FACTORS AFFECTING COMMUNICATION BETWEEN PHYSICIANS AND THEIR PATIENTS: IMPLICATIONS FOR HEALTH EDUCATION

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DEDICATION

I dedicate this work to:

the memory of my late father, MAOHUS

my mother, VICTORIA

my wife, EVA and

my daughter LINDA

ABSTRACT

Some of the attitudes of patients towards physicians as well as the sex and age of consulting physicians were studied. An attempt was also made to assess the influence of these attitudes on the satisfaction of patients with services provided as an index of effective communication between physicians and their patients.

This study was undertaken in the General Outpatients Department (G.O.P.D.) of the University College Hospital, Ibadan, Nigeria. The G.O.P.D. serves as the first point of medical contact for the majority of patients reporting at the hospital. One hundred and fifty seven outpatients were interviewed. They were selected by a systematic random sampling procedure over a period of eight clinic days. Every third patient registered for the clinic was interviewed.

The results indicate that the age as well as the sex of consulting physicians have no influence on physician-patient communication during medical consultations. Patients also have certain attitudes towards physicians. These attitudes however do not have any influence on the satisfaction of patients with medical consultations. These attitudes seem to have a socio-cultural basis. This probably arises as a result of the traditional setting where status and age are two respected characteristics. Physicians have at least one or both of these characteristics to their advantage and this could overshadow any

negative attitudes a patient could have had towards the consulting physicians.

The health education implications of these attitudes are discussed and the various ways and means by which some of the attitudes of patients could be modified are proposed. It is suggested that physicians, medical students and other health workers should be given orientation courses on the health-related cultural beliefs of the various people who are likely to consult them.

The major reason for this being that every experience a patient has is educational. Therefore physicians have a great opportunity to help modify the attitudes of patients. Since the face-to-face approach is the best method of undertaking any health education activities, physicians are in good positions to undertake the education of patients on health matters. The main focus of any such health education activities is the patient. However, the community cannot be left out and it is therefore proposed that the mass media as well as the local leaders have a role to play in achieving this.

Finally it is recommended that a study should be carried out to determine the attitudes of physicians to patients as well as to characteristics of patients such as age, sex and educational level. This will help provide an accurate picture of trends of opinions held by both physicians and patients about each other.

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CERTIFICATION

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INTRODUCTION

This is a study of attitudes and perceptions of patients which affect physician-patient communication in the outpatient consulting room setting. Many factors influence the quality of communication between physicians and patients. They include demographic variables, (Mohammed 1964); Cultural differences, (Foster 1956); previous experiences (Green 1976b); patients' health knowledge (Samora 1962); attitudes of patients, (Becker 1974) as well as the attitudes of physicians (Ademuwagun 1972); Broslow 1967).

Communication is one major tool used by physicians to diagnose diseases, prescribe medication and ensure that patients comply faithfully with prescriptions and medical advice. It takes the form of specific questions seeking information about the disease or condition which the patient presents and suggestions to improve the condition. The purpose of communication in Health Education is to encourage positive change or reinforcement in the knowledge, attitudes and practices of people. This presupposes that health personnel (physicians) must have knowledge of what patients know already about health, their attitudes towards health and health-related problems as well as their practices. This change can best be achieved if participants in

common, are knowledgeable about each other and if there is mutual participation in establishing this baseline as well as the goals and programmes of change. The effectiveness of any planned change is directly related to the degree to which there is mutual participation of all persons involved in establishing the baseline and in the formulation and reality-testing of goals and programmes of change, (Benne et. al. 1960).

If communication is defined as a relationship, then we must look at some of the things that go into a relationship. The people with whom we communicate best are the very people with whom we have good relationships. In effect, communication and relationship represent two sides of the same coin, (Kiester 1969). There must be certain things present in any relotionship before effective communication can result. The right "culture" or medium must be present. Mutual trust is one necessary element while the intentions of each partner must also be understood and oooepted, (Kiester op. cit). Both patient and physician must have some awareness of each other since this is o crucial aspect of any relationship. Each of them should be able to identify the couoal factors of any behaviour. Chartier (1974) notes that the more the

the communicator and communicatee know about each other, the more effective and efficient communication is.

The nature of the physician-patient relationship is an important factor in determining whether the patient will comply with instructions and advice. But the relationship is affected by many variables. The first being the demographic one such as age, sex, level of education and social status.

Secondly, culture plays a very crucial role. Do the patient and doctor come from the same culture? Culture, being a common way way of life of any given group of people, involves the sharing of beliefs, value systems, attitudes, behaviour, ceremonies and language symbols. Taboos and superstitions as well as the value systems of a particular culture or subculture reflects on the way people perceive and react to issues and situations. It is therefore quite clear that if the physician and patient belong to different cultures, they may place different emphasis on issues.

Culture is important since needs, as values, are meaningful when they are considered within the cultural setting. It is important that professional people working with a target group recognize those values in order to fit into the mainstream of the community's

value system. Cassel (1955) pointed out that a thorough understanding of local ways and values is essential if lasting results are to be achieved.

A patients' personal experiences also affect his relationship with the physician. The way people perceive clinical diagnosis and treatment depends, among other things, on past experiences which in turn determine beliefs, cognition and perceptions. A patients' past experience at one hospital or clinic may encourage him or, on the other hand, discourage him from having anything to do with hospitals and clinics.

An attitude may be defined as an inter-related set of opinions organised around a point of reference (Lewis 1938), the elements involved being underlying beliefs. These underlying beliefs are simple propositions, conscious or unconscious, inferred from what a person says or does, capable of being preceded by the phrase "I believe that...." An attitude predisposes one to make a preferential response and avoids the implication that the response is either affective or evaluative. It may, and usually does, involve both (both positive or both negative), or it may be a separate assessment of affective and evaluative predispositions underlying the response. A favourable or unfavourable attitude toward physicians not only predisposes the person to respond preferentially to a physician when

they come into contact, but also to all others who take an attitudinal position with respect to such a physician. Finally, the preferential response may be directed towards the maintenance or preservation of the attitude itself. A person with a particular attitude is predisposed selectively, to perceive, recognize, judge, interpret, learn, forget, recall and think in ways congruent with his attitude. Such selective responses, while mediated by an attitude, are not necessarily responses directed towards the attitude object or situation itself.

How a person will behave with respect to an object-within-a-situation will depend, on the one hand, on the particular beliefs or predispositions activated by the situation. It could therefore be postulated that a persons' social behaviour must always be mediated by at least two types of attitudes - one activated by the object, the other activated by the situation. This implies that the two (attitude towards object and attitude towards situation) will have different degrees of importance with respect to one another, thereby resulting in behaviour that will be differentially influenced by the two kinds of attitudes. In one case an attitude object may activate relatively more powerful beliefs than those activated by the situation, thereby accounting for the generality of behaviour with

respect to an object. On the other hand, the situation may activate the more powerful beliefs, thereby accounting for the specificity of behaviour with respect to an attitude object. It has been suggested that certain situations, because of the greater social pressures inherent in them, consistenly activate discriminatory behaviour towards a specific attitude object more than do other situations. (Campbell 1963).

The content of a belief may describe the object of belief as true or false, correct or incorrect; evaluate it as good or bad; or advocate a certain course of action or a certain state of existence as desirable or undesirable. Whether or not the content of a belief is to describe, evaluate or exhort, all beliefs are predispositions to action. An attitude is thus a set of interreloted predispositions to action organised around an object or situation.

Each belief has three components: a cognitive component because it represents a persons' knowledge; an affective component because under suitable conditions the belief is capable of arousing affect of varying intensity centering around the object of belief; taking a positive or negative position with respect to the object of belief and finally a behavioural component, because the belief being a response predisposition of varying threshold must lead to some action when it is suitably activated. The kind of action it leads to is

strictly dictated by the content of the belief.

What all this means is that patients are likely to hold certain beliefs about certain issues as they come for consultation. They will therefore have certain attitudes towards both physician (object) and clinic (situation). The attitudes of patients are therefore likely to determine the nature and quality of their communication with the physician. These attitudes are influenced by the expectations of the patient as well as his past experiences. These past experiences result from his contact with other patients as well as other physicians and influence his expectations as well.

What this study has tried to do is to determine what some of these beliefs are. This will give some idea of what the cognitions and perceptions of patients are. With this as a foundation or background, an assessment of some of the attitudes of patients can be made since cognition and perceptions of an individual affect his attitudes and therefore his behaviour (Ademuwagun 1972).

It may be necessary to ask why it is important to know the attitudes of patients towards physicians and the clinic. The reason is that the ultimate positive sick role behaviour is compliance with regimen (Becker 1974). This compliance is influenced or affected by a number of factors including the attitudes of the patient. It is also necessary that planners and

providers of health care know the needs, interests, moods, feelings, beliefs, problems and expectations of the consumers (patients), since attitudes embrace all the above subfactors, (Ademuwagun 1972). This will enable them to plan for the health care delivery system in order to achieve maximum results. Finally, medical students need to be aware of these attitudes so as to enable them predict the behaviour of patients and be in a better position to handle such situations.

Chapter one reviews literature relevant to the study. Factors affecting communication between physicians and patients are identified. These include perceptions, expectations, patients' health knowledge, anxiety, physician-patient relationship, social status of both physician and patients, their demographic variables and culture. Two models which show the inter-relationships between factors which influence positive sick role behaviour are constructed and explained. The models also show the central nature of physician patient communication and how it is influenced by the above mentioned factors and how physician-patient communication influences compliance with regimen.

Chapter two describes the systematic interviewing of patients in the general outpatient department of the University College Hospital where the study was conducted. The study was limited to assessing the

attitudes, beliefs and perceptions of patients which might influence communication between physicians and patients and not the whole communication process. The data, which was collected by means of an interview schedule, was used to test hypotheses relating socio-demographic factors with preconsultation attitudes and these same attitudes with post-consultation opinions related to satisfaction with the service.

The results are presented in Chapter Three. The findings are analysed and discussed in Chapter Four. The implications of the findings for health education are also discussed in this same Chapter. In the light of the findings, recommendations are made on how to overcome or circumvent these attitudes. Also, recommendations for future research are made.

CHAPTER ONE

AN OVERVIEW OF FACTORS INFLUENCING PHYSICIAN-PATIENT COMMUNICATION

Introduction:

Various models have been put forward to explain the factors and their inter-relationships that determine and influence compliance with regimen. Two of these models are explained in the attempt to throw a clearer picture on why some patients comply with regimen and others do not. The central role played by physician-patient communication is clearly evident, as were factors that influence this communication, such as anxiety, culture, expectations, physician-patient relationship, attitudes of both patients and physicians, perceptions, social status of both patients and physicians, potients' health knowledge and demographic variables.

1.1. MODELS OF HEALTH BEHAVIOUR

1.1.1. The Health Belief Model

Becker proposes that the ultimate positive sick role behaviour is "compliance with prescribed regimen." This compliance comprises either all or some of the following: faithful taking of drugs; strict adherence to diet and exercise; regulation of the patients' personal and work habits; following up tests and keeping up referals and appointments; and finally entering or continuing a treatment programme. (Becker 1974).

Three broad factors determine whether a person will be ready to undertake sick role behaviour. These are Motivation; Value of the reduction of illness threat and the Probablity that compliant behaviour will reduce the illness threat (see Figure 1.1.). A number of Modifying and Enabling factors affect the readiness of the person to undertake sick role behaviour as outlined in Fig. 1.1. The Modifying factors are demographic; structural; attitudinal and interactional. It should be noted that the factors which determine the patients' readiness to undertake sick role behaviour also influence the Modifying and Enabling factors. Since it is important that the patient complies with the regimen, there is the need to harness all the positive aspects of the Modifying and Enabling factors to ensure that a patient complies with regimen. It is very important, therefore, that some of these be looked at to throw some light on why patients behave the way they do.

FIG. 1.1.

SUMMARY OF HEALTH BELIEF MODEL FOR PREDICTING AND EXPLAINING SICK ROLE BEHAVIOUR

READINESS TO UNDERTAKE SICK ROLE BEHAVIOUR

MOTIVATION

Concern about health matters in general
Willingness to seek and accept medical direction
Intention to comply
Positive health activities

Value of reduction of illness threat

Subjective estimates of:
Susceptibility or resusceptibility (including belief in diagnosis)
Vulnerability to illness in general
Extent of possible bodily harm
Extent of possible interence with social roles.
Presence of (or past experience with) symptoms

Probability that compliant behaviour will reduce the threat

Subjective estimates:
The proposed regimens' safety
The proposed regimens' efficacy (including "faith in doctors and medical care" and chance of recovery

MODIFYING AND ENABLING FACTORS

Demographic (very young or old)
Structural (cost, duration, complexity, side effects, accessibility of regimen, need for new patterns of behaviour).
Attitudes (satisfaction with visit, physician, other staff clinic Procedures and facilities).
Interaction (length, depth, continuity, mutuality of expectation, quality and type of physician-patient relationship; physician agreement with patient, feedback to patient).
Enabling (Prior experience with action, illness or regimen, source of advice and referal.)

