When replying please quote

JARAMOGI OGINGA ODINGA TEACHING &
REFERRAL HOSPITAL
P.O. BOX 849-40100
KISUMU

08TH MARCH, 2019

Ref: GEN/21A/V

Date

Claris Kasamba
NAROK

Dear Claris,

RE: PERMISSION TO COLLECT DATA

Following approval of protocol titled "Communication intricacies between patients and healthcare personnel on management of chronic conditions at JOOTRH ", you are hereby permitted to proceed with the activity.

Thank you.


DR. OKOTH PETER
CHIEF EXECUTIVE OFFICER
JOOTRH - KISUMU

CHIEF EXECUTIVE OFFICER
JARAMOGI OGINGA ODINGA TEACHING &
REFERRAL HOSPITAL (JOOTRH)
P.O. BOX 849-40100, KISUMU
DATE: 8.03.2019

PLAGIARISM REPORT

SR839

ISO 9001:2019 Certified Institution**THESIS WRITING COURSE***PLAGIARISM AWARENESS CERTIFICATE*

This certificate is awarded to

*Kasamba Claris Kavulani***SHRD/Ph. Dc/01/13**

In recognition for passing the University's plagiarism

Awareness test for Thesis entitled: **COMMUNICATION EXPERIENCES OF PATIENTS AND HEALTHCARE PROVIDERS IN MANAGING CHRONIC ILLNESSES AT ONE REFERRAL HOSPITAL IN KENYA** with similarity index of 7% and striving to maintain academic integrity.

Word count:51099

Awarded by

Prof. Anne Syomwene Kisilu
CERM-ESA Project Leader Date: 05//05//2025