SICK ROLE BEHAVIOURS

Likelihood of:
Compliance with prescribed regimen (e.g. drugs, diet, exercise, personal and work habits, follow up tests, referals and follow up appointments, entering or continuing a treatment programme.

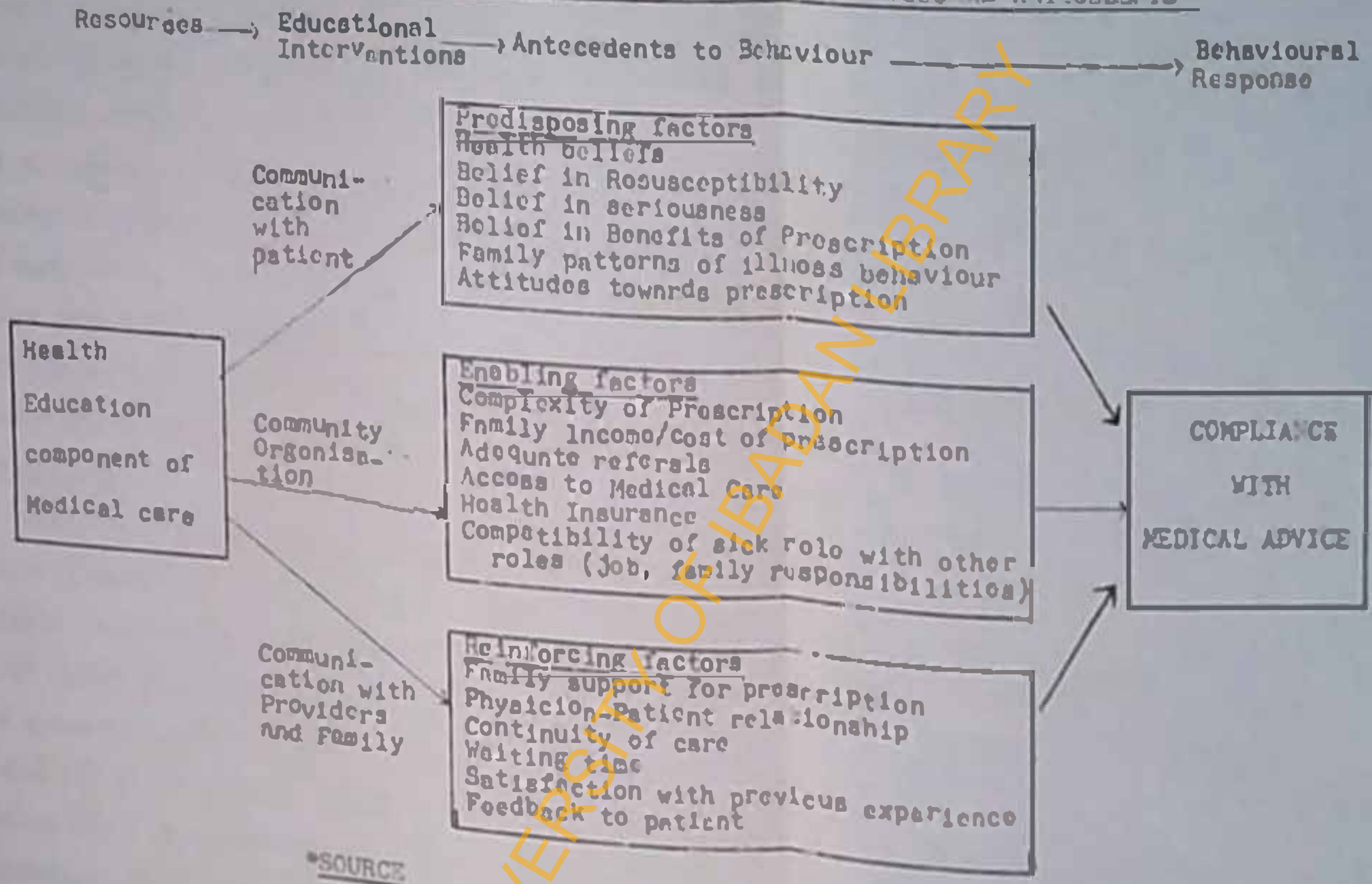
1.1.2. Green's Model

A slightly different model showing the relationship between compliance with regimen and its behavioural antecedents' has been proposed by Green (1976b). The model proposes that resources are utilised through educational interventions which may lead to compliance (which is the behavioural response). Certain predisposing; Enabling and Reinforcing factors affect the behavioural response. The physician-patient relationship as well as satisfaction with previous experiences are reinforcing factors while the individual's health beliefs (which determine his attitudes) and attitudes toward prescriptions will, among other things, determine his predisposition to action (Fig. 1.2).

1.2 FACTORS INFLUENCING PHYSICIAN-PATIENT COMMUNICATION

Experience shows that when health personnel physicians, nurses, health educators, sanitorians etc. - work with people of their own general, social and economic background, they accomplish more. In part, this is because they are able to "communicate" effectively. Practitioner and patient are able to understand the nature of the problem and each other with a minimum of difficulty, (Foster 1956). As differences in social and economic backgrounds become

Fig. 1.2 RELATIONSHIP BETWEEN COMPLIANCE AND ITS BEHAVIOURAL ANTECEDENTS*



*SOURCE

GREEN, L.W. and D. Roter, (1976b)

Anxiety level may be related to the seriousness of the

more pronounced, patient and practitioner have greater difficulty in communication and in understanding what the other person wishes to do.

Communication difficulties mean much more than simple language differences; they stem from the very different premises on which the outlook and understanding of people of diverse backgrounds are based. Whether we are dealing with physician and patient, public health nurse and mother or health educator and audience, there are at least two individuals who are interacting with each other. To a very great extent, the success of this interection reflects the extent to which the participants have learned the behavioural and expectation patterns of each other.

1.2.1 Anxiety

There is a great deal of anxiety during physician-patient interaction, (Jacobs 1971). This is due to the patients' feeling of helplessness and ignorance. The clinic visit is a potentially stressful situation for many patients and parents of patients as well. A person who is already not in distress over a presenting problem may become worried or anxious when faced with a previously undetected condition, (Jacobs op. cit.); (Korsch et. al. 1972).

Since the clinic visit can be stressful, it is important to examine the reactions of patients. Anxiety level may be related to the seriousness of the

condition, (Glaser et. al. 1961), or it may depend on individual differences. As an independent variable, anxiety has been found by some to be helpful in learning situations (Lazarus et. al. 1952) while others have found that a high degree of initial anxiety can create resistances to communication, (Janis et. al. 1962). As a dependent variable, anxiety level has been found to decrease with improved communication.

Skipper (1964a) tried to determine what communication means to patients. He realised that in any culture, illness brings about a degree of fear and anxiety to the stricken individual. His expected behaviour changes and this results in problems for the physician as well.

1.2.2. Culture

In India, regardless of what the curer or local healer believes, he must reassure the patient and his family even when it is clear to all parties that the patient will be dead in half an hour. This reassurance proves tothe family that the healer knows his business, (Foster 1956). A doctor trained in Western Medicine who jolts the emotions of the patients' family with the obvious truth will not be accepted easily. This illustrates a general proposition: When medical practice involves individuals from different cultures, what is done or attempted by those in the healing role may not be fully nor correctly interpreted by those in

the patient role, (Foster op. cit.) Various studies also show that when persons of different cultures are involved in a medical relationship, the goal of this relationship is more readily achieved under the following conditions:

a. When the healer is aware of the cultural premises upon which he operates and particularly when he grasps the significance of his culturally conditioned role and role expectations;

b. When the healer knows something of the cultural premises and role expectations brought into the relationship by the patient, (Foster op. cit.)

Therefore in working with people of different cultural backgrounds from ones own, there is no single set of rules that makes for success. Patience, sympathy and understanding are basic. It is important that the physician appreciates the cultural implications of the patients' behaviour. Sympathising with and understanding for the patient are necessary because the patient unconsciously behaves in a manner that is a true reflection of his or her needs and interests. Beyond this, awareness of the nature of one's own role and enough knowledge of the other person's culture, so that his concept of role

behaviour can be grasped, have been found to be useful in promoting effective communication.

One of the obvious principles of human communication is that the transfer of ideas occurs most frequently between a source and a receiver who are alike in the following characteristics: age; sex; level of education; social status and also have similar cultural backgrounds, (Rogers et. al. 1971). "Better communication" occurs when source and receiver are homophilous and their communication is rewarding to those involved in it, homophily being the degree to which an interacting pair are similar in certain attributes. In the free choice situation, when a source can interact with any one of a number of receivers, there is a strong tendency for him to select a receiver who is most like himself. This situation arises because the more similar they are in certain characteristics, the more likely it is that they will understand each other. To a great extent, similar individuals are more likely to belong to the same groups, to live near each other and to be drawn by the same interests. In effect, "more effective" communication occurs when source and receiver are homophilous, (Rogers op. cit.).

Problems arise when they do not share common meanings, a mutual subcultural language and are not alike in social and personal characteristics. On the other hand, if they share these characteristics, the communication of ideas is likely to have greater effects in terms of knowledge gain, attitude formation and change as well as overt behaviour change. One of the distinct problems in the communication of innovations is that the source is usually quite heterophilous to the receiver. This frequently leads to ineffective communication because heterophily leads to message distortion, (Barlund et. al. 1963).

The more communication there is between an interacting pair, the more likely they are to become homophilous; the more homophilous they are, the more likely it is that communication will be effective. Therefore, homophily may be the result of interaction or the basis of choice of those with whom one interacts, (Lazarsfeld et. al. 1964). As a result, individuals who break the homophily barrier (or boundary) and attempt to communicate with others quite different from themselves are beset with the frustrations of ineffective communication. This is likely to manifest itself to a considerable degree in the consulting room. Aside from that, differences in technical competence, social status, attitudes and

and beliefs all contribute to heterophily in language and meaning, thereby leading to messages that go unheeded.

One approach to decrease heterophily and thereby facilitate more effective communication is to raise the technical competence level of clients. This is almost impossible. It also appears that in some "helping" professions, some change agents work hard to maintain a "safe distance" from their clients in technical competence and social status, (Rogers et. al. 1971).

1.2.3. Perceptions of patients

A problem which the change agent faces, especially when dealing with heterophilous clients, is that they perceive his role quite differently from the way he perceives it. For instance, the change agent may perceive himself as a primary disseminator of information and technical expertise. This self image may contrast with the client's perception of the change agents' role; they may see him in terms of his ethnic background, age, education, marital status or other personal characteristics as well as his technical ability. Obviously, it is how the clients perceive the change agent that matters most in explaining his success or failure to reach them, (Rogers et. al. 1971).

The patients perception of the practitioner's concern and competence appear to be important. Patients are more likely to be more "non-compliant" if their expectations in seeking care are not met, if they perceive lack of warmth in the practitioner or if they fail to receive an explanation of their illness, (Francis et. al. 1969); (Korsch et. al. 1968).

1.2.4. Expectations of patients

The patient on entering hospital may have some idea of what staff expect of him but cannot be too sure of what these expectations are. Sometimes the physician may even limit his communication in order to protect himself from ever having to admit a mistake in diagnosis, (Skipper et. al. 1964b).

Stimson (1974) views patients' "defaulting" as a function of the patient's expectations of the physician and emphasizes the social context in which illnesses are lived and treatment used. Other investigations have linked non-compliance to the physician's failure to communicate the purpose of treatment, (Mohler et. al. 1955); (Wilson 1973); or the need for follow up treatment (Becker et. al. 1974). Other studies also show positive correlations between satisfaction of patients (with the visit, the therapist or the clinic) and compliance (Becker op. cit.); (Diamond et. al. 1968); (Korsch op. cit.).

One important issue is the patient's satisfaction with the care and information provided. Patients have reported satisfaction even though they did not understand the medical information (De Castro 1972); (Ordonez Playa 1968). However, other studies (Cartwright 1964); (Korsch op. cit. 1968) have found that patients were most satisfied when they felt they had received adequate information. It could well be that patients' perceptions of adequacy of information may be more important than how much they really remember.

On the other hand, what the patient tells the physician is influenced, for example, by what cues and interests he perceives and thus what he thinks that the physician wants to hear. What the physician wants to hear is, in turn the product of his (the physicians) own background, training and specialty orientation, (Zola 1963).

1.2.5. Physician-patient relationship

As a result of the large numbers of patients seen in the course of a clinic day, time is often too short for a relationship to develop between the physician and the patient. Even if the physician takes the time to discuss the implications of the case with the patient, a different physician may see the patient at the next visit and the process must

begin again, (Rupst et. al. 1975). Patterns of communication which deviate from the normative Physician-patient relationship will be associated with the patients' failure to comply with the physicians' advice; such deviations include circumstances where tension in the interaction is not released and where the physician is formal, disagrees completely with the patient or interviews the patient without subsequent feedback, (Davis 1968). Similarly, Gouldner (1960) noted that non-compliance was more likely with less reciprocal interaction between patients and physicians.

1.2.6. Social status of physicians and patients

Barriers to effective communication between physician and patient arise out of a number of factors including those

> ...associated with social class or ethnic group membership and in the different role expectations patients and physicians may have of themselves and each other. (Sanora 1961).

Also the professional health worker has particular norms with which he is identified. He feels compelled to identify himself with the norms of his reference group if he does not want to become an outcast (Ademuwagun 1972).

1.2.7. Patients' health knowledge

Some problems may arise from differences in technical knowledge and language between health

professionals and their patients, (Wessen 1965). Very often health professionals judge this disparity improperly and inaccurately, either that the patient knows absolutely nothing about human anatomy, physiology and medicine or that he understands correctly the professional jargon used and the advice given.

Samora (1962) conducted health knowledge tests about specific diseases on four different population samples. These samples included in-patients, out-patients and members of representative community population groups. Selected findings were:

a. age alone was not a significant factor with respect to ability to perform well on a such a test;

b. ethnicity was not a significant factor in health knowledge except when cultural differences were substantial;

c. the higher the educational level, the higher the knowledge scores obtained;

d. socio-economic status per se was not clearly related to health knowledge - the educational component was the key variable.

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d. socio-economic status per se was not clearly related to health knowledge - the educational component was the key variable.

In the light of the above findings, be concluded that the knowledge a patient possesses with respect to health can be an important factor in physician-patient communication and that awareness of a low level of knowledge (and the social factors with which it is associated) may be important in securing effective communication between patients and physicians.

A comparative analysis of diabetic patients on good, poor and very poor control was done by Ellis (1964) as a basis for determining educational needs of the patients. The major finding was that knowledge about diabetes varied inversely with the level of control. Also, statistically significant relationships were found between knowledge and the following variables: age, sex, race and education.

1.2.8. Demographic variables of physicians and patients

In his study of barriers to effective communication, Samora (1962) isolated some of the factors associated with observed differences in levels of understanding among in patients in a public general hospital. Findings suggest that there is the possibility of misunderstanding or non-understanding on the part of the patient due to vocabulary deficiency. He therefore, concluded that the probability of misunderstanding is increased in patients with little formal education who come

from a low social class environment and who speak a language other than that used in local medical conversation.

Patients understanding of written health information was the focus of a study by Mohammed (1964). She found out that the lower the age of the patient, the higher the test score and no significant differences existed between the sexes. The amount of formal education appears to be the best predictor of comprehonsion of written materials.

1.3. SUMMARY

Two models, showing the relationship between factors that determine and influence compliance, are used to throw a clearer picture on the central nature of physician-patient communication in determining and influencing compliance with regimen. Factors that affect physician-patient communication include anxiety, perceptions, expectations and health knowledge of patients, the physician-patient relationship, social status of physicians and patients, culture and demographic variables. These interweave to determine the attitudes of patients. An attitude could be defined as an inter-related set of opinions organised around a point of reference, (Lewis 1938), the major elements involved being underlying beliefs which depend on his previous experiences, expectations and relationships with other people. Therefore a persons' attitudes (a summation of his beliefs) will influence his relationship and consequently his communication with the physicians. Eventually the nature of the physician-patient communication will in conjunction with other factors, influence the patients' compliance with regimen.

The foregoing literature review clearly shows the extent to which various factors determine and

influence physician-patient communication which, in turn, has a bearing on whether a patient will comply with regimen or not. Although there are no records of studies of attitudes of patients and their effects on physician-patient communication, the very nature of attitudes indicates a strong possibility that they could adversely affect or influence the physician-patient communication and subsequently compliance with regimen. Some of the various ways and means by which attitudinal effects could manifest themselves are set as hypotheses in the next chapter. But whether these attitudes exist and how they exert an influence on the physician-patient communication will soon become evident.

CHAPTER TWO

THE STUDY

2.1 Purpose of the study

In the preceding chapter, various studies involving factors affecting doctor-patient communication were reviewed. Briefly these factors are the anxiety, perceptions and the health knowledge of the patients, as well as the physician-patient relationship, the social status of the physician and patient, their demographic variables and culture. By and large they contribute immensely towards the types of attitudes patients' may have. It has also been shown that the attitudes of patients affect the nature of the physician-patient communication. These attitudes also influences his expectations and eventually both, in conjunction with the physician-patient communication, will determine the patient's satisfaction with the visit and ultimately, compliance with regimen.

In many health and medical facilities, information on the demographic, personal and social characteristics of patients are recorded but it is doubtful whether these are used extensively to ensure good physician-patient relationships as well as to facilitate physician-patient communication. In Yoruba culture, where this study took place, the young are expected to accord the highest possible respect to the elderly. With the rather poor physician-

patient ratio, it is impossible to employ only Yoruba-speaking physicians who would be aware and conscious of the intricacies of Yoruba culture. Neither is it possible to control for other socio-demographic variables so that it is not impossible that some of the cultural norms will be infringed. For a patient who is consulting for the first time, this would be a disconcerting experience. There is the need therefore to ascertain what the attitudes of patients are.

As noted in the last chapter, one approach to decrease heterophily is to increase the technical competence level of clients. This is impossible in the present circumstances. An alternative solution is to raise the technical competence level of physicians. This is precisely where this study falls into place. By assessing the attitudes of patients and the potential influence these could have on the physician-patient communication, strategies could be worked out to eliminate the adverse effects of these attitudes. These strategies could involve inputs into the medical curriculum in such a way that physicians will become aware of the potential influence attitudes could have on the outcome of a patient's visit and be in a position to steer around the problem. It is impossible that a patient will be assigned to a physician of his own sex, age group or social status, etc. But if physicians are made aware that overlooking these differences could lead to a distraction of the effort they put into their work, a useful step would have been made

in the direction towards achieving a healthier nation and therefore increased productivity.

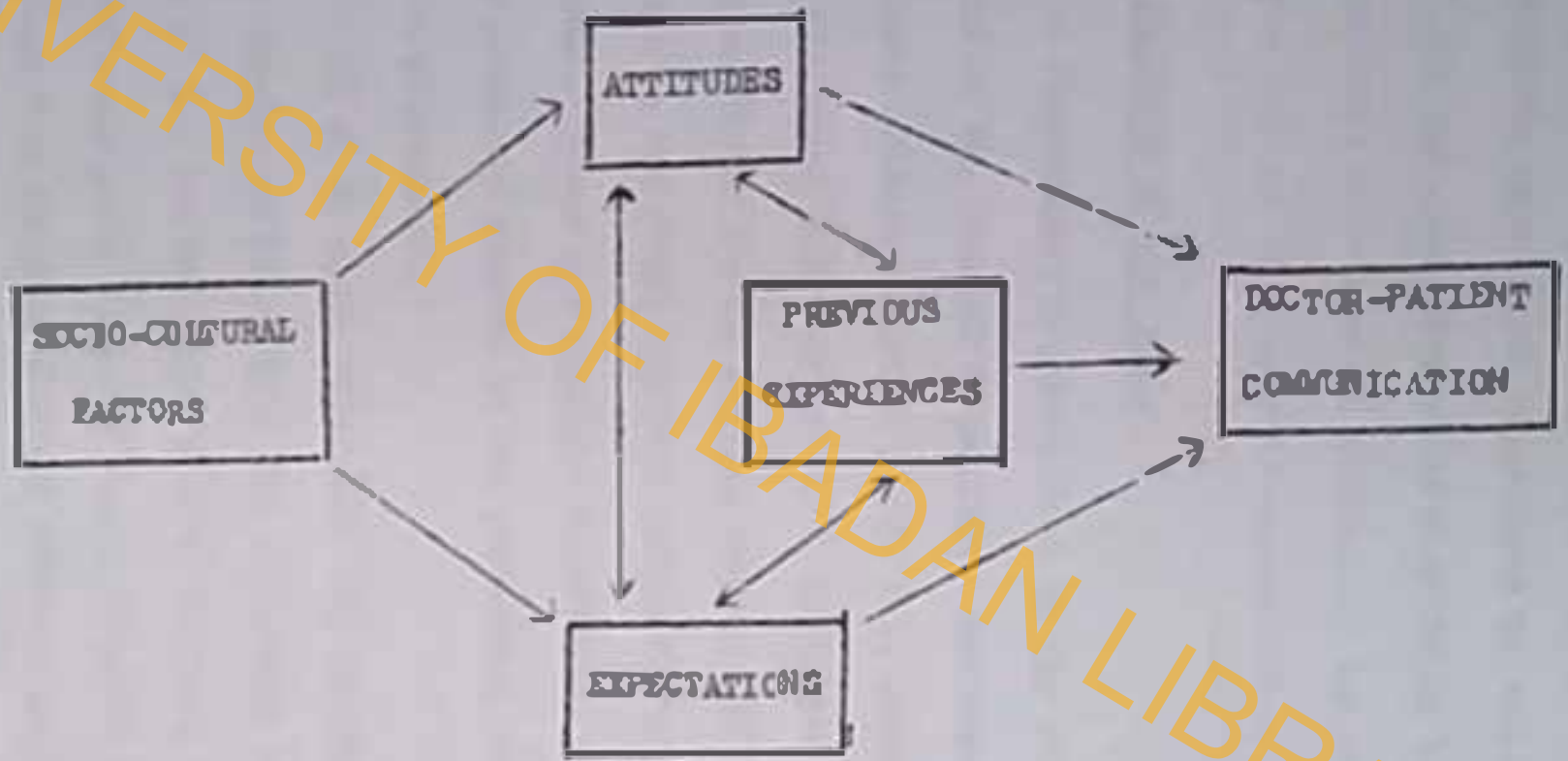
2.2 Scope of the study

This study looked at how the attitudes of patients towards physicians are influenced by certain characteristics of physicians and patients, such as sex and age. It also investigated in what way those attitudes could influence satisfaction of patients during medical consultations.

Figure 2.1 illustrates in simple diagrammatic form how various factors could influence physician-patient communication. Attitudes of patients towards physician-patient communication depend on socio-cultural factors, likewise certain personal characteristics of the physician could also influence the attitudes to sickness and health care. All these factors determine to a large extent the expectations of patients which could have a reciprocal effect on their attitudes. The patients' past personal experiences as well as their expectations affect their attitudes. Both attitudes and expectations are influenced by socio-cultural factors. All three (i.e. attitudes, expectations and previous experiences) influence the patients and determine the success of the physician-patient communication.

FIGURE 2.1

FACTORS AFFECTING PHYSICIAN-PATIENT COMMUNICATION



This study was designed to find out what perceptions and attitudes patients have about physicians in relation to the physicians' sex and age. The study also tried to identify what attitudes patients have towards physicians and how these could influence the outcome of a medical consultation.

2.3 Location of the study

All the respondents who took part in the study were patients who reported at the General Outpatients Department (G. O. P. D.) of the University College Hospital (U. C. H.), Ibadan during the period the study was being undertaken. U. C. H. is the Teaching Hospital of the University of Ibadan Medical School. It is a 512-bed hospital and is the final referral centre for all patients in and around Ibadan. There are nineteen departments within the hospital and these are currently staffed by 228 physicians ranging from House Officers to Professors.

The G. O. P. D. where this study was undertaken is staffed by eleven physicians (Table 2). The physicians comprise the Head of the G. O. P. D., one Principal Medical Officer, two Senior Hospital Medical Officers grade I, three Senior Hospital Medical Officers grade II and four Hospital Medical Officers grades I and II.

TABLE 2.1

PHYSICIANS AT POST IN THE GENERAL OUTPATIENT DEPARTMENT AS AT FEBRUARY 28, 1979*

	ESTABLISHMENT	ACTUAL	VACANCIES
Head of Department	1	1	-
Principal Medical Officers	2	1	1
Senior Hospital Medical Officers Grade I	4	2	2
Senior Hospital Medical Officers Grade II	4	3	1
Hospital Medical Officers Grades I and II	5	4	1
Total	16	11	5

*Source: Medical Records, U. C. H.

The physicians work in two shifts: morning and afternoon. The morning shift commences at 7.30 a.m. and ends at 3.00 p.m. This shift is run by eight (8) physicians. Six (6) of them perform actual consultation while the Head does mainly administration and handles emergencies while the remaining one (1) screens the malnutrition cases. The three (3) other physicians run the afternoon shift as well as being on call. Of the six consulting physicians, two are males and four are females, (Table 2.2).

They are made up of two Ghanaians (one male and one female), one Sierra Leonean (female), one Indian (male) and two Nigerians (females who are Yoruba speaking).

Method of communication between physicians and patients at the G. O. P. D.: At the University College Hospital, because of the diversity in the nationality of physicians working there, a group of female health workers are employed who are Yorubas and have a basic primary school education and speak Yoruba and English fluently. These women act as interpreters between the physicians and especially the non-Yoruba speaking physicians and their patients. These female interpreters had been trained in the translation of medical terminologies and had been employed in the U. C. H. for many years.

As only two of the six consulting physicians at the G. O. P. D. are Yoruba speaking most of the communication that take place between the physicians and the patients pass through the interpreters.

TABLE 2.2

SEX DISTRIBUTION OF C. O. P. D. PHYSICIANS*

SHIFT	FUNCTION OF PHYSICIAN	SEX	
		MALES	FEMALES
MORNING	Administration/ Emergencies	-	1
	Malnutrition screening	-	1
	Consultation	2	4
AFTERNOON	Emergency/Call	2	1
Total		4	7

*During February 1979.

In 1978 (January to December) a total of 45,824 patients were seen at the General Outpatient Department, (Table 2.3) while in February 1979, a total of 2,847 patients were seen over 23 clinic days. (Table 2.4)

TABLE 2.3

ATTENDANCE AT THE GENERAL OUTPATIENT DEPARTMENT, U. C. H. (JAN. 1978 - DEC. 1978)*

MONTH	NO. OF CLINIC DAYS	NEW PATIENTS	TOTAL G.O.P. ATTENDANCE	AVERAGE ATTENDANCE PER CLINIC DAY **
Jan. 1978	26	2,179	4,331	167
Feb. 1978	23	1,635	3,439	150
Mar. 1978	25	1,669	3,638	146
Apr. 1978	25	1,641	3,190	128
May 1978	27	1,483	3,237	120
June 1978	26	1,650	3,414	131
July 1978	26	1,907	4,142	160
Aug. 1978	27	2,369	5,046	187
Sept. 1978	23	1,669	3,865	168
Oct. 1978	26	1,719	3,987	153
Nov. 1978	23	1,521	3,698	161
Dec. 1978	24	1,618	3,843	160
Total	301	21,080	45,824	153

* Source: Medical Records, U. C. H.

** To nearest whole number

TABLE 2.4

ATTENDANCE AT THE GENERAL OUTPATIENT DEPARTMENT, U.C.H. (JANUARY AND FEBRUARY 1979)*

MONTH	NO. OF CLINIC DAYS	NEW PATIENTS	TOTAL G.O.P. ATTENDANCE	AVERAGE ATTENDANCE PER CLINIC DAY**
Jan. 1979	26	1,738	3,819	147
Feb. 1979	23	1,379	2,847	124
Total	49	3,117	6,666	136

2.4 Objectives of the study

a. To determine some of the attitudes of patients towards physicians;

b. To assess the influence of such attitudes on patient satisfaction with services as an index of effective communication;

c. To determine the health education implications of those influences;

d. To propose educational strategies that could help in minimising the possible adverse effects of those influences and thereby promote better communication during medical consultation.

In order to carry out the first two objectives, the following relationships were studied:

a. The attitudes of patients towards sex of doctor in relation to sex as well as age of patients;

b. The attitudes of patients towards age of doctor in relation to sex as well as age of patients;

c. The satisfaction of patients with the medical consultations in relation to the sex of the doctor, (by sex and age of patients);

d. The satisfaction of patients in relation to attitudes of patients towards sex of doctor matched against sex and age of patients.

2.5 Materials and Methodology

This study was a descriptive and opinion research one. A questionnaire/interviewing schedule was used (see Appendix).

2.5.1 Selection of sample

All the respondents were patients who reported at the General Outpatient Department of U. C. H. during the period of the study. The General Outpatients Department was selected because it afforded the opportunity of coming into contact with a variety of patients with varied health problems. It also serves as the first point of contact with medical personnel for the majority of patients. Although a sample size of two hundred patients was originally proposed for the study, only 157 patients could be interviewed for reasons which will be explained later. An average of twenty interviews per clinic day were conducted for eight days in February 1973 using a systematic random sampling procedure. Every third patient registered for the clinic was interviewed. These patients were later distributed among six physicians for consultation.

In the case of patients below the age of 15 years, their parents/guardians/relations who accompanied the patients were interviewed. The idea behind this being that these parents/guardians/relations were the actual people who communicated with the physicians.

2.5.2 Instrument used for the data collection

The main instrument used was a structured interview schedule. There were seventy-seven (77) items to which the interviewee had to respond. Forty-seven of these items were attitudinal statements, thirty three (33) of them being pre-consultation and the remainder post-consultation.. The items covered the following variables and areas:

a. General demographic variables of patients;

b. Information on previous contact with health care setting;

c. Attitudes towards physicians.

The items were first formulated to draw out specific responses from the interviewees. This schedule was then pre-tested in the General Outpatient Department of U. C. H. It was then modified and arranged into a more systematic and logical form to elicit better attitudinal responses.

The schedule was divided into two parts. The first part was administered before each interviewee consulted a physician, while the second part took place immediately after medical consultation. The division of the schedule into two parts was necessary to determine the expectations/attitudes of the interviewees before and after consultations as well as to determine the satisfaction of patients with the service. The procedure also facilitated the cross-checking of the responses.

The attitude scale used in the schedule was based on that proposed by Likert. A five point scale ranging from "agree strongly" to "agree"; "Do not know, not sure"; "Disagree" and "Disagree strongly" was used to measure the following attitudes of patients to:

a. age of physician

b. sex of physician

c. level of education of patient

d. language used during consultation, and

e. presence of nurse or interpreter during consultation.

But as mentioned in the scope and objectives the study analysed in depth only the first two. Two trained interviewers were employed to conduct the interviews. Both of them have passed the West African Examinations Council school certificate exams and speak Yoruba and English fluently. Both are Yoruba by tribe and have spent their entire lives in Yoruba speaking areas of Nigeria. They were given an orientation course on the procedure for administration of the interviewing schedule and also undertook the pre-testing of the interview schedule.

To ensure the reliability of the instrument, the interviewers were provided with a Yoruba text of the schedule. The Yoruba translation was cross-checked by Yoruba speaking lecturers in the Department of Linguistics, University of Ibadan. Validity of the instrument was ensured by the varied wording of the attitudinal statements as well as the same idea being stated both positively

and negatively. Also the use of pre and post-consultation attitudinal statements ensured validity of the instrument. Reliability of the findings was ensured by the re-interviewing of most of the respondents who reported to keep appointments with their physicians. Consistency of the results was good to a considerable degree.

2.6 Limitations of the study

As mentioned earlier in the introduction, a persons' social behaviour must always be mediated by at least two types of attitudes - one activated by the object (doctor), the other by the situation (clinic). These will have different degrees of importance with respect to each other. How a person behaves towards an object within a situation depends on which beliefs evoke the strongest responses. Ideally this condition should have necessitated the investigation of the clinic situation and the determination of its' effects on physician-patient communication. This state could not be achieved because of the U. C. H. General Outpatient Departmental set up and operational procedures. Firstly, it was impossible to sit-in during consultation because it was not allowed. Secondly, observation of the physician-patient communication would have put the physicians on the alert and as a result would have made them modify their interaction with the patients. Although they were informed about the study they were not made aware of which patients were selected. This non-observation

of the physician-patient interaction did not afford the author the opportunity of getting first hand and unbiased information about the interaction. It was assumed that the interviewee post consultation responses will reflect accurately what really transpired during the medical consultations.

The procedure of interviewing in the precincts of the C.C.P.D. also had its' drawbacks. Firstly, patients were likely to give more favourable responses about physicians during such interviews. Secondly, as a result of having to wait for varying periods before they could see a doctor, most patients became rather anxious and this could affect responses.

Compliance with regimen is the expected sick role behavioural response. This aspect, unfortunately, could not be investigated at all as this would have necessitated a follow up of the patients for varying periods. Home visiting in Ibadan is very difficult as most parts of Ibadan are not systematically numbered. In the circumstances, the expressed satisfaction of patients with the visit to the hospital was measured by directly asking respondents to rate certain statements on attitudinal scales. Finally the type and structure of the health care setting may have its' own influence on attitudes of patients and the physician-patient communication. For instance, most of the respondents are illiterates and come from low-income groups. They live in crowded areas and are not used to the standard of cleanliness and hygiene

that exist in the hospital, in addition to the elaborate system of registration of patients. The whole environment of the hospital is strange and foreign to most of the patients. The patients have to wait in a queue before seeing the physicians. In the meantime they see physicians and other health workers going up and down. It may seem to them that these health workers are wasting their time in the hospital. After consultation they have to go and queue up again for long periods in order to collect their drugs. All these contribute towards the formation of attitudes.

Ideally, reliability of the findings should have been checked two weeks after the interviews were conducted. This was not done on the grounds that it was impossible to follow up patients to their homes. However, some of the patients who came back for follow up appointments and collection of laboratory test reports were re-interviewed. The findings of these latter interviews were found to be consistent with the original responses to a considerable degree. To ensure reliability too, many statements were inserted to act as a cross-check.

Only 157 patients instead of the original 200 could be interviewed as the two interviewers employed for the study had to leave before the completion of the study and the employment of new interviewers could give rise to significant inter-observer errors which could be difficult to check.

CHAPTER THREE

RESULTS

3.1 SOCIO-DEMOGRAPHIC CHARACTERISTICS

3.1.1 Age and sex distribution

The age and sex distribution of the respondents is shown in Table 3:1. 23.56% of the respondents are between 15 and 19 years of age. These are classified as the youths. Those between 20 and 49 years are classified as productive adults and they constitute 70.80% of the sample, while those respondents who are 50 years and above are classified as elderly. They form 5.73% of the sample.

3.1.2 Level of education

66.88% of the respondents were illiterates compared to 33.12% who had received some form of formal education. 14.01% of the respondents completed primary education while 7.01% had some post primary education. 6.37% had completed post primary education and 0.64% had had university education. Illiterates and those who had had education up to primary level constituted 85.98% of the respondents, (Table 3.2)

TABLE 3:1

AGE AND SEX DISTRIBUTION OF RESPONDENTS

AGE CLASS	MALES		FEMALES		TOTAL	
	No	%	No	%	No	%
15 - 19	23	28.75	14	18.18	37	23.56
20 - 24	14	17.50	25	32.47	39	24.84
25 - 29	19	23.75	20	25.97	39	24.84
30 - 34	5	6.25	6	7.79	11	7.01
35 - 39	3	3.75	2	2.59	5	3.18
40 - 44	7	8.75	4	5.20	11	7.01
45 - 49	5	6.25	1	1.30	6	3.82
50 - 54	2	2.50	1	1.30	3	1.91
55 - 59	-	-	4	5.20	4	2.55
60 - 64	2	2.50	-	-	2	1.28
Total	80	100.00	77	100.00	157	100.00

TABLE 3:2

DISTRIBUTION OF RESPONDENTS BY LEVEL OF EDUCATION

LEVEL OF EDUCATION	MALES		FEMALES		TOTAL	
	No	%	No	%	No	%
Illiterates	53	66.25	52	67.53	105	66.88
Some primary educ.*	4	5.00	4	5.19	8	5.09
Completed prim. educ.	13	16.25	9	11.70	22	14.01
Some post prim. educ.	8	10.00	3	3.90	11	7.01
Completed post primary	2	2.50	8	10.39	10	6.37
University education	-	-	1	1.29	1	0.64
Total	80	100.00	77	100.00	157	100.00

*These are people who have less than 4 years of primary school education which actually lasts for 6 years.

3.1.3 Language

Table 3.3 shows the distribution of respondents by the languages they speak. It is worthwhile to note here that 85.98% of the respondents claimed to speak only Yoruba language. This suggests that most of the respondents can only communicate effectively in the local languages.

TABLE 3:3

DISTRIBUTION OF RESPONDENTS BY LANGUAGES SPOKEN

LANGUAGE	MALES		FEMALES		TOTAL	
	No	%	No	%	No	%
Yoruba	70	87.50	65	84.41	135	85.98
English and Yoruba	6	7.50	8	10.39	14	8.90
English	-	-	1	1.30	1	0.64
Ibo	1	1.25	1	1.30	2	1.28
English and Ibo	2	2.50	-	-	2	1.28
Yoruba and Ibo	-	-	1	1.30	1	0.64
Hausa	-	-	1	1.30	1	0.64
Eng., Yoruba and Hausa	1	1.25	-	-	1	0.64
Total	80	100.00	77	100.00	157	100.00

Table 3:4 shows the distribution of respondents by the language they would prefer to communicate with the physician with. Most of the respondents (91.72%) would prefer to communicate with the physicians in Yoruba.

TABLE 3:4

LANGUAGE RESPONDENTS PREFER TO COMMUNICATE WITH THE PHYSICIAN WITH

LANGUAGE	MALES		FEMALES		TOTAL	
	No	%	No	%	No	%
Yoruba	74	92.50	70	90.91	144	91.72
English	5	6.25	6	7.79	11	7.00
Hausa	-	-	1	1.30	1	0.64
Ibo	1	1.25	-	-	1	0.64
Total	80	100.00	77	100.00	157	100.00

3:2 PRE-CONSULTATION ATTITUDES

3.2.1 Attitudes towards the sex of physicians

66.88% of the respondents agreed that male physicians are more sympathetic towards their patients and made them feel at ease while 8.92% disagreed with this (Table 3:5). The remaining 24.29% said they did not know or were not sure. Of those who agreed, 47.62% were females and 52.38% were males. There is however no significant association between this attitude and the sex of the patient, (x^2 = 2.619; 4 degrees of freedom; $0.70 > P > 0.50$). Table 3:6 shows that there is no significant relationship between the age groups and this attitude, (x^2 = 5.794; 8 degrees of freedom; $0.70 > P > 0.50$).

When respondents were asked to rate the statement that male physicians do not understand women's problems and vice-versa, 56.05% agreed (Males 60.0% Females 51.99%) while 35.03% disagreed (Males 35.0% Females 35.08%). The remaining 8.92% said they were not sure or did not know, (Table 3:7). There is no significant relationship between this attitude and sex of the respondents. There is however a significant association between age of patients and this attitude as shown in Table 3:8., (x^2 = 35.056; 8 degrees of freedom; $P < 0.01$).

94.28% of the respondents claimed that the sex of the physician is immaterial so long as the patients are being helped to overcome the problem. 3.16% disagreed while 2.55% said they did not know or were not sure (Table 3:9). Those who disagreed

TABLE 3:5

SEX DISTRIBUTION OF RESPONSES TO THE STATEMENT "MALE PHYSICIANS ARE MORE SYMPATHETIC ABOUT THEIR PATIENTS AND MAKE THEM FEEL AT EASE"

Sex of Patient	Agree Strongly	Agree	Do not Know	Disagree	Disagree Strongly	Total
Males	44	11	16	4	5	80
Females	39	11	22	3	2	77
Total	83	22	38	7	7	157

$x^2 = 2.619$; 4 degrees of freedom; $0.70 > P > 0.50$

TABLE 3:6

AGE DISTRIBUTION OF RESPONSES TO THE STATEMENT "MALE PHYSICIANS ARE MORE SYMPATHETIC ABOUT THEIR PATIENTS AND MAKE THEM FEEL AT EASE"

Age Group of Patient	Agree Strongly	Agree	Do not know	Disagree	Disagree Strongly	Total
Youth	22	6	5	1	3	37
Productive adult	57	14	30	6	4	111
Elderly	4	2	3	-	-	9
Total	83	22	38	7	7	157

$x^2 = 5.794$; 8 degrees of freedom; $0.70 > P > 0.50$

TABLE 3:7

SEX DISTRIBUTION OF RESPONSES TO THE STATEMENT "MALE (FEMALE) PHYSICIANS DO NOT UNDERSTAND THE PROBLEMS OF WOMEN (MEN)"

Sex of patient	Agree Strongly	Agree	Do not know	Disagree	Disagree Strongly	Total
Males	47	1	4	8	20	80
Females	36	4	10	6	21	77
Total	83	5	14	14	41	157

x^2 = 6.039; 4 degrees of freedom; $0.20 > P > 0.10$

TABLE 3·8

AGE DISTRIBUTION OF RESPONSES TO THE STATEMENT "MALE (FEMALE) PHYSICIANS DO NOT UNDERSTAND THE PROBLEMS OF WOMEN (MEN)"

Age group of patient	Agree Strongly	Agree	Do not know	Disagree	Disagree Strongly	Total
Youth	25	-	1	1	10	37
Productive adult	56	2	12	13	28	111
Elderly	2	3	1	-	3	9
Total	83	5	14	14	41	157

x^2 = 35.056; 8 degrees of freedom; $P < 0.01$

TABLE 3:9

SEX DISTRIBUTION OF RESPONSES TO THE STATEMENT "PHYSICIANS' SEX DOES NOT MATTER SO LONG AS PATIENTS ARE BEING HELPED"

Sex of patient	Agree Strongly	Agree	Do not know	Disagree	Disagree Strongly	Total
Males	6[illegible]	6	4	1	4	80
Females	63	14	-	-	-	77
Total	128	20	4	1	4	157

x^2 = 11.847; 4 degrees of freedom; P < 0.01

TABLE 3:10

AGE DISTRIBUTION OF RESPONSES TO THE STATEMENT "PHYSICIANS' SEX DOES NOT MATTER SO LONG AS PATIENTS ARE BEING HELPED".

Age group of patient	Agree Strongly	Agree	Do not know	Disagree	Disagree Strongly	Total
Youth	33	3	-	1	1	37
Productive adult	89	16	4	-	2	111
Elderly	6	2	-	-	1	9
Total	128	20	4	1	4	157

x^2 = 9.463; 8 degrees of freedom; 0.50 > P > 0.30

were all males while all the female respondents agreed as did 88.79% of the males. There is a significant association between the sex of the patient and this attitude (x^2 = 11.847; 4 degrees of freedom, P < 0.01). There is however no significant association between this attitude and age of patients as shown in Table 3:10, (x^2 = 9.4633; 8 degrees of freedom, 0.50 > P > 0.30).

When respondents were asked whether men should not disclose their personal and health problems to a woman and vice-versa, 47.77% of them agreed, 11.46% said they were not sure while 40.76% disagreed (Table 3:11). While more men agreed (Males 48.75%, Females 46.75%), more women disagreed (Males 35.0%, Females 46.75%). However there is no significant relationship between the sexes and this variable, (x^2 = 6.587; 4 degrees of freedom; 0.20 > P > 0.10). Similarly there is no significant relationship between age of respondents and this statement as shown in Table 3:12 (x^2 = 8.680; 8 degrees of freedom; 0.50 > P > 0.30).

The majority of the respondents, (64.97%) held the view that it is easier for male patients to talk to male physicians and vice-versa, Table 3:13). 24.84% disagreed and 10.19% were not sure. Of those who disagreed, 28.75% were males while females constituted 20.78%. There is no significant relationship between sex and this statement. (x^2 = 6.507; 4 degrees of freedom, 0.20 > P > 0.10). However there is a significant association between age of the patients and this statement as shown in Table 3:14, (x^2 = 18.7432; 8 degrees of freedom, P < 0.01).

TABLE 3:11

SEX DISTRIBUTION OF RESPONSES TO THE STATEMENT "MEN (WOMEN) SHOULD NOT DISCLOSE THEIR PERSONAL AND HEALTH PROBLEMS TO A WOMAN (MAN)"

Sex of patient	Agree Strongly	Agree	Do not know	Disagree	Disagree Strongly	Total
Males	29	10	13	14	14	80
Females	30	6	5	13	23	77
Total	59	16	18	27	37	157

$x^2 = 6.587$; 4 degrees of freedom; $0.20 > P > 0.10$

TABLE 3:12

AGE DISTRIBUTION OF RESPONSES TO THE STATEMENT "MEN (WOMEN) SHOULD NOT DISCLOSE THEIR PERSONAL AND HEALTH PROBLEMS TO A WOMAN (MAN)"

Age Group of patient	Agree Strongly	Agree	Do not know	Disagree	Disagree Strongly	Total
Youth	15	2	3	6	11	37
Productive adult	43	12	12	20	24	111
Elderly	1	2	3	1	2	9
Total	59	16	18	27	37	157

$x^2 = 8.680$; 8 degrees of freedom; $0.50 > P > 0.30$

TABLE 3:13

SEX DISTRIBUTION OF RESPONSES TO THE STATEMENT "EASIER FOR MALE (FEMALE) PATIENTS TO TALK TO MALE (FEMALE) PHYSICIANS"

Sex of patient	Agree Strongly	Agree	Do not know	Disagree	Disagree Strongly	Total
Males	48	2	7	10	13	80
Females	44	8	9	10	6	77
Total	92	10	16	20	19	157

$x^2 = 6.5471$; 4 degrees of freedom; $0.20 > P > 0.10$

TABLE 3:14

AGE DISTRIBUTION OF RESPONSES TO THE STATEMENT "EASIER FOR MALE (FEMALE) PATIENTS TO TALK TO MALE (FEMALE) PHYSICIANS"

Age group of patient	Agree Strongly	Agree	Do not know	Disagree	Disagree Strongly	Total
Youth	25	3	2	4	3	37
Productive adult	66	7	10	15	13	111
Elderly	1	-	4	1	3	9
Total	92	10	16	20	19	157

$x^2 = 18.7432$; 8 degrees of freedom; $P < 0.01$

3.2.2 Attitude towards the age of physicians

91.72% of the respondents agreed that both young and old physicians exhibit similar characteristics with regards to their personal relations with patients while the rest, 8.28% disagreed. (Table 3:15). All those who disagreed belonged to the productive adult age group. However, there was no significant association between this variable and the sexes and age groups respectively; (x^2 = 3.3324; 3 degrees of freedom; $0.50 > P > 0.30$); (x^2 = 6.4096; 6 degrees of freedom; $0.50 > P > 0.30$). Tables 3:15 and 3:16.

On the other hand, 18.47% disagreed that older physicians exhibit better interpersonal relations while the majority (67.52%) agreed and 14.01% did not know, (Table 3:17). There is no significant association between the sexes and this attitude, (x^2 = 9.4871; 4 degrees of freedom; $0.10 > P > 0.05$). Neither is there any significant association between age groups and this attitude (x^2 = 9.2230; 8 degrees of freedom, $0.50 > P > 0.30$).

Although 81.44% of the respondents were in agreement that older physicians should be made available during medical consultations involving junior physicians, 8.92% disagreed and 7.64% were not sure (Table 3:19), there is no significant association between this variable and sex of patient. (x^2 = 2.8687; 4 degrees of freedom, $0.70 > P > 0.50$). Similarly, there is no significant association between this variable and the age of the patients. (Table 3:20).

TABLE 3:15

SEX DISTRIBUTION OF RESPONSES TO THE STATEMENT "BOTH YOUNG AND OLD PHYSICIANS EXHIBIT SIMILAR PERSONAL RELATIONS WITH PATIENTS"

Sex of patient	Agree Strongly	Agree	Do not know	Disagree	Disagree Strongly	Total
Males	72	3	-	5	-	80
Females	67	2	-	5	3	77
Total	139	5	-	10	3	157

$x^2 = 3.324$; 3 degrees of freedom; $0.50 > P > 0.30$

TABLE 3:16

AGE DISTRIBUTION OF RESPONSES TO THE STATEMENT "BOTH YOUNG AND OLD PHYSICIANS EXHIBIT SIMILAR PERSONAL RELATIONS WITH PATIENTS"

Age group of patient	Agree Strongly	Agree	Do not know	Disagree	Disagree Strongly	Total
Youth	36	1	-	-	-	37
Productive adult	94	4	-	10	3	111
Elderly	9	-	-	-	-	9
Total	139	5	-	10	3	157

$x^2 = 6.4096$; 8 degrees of freedom; $0.50 > P > 0.30$

TABLE 3:17

SEX DISTRIBUTION OF RESPONSES TO THE STATEMENT "OLDER PHYSICIANS EXHIBIT BETTER INTERPERSONAL RELATIONS"

Sex of patient	Agree Strongly	Agree	Do not know	Disagree	Disagree Strongly	Total
Males	41	12	13	4	10	80
Females	46	7	9	12	3	77
Total	87	19	22	16	13	157

x^2 = 9.4871; 4 degrees of freedom; $0.10 > P > 0.05$

TABLE 3:18

AGE DISTRIBUTION OF RESPONSES TO THE STATEMENT "OLDER PHYSICIANS EXHIBIT BETTER INTERPERSONAL RELATIONS"

Age group of patient	Agree Strongly	Agree	Do not know	Disagree	Disagree Strongly	Total
Youth	22	3	7	3	2	37
Productive adult	62	15	12	13	9	111
Elderly	3	1	3	-	2	9
Total	87	19	22	16	13	157

x^2 = 9.2238; 8 degrees of freedom; $0.50 > P > 0.30$

TABLE 3:19

SEX DISTRIBUTION OF RESPONSES TO THE STATEMENT "OLDER PHYSICIANS SHOULD BE MADE AVAILABLE DURING MEDICAL CONSULTATIONS INVOLVING JUNIOR PHYSICIANS"

Sex of patient	Agree Strongly	Agree	Do not know	Disagree	Disagree Strongly	Total
Males	55	12	4	6	3	80
Females	54	10	8	4	1	77
Total	109	22	12	10	4	157

x^2 = 2.8669; 4 degrees of freedom. $0.70 > P > 0.50$

TABLE 3:20

AGE DISTRIBUTION OF RESPONSES TO THE STATEMENT "OLDER PHYSICIANS SHOULD BE MADE AVAILABLE DURING MEDICAL CONSULTATIONS INVOLVING JUNIOR PHYSICIANS"

Age group of patient	Agree Strongly	Agree	Do not know	Disagree	Disagree Strongly	Total
Youth	30	4	-	3	-	37
Productive adult	75	15	11	7	3	111
Elderly	4	3	1	-	1	9
Total	109	22	12	10	4	157

x^2 = 12.2789; 8 degrees of freedom; $0.20 > P > 0.10$

The majority of respondents (92.35%) disagreed with a suggestion that young physicians may not be able to interact well with patients while 7.0% agreed and 0.65% did not know, (Table 3:21). There was no significant association between sex of patients and this variable. However there is a significant association between age of patient and this attitude, (x^2 = 29.597; 8 degrees of freedom, $P < 0.01$); (Table 3:22).

97.45% of the respondents agreed that the age of the physician does not determine whether a physician can interact well with patients while 1.91% disagreed and 0.64% did not know or were not sure, (Table 3:23). There was no significant association between sex and age group of patients and this statement, (Tables 3:23 and 3:24).

Respondents were asked to rate the statement that young people feel uncomfortable telling their problems to older people. 58.6% disagreed while 21.0% agreed. As many as 20.38% said they did not know, (Table 3:25). There is no significant association between sex and age of patient and this variable. On the contrary most respondents (85.98%) hold the view that a young person would rather tell his problems to a young physician (Table 3:27). 8.28% disagreed while 5.74% did not know. There is no significant association between this attitude and sex of patient. Similarly there is no significant association between

TABLE 3:21

SEX DISTRIBUTION OF RESPONSES TO THE STATEMENT "YOUNG PHYSICIANS MAY NOT BE ABLE TO INTERACT WELL WITH PATIENTS"

Sex of patient	Agree Strongly	Agree	Do not know	Disagree	Disagree Strongly	Total
Males	4	2	-	16	58	80
Females	1	4	1	16	55	77
Total	5	6	1	32	113	157

$x^2 = 3.5162$; 4 degrees of freedom, $0.50 > P > 0.30$

TABLE 3:22

AGE DISTRIBUTION OF RESPONSES TO THE STATEMENT "YOUNG PHYSICIANS MAY NOT BE ABLE TO INTERACT WELL WITH PATIENTS"

Age group of patient	Agree Strongly	Agree	Do not know	Disagree	Disagree Strongly	Total
Youth	2	-	-	1	34	37
Productive adult	3	6	-	28	74	111
Elderly	-	-	1	3	5	9
Total	5	6	1	32	113	157

$x^2 = 29.597$; 8 degrees of freedom; $P < 0.01$

TABLE 3:23

SEX DISTRIBUTION OF RESPONSES TO THE STATEMENT "THE AGE OF A PHYSICIAN DOES NOT DETERMINE WHETHER A PHYSICIAN CAN INTERACT WELL WITH PATIENTS"

Sex of patient	Agree Strongly	Agree	Do not know	Disagree	Disagree Strongly	Total
Males	65	11	1	2	1	80
Females	67	10	-	-	-	77
Total	132	21	1	2	1	157

$x^2 = 4.0150$; 4 degrees of freedom, $0.50 > P > 0.30$

TABLE 3:24

AGE DISTRIBUTION OF RESPONSES TO THE STATEMENT "THE AGE OF A PHYSICIAN DOES NOT DETERMINE WHETHER A PHYSICIAN CAN INTERACT WELL WITH PATIENTS"

Age Group of patient	Agree Strongly	Agree	Do not know	Disagree	Disagree Strongly	Total
Youth	32	4	-	-	1	37
Productive adult	93	16	1	1	-	111
Elderly	7	1	-	1	-	9
Total	132	21	1	2	1	157

$x^2 = 11.7503$; 8 degrees of freedom, $0.20 > P > 0.10$

TABLE 3:25

SEX DISTRIBUTION OF RESPONSES TO THE STATEMENT "YOUNG PEOPLE FEEL UNCOMFORTABLE TELLING THEIR PROBLEMS TO OLDER PEOPLE"

Sex of patient	Agree Strongly	Agree	Do not know	Disagree	Disagree Strongly	Total
Males	5	12	16	30	17	80
Females	10	6	16	35	10	77
Total	15	18	32	65	27	157

$x^2 = 5.808$; 4 degrees of freedom, $0.30 > P > 0.20$

TABLE 3:26

AGE DISTRIBUTION OF RESPONSES TO THE STATEMENT "YOUNG PEOPLE FEEL UNCOMFORTABLE TELLING THEIR PROBLEMS TO OLDER PEOPLE"

Age group of patient	Agree Strongly	Agree	Do not know	Disagree	Disagree Strongly	Total
Youth	6	3	6	14	8	37
Productive adult	9	15	23	46	18	111
Elderly	-	-	3	5	1	9
Total	15	18	32	65	27	157

$x^2 = 6.810$; 8 degrees of freedom, $0.70 > P > 0.50$

TABLE 3:27

SEX DISTRIBUTION OF RESPONSES TO THE STATEMENT "A YOUNG PERSON WOULD RATHER TELL HIS PROBLEMS TO A YOUNG PHYSICIAN"

Sex of patient	Agree Strongly	Agree	Do not know	Disagree	Disagree Strongly	Total
Males	51	19	1	5	4	80
Females	45	20	8	3	1	77
Total	96	39	9	8	5	157

$x^2 = 7.8808$, 4 degrees of freedom, $0.10 > P > 0.05$

TABLE 3:28

AGE DISTRIBUTION OF RESPONSES TO THE STATEMENT "A YOUNG PERSON WOULD RATHER TELL HIS PROBLEMS TO A YOUNG PHYSICIAN"

Age Group of Patient	Agree Strongly	Agree	Do not know	Disagree	Disagree Strongly	Total
Youth	29	6	1	-	1	37
Productive adult	64	29	8	7	3	111
Elderly	3	4	-	1	1	9
Total	96	39	9	8	5	157

$x^2 = 10.5731$, 8 degrees of freedom, $0.30 > P > 0.20$

TABLE 3:27

SEX DISTRIBUTION OF RESPONSES TO THE STATEMENT "A YOUNG PERSON WOULD RATHER TELL HIS PROBLEMS TO A YOUNG PHYSICIAN"

Sex of patient	Agree Strongly	Agree	Do not know	Disagree	Disagree Strongly	Total
Males	51	19	1	5	4	80
Females	45	20	8	3	1	77
Total	96	39	9	8	5	157

$x^2 = 7.8808$; 4 degrees of freedom. $0.10 > P > 0.05$

TABLE 3:28

AGE DISTRIBUTION OF RESPONSES TO THE STATEMENT "A YOUNG PERSON WOULD RATHER TELL HIS PROBLEMS TO A YOUNG PHYSICIAN"

Age group of patient	Agree Strongly	Agree	Do not know	Disagree	Disagree Strongly	Total
Youth	29	6	1	-	1	37
Productive adult	64	29	8	7	3	111
Elderly	3	4	-	1	1	9
Total	96	39	9	8	5	157

$x^2 = 10.5731$; 8 degrees of freedom; $0.30 > P > 0.20$

TABLE 3:27

SEX DISTRIBUTION OF RESPONSES TO THE STATEMENT "A YOUNG PERSON WOULD RATHER TELL HIS PROBLEMS TO A YOUNG PHYSICIAN"

Sex of patient	Agree Strongly	Agree	Do not know	Disagree	Disagree Strongly	Total
Males	51	19	1	5	4	80
Females	45	20	8	3	1	77
Total	96	39	9	8	5	157

$x^2 = 7.8808$; 4 degrees of freedom, $0.10 > P > 0.05$

TABLE 3:28

AGE DISTRIBUTION OF RESPONSES TO THE STATEMENT "A YOUNG PERSON WOULD RATHER TELL HIS PROBLEMS TO A YOUNG PHYSICIAN"

Age group of patient	Agree Strongly	Agree	Do not know	Disagree	Disagree Strongly	Total
Youth	29	6	1	-	1	37
Productive adult	64	29	8	7	3	111
Elderly	3	4	-	1	1	9
Total	96	39	9	8	5	157

$x^2 = 10.5731$; 8 degrees of freedom; $0.30 > P > 0.20$

age of patients and this attitude (x^2 = 10.5731, 8 degrees of freedom, $0.30 > P > 0.20$), Table 3.28.

Almost a quarter of the respondents (24.81%) said they did not know whether old people do not like telling their problems to young people. 50.95% of the respondents disagreed while the rest (24.21%) agreed, (Table 3:29). There is no significant association between sex of patients and this statement. However there is a significant association between age of patients and this statement, (Table 3:30).

Only 2.54% agreed that young physicians do not like being consulted by old people. Another 14.01% said they did not know while 83.46% disagreed. All those who disagreed were females (Table 3:31), made up of 11.11% of the elderly and 2.70% of the productive adults. There is no significant association between the sex of patient and this statement, (x^2=4.5)3, 3 degrees of

TABLE 3:29

SEX DISTRIBUTION OF RESPONSES TO THE STATEMENT "AN OLD PERSON DOES NOT LIKE TO TELL HIS PROBLEMS TO A YOUNG PERSON"

Sex of patient	Agree Strongly	Agree	Do not know	Disagree	Disagree Strongly	Total
Males	15	7	16	24	18	80
Females	8	8	23	29	9	77
Total	23	15	39	53	27	157

x^2 = 6.8576; 4 degrees of freedom, 0.20 > P > 0.10

TABLE 3:30

AGE DISTRIBUTION OF RESPONSES TO THE STATEMENT "AN OLD PERSON DOES NOT LIKE TO TELL HIS PROBLEMS TO A YOUNG PERSON"

Age group of patient	Agree Strongly	Agree	Do not know	Disagree	Disagree Strongly	Total
Youth	5	2	12	8	10	37
Productive adult	14	11	27	42	17	111
Elderly	4	2	-	3	-	9
Total	23	15	39	53	27	157

x^2 = 17.1569; 8 degrees of freedom, P < 0.02

TABLE 3:29

SEX DISTRIBUTION OF RESPONSES TO THE STATEMENT "AN OLD PERSON DOES NOT LIKE TO TELL HIS PROBLEMS TO A YOUNG PERSON"

Sex of patient	Agree strongly	Agree	Do not know	Disagree	Disagree Strongly	Total
Males	15	7	16	24	18	80
Females	8	8	23	29	9	77
Total	23	15	39	53	27	157

x^2 = 6.8576; 4 degrees of freedom, 0.20 > P > 0.10

TABLE 3:30

AGE DISTRIBUTION OF RESPONSES TO THE STATEMENT "AN OLD PERSON DOES NOT LIKE TO TELL HIS PROBLEMS TO A YOUNG PERSON"

Age group of patient	Agree Strongly	Agree	Do not know	Disagree	Disagree Strongly	Total
Youth	5	2	12	8	10	37
Productive adult	14	11	27	42	17	111
Elderly	4	2	-	3	-	9
Total	23	15	39	53	27	157

x^2 = 17.1569; 8 degrees of freedom, P < 0.02

TABLE 3:31

SEX DISTRIBUTION OF RESPONSES TO THE STATEMENT "YOUNG PHYSICIANS DO NOT LIKE BEING CONSULTED BY OLD PEOPLE"

Sex of patient	Agree Strongly	Agree	Do not know	Disagree	Disagree Strongly	Total
Males	-	-	12	22	46	80
Females	-	4	10	18	45	77
Total	-	4	22	40	91	157

$x^2 = 4.5337$; 3 degrees of freedom, $0.30 > P > 0.20$

TABLE 3:32

AGE DISTRIBUTION OF RESPONSES TO THE STATEMENT "YOUNG PHYSICIANS DO NOT LIKE BEING CONSULTED BY OLD PEOPLE"

Age Group of patient	Agree Strongly	Agree	Do not know	Disagree	Disagree Strongly	Total
Youth	-	-	8	3	26	37
Productive adult	-	3	11	35	62	111
Elderly	-	1	3	2	3	9
Total	-	4	22	40	91	157

$x^2 = 16.8272$; 6 degrees of freedom, $P < 0.01$

freedom, $0.30 > P > 0.20$). However there is a significant association between age of patient and this statement, (Table 3:32).

3.2.3 General attitudes of patients

56.05% of the respondents agreed with a suggestion that patients feel upset when they fall ill and have to go to hospital. Another 37.58% disagreed while 6.37% said they did not know, (Table 3:33). 61.04% of the females agreed while 51.25% of the males agreed. 77.78% of the elderly patients disagreed compared to 34.23% of the productive adults and 43.24% of the youth who agreed. There is no significant association between sex nor age group of patient and this statement, (Tables 3:33 and 3:34).

The vast majority of patients (86.87%) however claimed to be happy whenever they finally get to see a physician. 1.27% said they did not know while 1.91% disagreed, (Table 3:35). All the elderly patients agreed. However there is no significant association between sex of patient and this statement. Similarly there is no significant association between age of patient and this statement. (Table 3:36).

Slightly more than half (53.50%) of the respondents disagreed with a suggestion that patients usually feel nervous before seeing a physician. 33.70% agreed while 12.80% said

TABLE 3:33

SEX DISTRIBUTION OF RESPONSES TO THE STATEMENT "PATIENTS FEEL UPSET WHEN THEY FALL ILL AND HAVE TO GO TO HOSPITAL."

Sex of patient	Agree Strongly	Agree	Do not know	Disagree	Disagree Strongly	Total
Males	33	8	8	15	16	80
Females	39	8	2	16	12	77
Total	72	16	10	31	28	157

$x^2 = 4.6789$; 4 degrees of freedom, $0.50 > P > 0.30$

TABLE 3:34

AGE DISTRIBUTION OF RESPONSES TO THE STATEMENT "PATIENTS FEEL UPSET WHEN THEY FALL ILL AND HAVE TO GO TO HOSPITAL"

Age group of patient	Agree Strongly	Agree	Do not know	Disagree	Disagree Strongly	Total
Youth	18	1	4	5	9	37
Productive adult	52	15	6	22	16	111
Elderly	2	-	-	4	3	9
Total	72	16	10	31	28	157

$x^2 = 13.4993$; 8 degrees of freedom, $0.10 > P > 0.05$

TABLE 3:31

SEX DISTRIBUTION OF RESPONSES TO THE STATEMENT "PATIENTS FEEL UPSET WHEN THEY FALL ILL AND HAVE TO GO TO HOSPITAL"

Sex of patient	Agree Strongly	Agree	Do not know	Disagree	Disagree Strongly	Total
Males	33	8	8	15	16	80
Females	39	8	2	16	12	77
Total	72	16	10	31	28	157

$x^2 = 4.6789$; 4 degrees of freedom. $0.50 > P > 0.30$

TABLE 3:32

AGE DISTRIBUTION OF RESPONSES TO THE STATEMENT "PATIENTS FEEL UPSET WHEN THEY FALL ILL AND HAVE TO GO TO HOSPITAL"

Age group of patient	Agree Strongly	Agree	Do not know	Disagree	Disagree Strongly	Total
Youth	18	1	4	5	9	37
Productive adult	52	15	6	22	16	111
Elderly	2	-	-	4	3	9
Total	72	16	10	31	28	157

$x^2 = 13.4993$; 8 degrees of freedom. $0.10 > P > 0.05$

TABLE 3:35

SEX DISTRIBUTION OF RESPONSES TO THE STATEMENT "PATIENTS ARE HAPPY WHEN THEY FINALLY GET TO SEE A PHYSICIAN"

Sex of Patient	Agree Strongly	Agree	Do not know	Disagree	Disagree Strongly	Total
Males	71	6	1	-	2	80
Females	67	8	1	1	-	77
Total	138	14	2	1	2	157

$x^2 = 3.316$; 4 degrees of freedom, $0.70 > P > 0.50$

TABLE 3:36

AGE DISTRIBUTION OF RESPONSES TO THE STATEMENT "PATIENTS ARE HAPPY WHEN THEY FINALLY GET TO SEE A PHYSICIAN"

Age group of patient	Agree Strongly	Agree	Do not know	Disagree	Disagree Strongly	Total
Youth	34	2	-	1	-	37
Productive adult	95	12	2	-	2	111
Elderly	9	-	-	-	-	9
Total	138	14	2	1	2	157

$x^2 = 7.0624$; 8 degrees of freedom, $0.70 > P > 0.50$

they did not know (Table 3:37). 40.26% of the female respondents and 27.5% of the male respondents are those who agreed. Half of the productive adults (52.25%) and about two thirds (67.57%) of the youth disagreed (Table 3:38). On the contrary only 11.11% of the elders agreed that patients usually feel nervous before seeing a physician.

There are significant associations between sex of patients as well as age group of patients and this statement, (Tables 3:37 and 3:38). 92.99% of the respondents think that a patient feels more at ease if the patient has been referred by another physician. 3.18% said they did not know, while 3.83% disagreed, (Table 3:39). All the males agreed while 7.75% of the females disagreed. These females are all in the productive adult age group. Also all the elderly respondents agreed, Table 3:40. There is no significant association between both sex of patients and age group and this statement (Tables 3:39 and 3:40).

76.44% of the respondents agreed that it is best to see the same physician again when a patient returns to the clinic or hospital (Table 3:41). 15.28% of the respondents disagreed while 8.28% of them did not know. 79.17% of those who disagreed belonged to the productive adult age group. (Table 3:42). There is neither any significant association between sex of patients nor age group of patients and this statement. (Tables 3:41 and 3:42).

they did not know (Table 3:37). 40.26% of the female respondents and 27.5% of the male respondents are those who agreed. Half of the productive adults (52.29%) and about two thirds (67.57%) of the youth disagreed (Table 3:38). On the contrary only 11.11% of the elders agreed that patients usually feel nervous before seeing a physician.

There are significant associations between sex of patients as well as age group of patients and this statement, (Tables 3:37 and 3:38). 92.99% of the respondents think that a patient feels more at ease if the patient has been referred by another physician. 3.18% said they did not know, while 3.83% disagreed, (Table 3:39). All the males agreed while 7.79% of the females disagreed. These females are all in the productive adult age group. Also all the elderly respondents agreed. Table 3:40. There is no significant association between both sex of patients and age group and this statement (Tables 3:39 and 3:40).

76.44% of the respondents agreed that it is best to see the same physician again when a patient returns to the clinic or hospital (Table 3:41). 15.28% of the respondents disagreed while 8.28% of them did not know. 79.17% of those who disagreed belonged to the productive adult age group. (Table 3:42). There is neither any significant association between sex of patients nor age group of patients and this statement. (Tables 3:41 and 3:42).

TABLE 3:37

SEX DISTRIBUTION OF RESPONSES TO THE STATEMENT "PATIENTS USUALLY FEEL NERVOUS BEFORE SEEING A PHYSICIAN"

Sex of patient	Agree Strongly	Agree	Do not know	Disagree	Disagree Strongly	Total
Males	9	13	11	16	31	80
Females	3	28	9	17	20	77
Total	12	41	20	33	51	157

x^2 = 11.0571 4 degrees of freedom, $P < 0.05$

TABLE 3:38

AGE DISTRIBUTION OF RESPONSES TO THE STATEMENT "PATIENTS USUALLY FEEL NERVOUS BEFORE SEEING A PHYSICIAN"

Age group of patient	Agree Strongly	Agree	Do not know	Disagree	Disagree Strongly	Total
Youth	4	3	5	11	14	37
Productive adult	7	35	11	22	36	111
Elderly	1	3	4	-	1	9
Total	12	41	20	33	51	157

x^2 = 18.4166; 8 degrees of freedom, $P < 0.02$

TABLE 3:37

SEX DISTRIBUTION OF RESPONSES TO THE STATEMENT "PATIENTS USUALLY FEEL NERVOUS BEFORE SEEING A PHYSICIAN"

Sex of patient	Agree Strongly	Agree	Do not know	Disagree	Disagree Strongly	Total
Males	9	13	11	16	31	80
Females	3	28	9	17	20	77
Total	12	41	20	33	51	157

$x^2 = 11.057$; 4 degrees of freedom. $P < 0.05$

TABLE 3:38

AGE DISTRIBUTION OF RESPONSES TO THE STATEMENT "PATIENTS USUALLY FEEL NERVOUS BEFORE SEEING A PHYSICIAN"

Age group of patient	Agree Strongly	Agree	Do not know	Disagree	Disagree Strongly	Total
Youth	4	3	5	11	14	37
Productive adult	7	35	11	22	36	111
Elderly	1	3	4	-	1	9
Total	12	41	20	33	51	157

$x^2 = 18.41661$; 8 degrees of freedom. $P < 0.02$

TABLE 3:39

SEX DISTRIBUTION OF RESPONSES TO THE STATEMENT "REFERRED PATIENTS FEEL MORE AT EASE WITH A PHYSICIANS"

Sex of patient	Agree Strongly	Agree	Do not know	Disagree	Disagree Strongly	Total
Males	60	18	2	-	-	80
Females	58	10	3	4	2	77
Total	118	28	5	4	2	157

x^2 = 8.4713; 4 degrees of freedom, $0.10 > P > 0.05$

TABLE 3:40

AGE DISTRIBUTION OF RESPONSES TO THE STATEMENT "REFERRED PATIENTS FEEL MORE AT EASE WITH A PHYSICIANS"

Age group of patient	Agree Strongly	Agree	Do not know	Disagree	Disagree Strongly	Total
Youth	30	5	2	-	-	37
Productive adult	79	23	3	4	2	111
Elderly	9	-	-	-	-	9
Total	118	28	5	4	2	157

x^2 = 7.0880; 8 degrees of freedom, $0.70 > P > 0.50$

TABLE 3:41

SEX DISTRIBUTION OF RESPONSES TO THE STATEMENT "IT IS BEST TO SEE THE SAME PHYSICIAN WHENEVER PATIENT RETURNS TO THE CLINIC"

Sex of patient	Agree Strongly	Agree	Do not know	Disagree	Disagree Strongly	Total
Males	53	10	5	8	4	80
Females	46	11	8	8	4	77
Total	99	21	13	16	8	157

x^2 = 1.706; 4 degrees of freedom, $0.80 > P > 0.70$

TABLE 3:42

AGE DISTRIBUTION OF RESPONSES TO THE STATEMENT "IT IS BEST TO SEE THE SAME PHYSICIAN WHENEVER PATIENT RETURNS TO THE CLINIC"

Age group of patient	Agree Strongly	Agree	Do not know	Disagree	Disagree Strongly	Total
Youth	28	1	5	1	2	37
Productive adult	67	17	8	14	5	111
Elderly	4	3	-	1	1	9
Total	99	21	13	16	8	157

x^2 = 13.855; 8 degrees of freedom, $0.10 > P > 0.05$

59.2% of the respondents agreed that physicians want to take their time to talk to a patient about a patient's problem. 4.96% disagreed while more than a third (36.31%) said they did not know, (Table 3:43). There is no significant association between sex of patients as well as age group of patients and this statement (Tables 3:43 and 3:44).

48.41% of the respondents disagreed with a suggestion that physicians are so busy that it is difficult to talk to them. Another 41.40% said they did not know while 10.19% agreed. 77.78% of the elderly respondents disagreed while more than a third (38.71%) of the productive adults said they did not know. There is no significant association between sex and age group of patients and this statement. (Tables 3:45 and 3:46).

Slightly more than half of the respondents (52.87%) agreed that the same physician a patient consulted should see the patient whenever he/she returns to the hospital or clinic. 12.10% said they did not know and 35.03% disagreed. (Table 3:47). There is no significant association between these responses and whether respondents got their preferences or not (Table 3:47). The male respondents who preferred male physicians and also consulted male physicians were highly in favour of this suggestion (Table 3:48). While most of the male respondents who preferred male doctors agreed, about a third disagreed.

59.24% of the respondents agreed that physicians want to take their time to talk to a patient about a patient's problem. 4.96% disagreed while more than a third (36.31%) said they did not know, (Table 3:43). There is no significant association between sex of patients as well as age group of patients and this statement (Tables 3:43 and 3:44).

48.41% of the respondents disagreed with a suggestion that physicians are so busy that it is difficult to talk to them. Another 41.40% said they did not know while 10.19% agreed. 77.78% of the elderly respondents disagreed while more than a third (38.71%) of the productive adults said they did not know. There is no significant association between sex and age group of patients and this statement. (Tables 3:45 and 3:46).

Slightly more than half of the respondents (52.87%) agreed that the same physician a patient consulted should see the patient whenever he/she returns to the hospital or clinic. 12.10% said they did not know and 35.03% disagreed. (Table 3:47). There is no significant association between these responses and whether respondents got their preferences or not (Table 3:47). The male respondents who preferred male physicians and also consulted male physicians were highly in favour of this suggestion (Table 3:48). While most of the male respondents who preferred male doctors agreed, about a third disagreed.

TABLE 3:43

SEX DISTRIBUTION OF RESPONSES TO THE STATEMENT "PHYSICIANS WANT TO TAKE TIME TO TALK TO .. PATIENT"

Sex of patient	Agree Strongly	Agree	Do not know	Disagree	Disagree Strongly	Total
Males	38	12	28	2	-	80
Females	24	19	29	4	1	77
Total	62	31	57	6	1	157

$x^2 = 6.3717$; 4 degrees of freedom, $0.50 > P > 0.30$

TABLE 3:44

AGE DISTRIBUTION OF RESPONSES TO THE STATEMENT "PHYSICIANS WANT TO TAKE TIME TO TALK TO A PATIENT"

Age group of patient	Agree Strongly	Agree	Do not know	Disagree	Disagree Strongly	Total
Youth	16	1	19	1	-	37
Productive adult	41	28	37	4	1	111
Elderly	5	2	1	1	-	9
Total	62	31	57	6	1	157

$x^2 = 12.5005$; 8 degrees of freedom, $0.20 > P > 0.10$

TABLE 3:45

SEX DISTRIBUTION OF RESPONSES TO THE STATEMENT "PHYSICIANS ARE SO BUSY THAT IT IS DIFFICULT TO TALK TO THEM"

Sex of patient	Agree Strongly	Agree	Do not know	Disagree	Disagree Strongly	Total
Males	5	4	31	13	27	80
Females	5	2	34	16	20	77
Total	10	6	65	29	47	157

$x^2 = 2.1016$; 4 degrees of freedom, $0.80 > P > 0.70$

TABLE 3:46

AGE DISTRIBUTION OF RESPONSES TO THE STATEMENT "PHYSICIANS ARE SO BUSY THAT IT IS DIFFICULT TO TALK TO THEM"

Age group of patient	Agree Strongly	Agree	Do not know	Disagree	Disagree Strongly	Total
Youth	2	2	21	4	7	37
Productive adult	7	3	43	24	34	111
Elderly	-	1	1	1	6	9
Total	10	6	65	29	47	157

$x^2 = 14.5588$; 8 degrees of freedom, $0.10 > P > 0.05$

TABLE 3:47

RESPONSES AS TO WHETHER PATIENTS SHOULD CONSULT THE SAME PHYSICIAN WHENEVER THEY RETURN TO HOSPITAL COMPARED WITH WHETHER THEY GOT THEIR PREFERENCE FOR SEX OF PHYSICIAN OR NOT.

Preference*	Agree	Do not know	Disagree	Total
Got	31	10	24	65
Did not get	52	9	31	92
Total	83	19	55	157

*Preference for sex of physician.

x^2 = 1.6581; 2 degrees of freedom, $0.50 > P > 0.30$

-79-

TABLE 14a

WHETHER PATIENTS SHOULD CONSULT THE SAME PHYSICIAN PREVIOUSLY THEY RETURN TO HOSPITAL COMPARED TO THEIR PREFERENCES AND THE SEX OF PHYSICIAN CONSULTED

Sex of Patient	Preference* for sex of physician	Sex of physician consulted	Agree		Do not know		Disagree		Total	
			No	%	No	%	No	%	No	%
Males	Male	Male	12	26.67	1	20.00	2	6.67	15	18.75
	Male	Female	33	73.33	2	40.00	18	60.00	53	66.25
	Female	Male	-	-	-	-	1	3.33	1	1.25
	Female	Female	-	-	2	40.00	9	30.00	11	13.75
—	—	Total	45	100.00	5	100.00	30	100.00	80	100.00
Females	Female	Female	19	50.00	7	50.00	11	44.00	37	48.05
	Female	Male	18	47.37	7	50.00	10	40.00	35	45.45
	Male	Male	-	-	-	-	2	8.00	2	2.60
	Male	Female	1	2.63	-	-	2	8.00	3	3.90
		Total	38	100.00	14	100.00	25	100.00	77	100.00

* Preference for sex of physician.

TABLE V:48

WHETHER PATIENTS SHOULD CONSULT THE SAME PHYSICIAN WHENEVER THEY RETURN TO HOSPITAL COMPARED TO THEIR PREFERENCES AND THE SEX OF PHYSICIAN CONSULTED

Sex of Patient	Preference* for sex of physician	Sex of physician consulted	Agree		Do not know		Disagree		Total	
			No	%	No	%	No	%	No	%
Males	Male	Male	12	26.67	1	20.00	2	6.67	15	18.75
	Male	Female	33	73.33	2	40.00	18	60.00	53	66.25
	Female	Male	-	-	-	-	1	3.33	1	1.25
	Female	Female	-	-	2	40.00	9	30.00	11	13.75
	Total		45	100.00	5	100.00	30	100.00	80	100.00
Females	Female	Female	19	50.00	7	50.00	11	44.00	37	48.05
	Female	Male	18	47.37	7	50.00	10	40.00	35	45.45
	Male	Male	-	-	-	-	2	8.00	2	2.60
	Male	Female	1	2.63	-	-	2	8.00	3	3.90
	Total		38	100.00	14	100.00	25	100.00	77	100.00

* Preference for sex of physician.

On the other hand, the majority of male respondents who preferred female physicians disagreed. However quite an appreciable number (18.18%) of the female respondents said they do not know whether a patient should consult the same physician on return to hospital.

3.3 POST-CONSULTATION ATTITUDES

3.3.1 Attitudes towards the sex of physicians.

64 (80.0%) of the male respondents consulted female physicians. 17.19% of these respondents wanted female physicians and most of them disagreed with the suggestion that they would want to consult male physicians next time. 64.19% of the males who did not want female physicians said they would like to consult male physicians next time while 20.75% said they would prefer female physicians. There is a significant association between whether they wanted the physician or not and their responses. (Table 3.49).

TABLE 3:49

WHETHER MALE RESPONDENTS WHO CONSULTED FEMALE PHYSICIANS WOULD LIKE TO CONSULT MALE PHYSICIANS ON THEIR RETURN TO HOSPITAL

Whether wanted female physicians or not	Agree	Do not know	Disagree	Total
Wanted	-	3	8	11
Did not want	34	8	11	53
Total	34	11	19	64

x^2 = 10.1311 2 degrees of freedom, P <0.0005

On the other hand, of the male respondents who got male physicians, the majority who initially wanted male physicians said they would like to consult female physicians on their next visit, (Table 3:50).

Most of the females who consulted male physicians and did not want them agreed that they would like to consult female physicians next time. On the contrary, some females who wanted female physicians and got them said they would like to consult male physicians next time, (Table 3:50).

TABLE 1:50

WHETHER PATIENT WOULD RATHER HAVE A PHYSICIAN OF THE OPPOSITE SEX ON NEXT VISIT.

SEX OF PATIENT	PREFERENCE	SEX OF PHYSICIAN CONSULTED	AGREE		DO NOT KNOW		DISAGREE		TOTAL	
			No	%	No	%	No	%	No	%
MALES	Male	Male	11	24.44	2	15.38	2	9.09	15	18.75
	Male	Female	34	75.56	8	61.54	11	50.00	53	66.25
	Female	Male	-	-	-	-	1	4.55	1	1.25
	Female	Female	-	-	3	23.08	8	36.36	11	13.75
	Total		45	100.00	13	100.00	22	100.00	80	100.00
FEMALES	Female	Male	18	51.43	9	47.37	8	34.78	35	45.45
	Female	Female	17	48.57	9	47.37	11	47.82	37	48.05
	Male	Male	-	-	-	-	2	8.70	2	2.60
	Male	Female	-	-	1	5.26	2	8.70	3	3.90
	Total		35	100.00	19	100.00	23	100.00	77	100.00

Preference for sex of physician.

TABLE 3:50

WHETHER PATIENT WOULD RATHER HAVE A PHYSICIAN OF THE OPPOSITE SEX ON NEXT VISIT.

SEX OF PATIENT	PREFERENCE*	SEX OF PHYSICIAN CONSULTED	AGREE		DO NOT KNOW		DISAGREE		TOTAL	
			No	%	No	%	No	%	No	%
MALES	Male	Male	11	24.44	2	15.38	2	9.09	15	18.75
	Male	Female	34	75.56	8	61.54	11	50.00	53	66.25
	Female	Male	-	-	-	-	1	4.55	1	1.25
	Female	Female	-	-	3	23.08	8	36.36	11	13.75
	Total		45	100.00	13	100.00	22	100.00	80	100.00
FEMALES	Female	Male	18	51.43	9	47.37	8	34.78	35	45.45
	Female	Female	17	48.57	9	47.37	11	47.82	37	48.05
	Male	Male	-	-	-	-	2	8.70	2	2.60
	Male	Female	-	-	1	5.26	2	8.70	3	3.90
	Total		35	100.00	19	100.00	23	100.00	77	100.00

*Preference for sex of physician.

3.3.2 Satisfaction of patients with visit

69.1% of the respondents disagreed with a suggestion that the physician made them feel nervous (Table 3:51). 19.1% agreed and 11.5% said they did not know. There is a significant association between sex of patients and response. (x^2 = 6.1771; 2 degrees of freedom, P< 0.05).

TABLE 3:51

WHETHER THE PHYSICIAN MADE THE PATIENT NERVOUS

Sex of patient	Agree	Do not know	Disagree	Total
Male	9	10	61	80
Female	21	8	48	77
Total	30	18	109	157

x^2 = 6.1771 2 degrees of freedom P< 0.05

The female respondents were more nervous around female physicians than around male physicians, (Tables 3:52 and 3:53).

TABLE 3:52

RESPONSES OF FEMALE PATIENTS AS TO WHETHER THE CONSULTING PHYSICIANS MADE THEIR MANNERS

Sex of physician	Agree	Do not know	Disagree	Total
Male	7	1	29	37
Female	14	7	19	40
Total	21	8	48	77

$x^2 = 8.809$; 2 degree of freedom, $P < 0.02$

TABLE 3:53

RESPONSES OF MALE PATIENTS AS TO WHETHER THE CONSULTING PHYSICIAN MADE THEIR MANNERS

Sex of physician	Agree	Do not know	Disagree	Total
Male	1	3	12	16
Female	8	7	49	64
Total	9	10	61	80

$x^2 = 1.0735$; 2 degree of freedom, $0.70 > P > 0.50$

TABLE 3:52

RESPONSES OF FEMALE PATIENTS AS TO WHETHER THE CONSULTING PHYSICIANS MADE THEM HONOURS

Sex of physician	Agree	Do not know	Disagree	Total
Male	7	1	29	37
Female	14	7	19	40
Total	21	8	48	77

$x^2 = 8.809$; 2 degrees of freedom, $P < 0.02$

TABLE 3:53

RESPONSES OF MALE PATIENTS AS TO WHETHER THE CONSULTING PHYSICIAN MADE THEM HONOURS

Sex of physician	Agree	Do not know	Disagree	Total
Male	1	3	12	16
Female	8	7	49	64
Total	9	10	61	80

$x^2 = 1.0735$; 2 degrees of freedom, $0.70 > P > 0.50$

almost all the respondents (95.51%) agreed that the physicians they consulted listened to everything they said while the rest (4.16%) said they did not know. There were no disagreements. On the other hand, 16.50% of the respondents said the consulting physicians could have paid more attention to them while 29.30% disagreed. 54.16% said they did not know.

Summary of Results

The responses of the respondents show that some patients have certain attitudes. These could be briefly summarised under four broad headings as follows; that:

a. Attitudes of patients towards sex of physicians: Although some patients believe that male physicians are more sympathetic about their patients and also that some physicians do not understand the problems of the opposite sex, there is an overwhelming claim by patients that the sex of the consulting physician does not matter so long as patients are being helped to overcome their health problems;

b. Attitudes of patients towards age of physicians: The majority of patients claim that both young and old physicians exhibit similar interpersonal relations with their patients. Likewise they claim that young physicians are able to interact very well with their patients and that the age of a physician does not determine how well a physician can interact with his or her patients;

c. General attitudes of patients: Some youths and productive adults believe that old people do not like telling their problems to young people. Some youths and productive adults also feel uncomfortable telling their problems to older people. Some patients feel upset when they fall ill and have to go to hospital but become happy when they finally get to consult their physicians. The fact that some patients usually feel nervous before medical consultations could be an indication of the existence of attitudes but not necessarily towards physicians.

d. Satisfaction of patients: Since the majority of patients said the physicians listened to everything they said and only a quarter of them said the physicians made them nervous, it could be said that most of the patients were satisfied with the medical consultations in spite of any attitudes they might hold.

Female patients usually felt more nervous before consulting physicians than male patients, (Table 3:37). The majority of the female patients (Table 3:1) were within the childbearing age range (15-45 years). Therefore it is possible that most of them attend clinics to seek treatment not only for themselves but also for their sick children. It was not established whether the anxiety was for the mothers' conditions or for their children but judging from experience one might assume that the anxiety was probably a result of the conditions of their children. This was more likely to be the situation if they had been referred from another clinic or hospital. At that time, it may have occurred to them that the conditions of the children were serious. On arrival at the clinic they had to go through an elaborate system of registration for the clinic. To make matters worse they usually waited for varying periods of time after registration before they consulted their physicians. This could further increase their anxieties.

Secondly, most of the females were illiterates (Table 3:2) and possibly belonged to the low income groups. Most of them were not used to the high standards of hygiene and cleanliness which they found in the hospital. The whole hospital environment could be foreign and strange to them if it were their first experience, and this could make them nervous before they consulted the physicians. Also a mother who was bringing a

child for a second or third time to the hospital for the same illness might be nervous for the fear that she might be scorned, especially if she had failed to comply with previous instructions by the physicians.

The productive adults felt more nervous before consulting physicians while the youths did not feel so, (Table 3:38). If it is assumed that most of the productive adults are in the working class and are employed whereas the youths are mainly of school age the adults could be worried over loss of working time (which could result in loss of earnings), more especially if there is the possibility of hospitalisation. They therefore see the illness as a threat to their domestic and social security. Another source of worry could be cost of drugs as was found by Green et. al. (1976b). If these problems engaged the minds of patients before seeing the physicians, the communication flow between them and the physician would be affected. Most of these factors might not apply to some of the youths because children and youths up to the age of 18 years of age do not pay any hospital fees. Only patients who are 18 years of age and above pay hospital fees.

During the medical consultations, more of the female patients than the males said they were nervous, (Table 3:15). It is also worthwile to note that of the female patients who claimed to be nervous, a greater percentage of them consulted

child for a second or third time to the hospital for the same illness might be nervous for the fear that she might be scorned, especially if she had failed to comply with previous instructions by the physicians.

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During the medical consultations, more of the female patients than the males said they were nervous. (Table 3:15). It is also worthwhile to note that of the female patients who claimed to be nervous, a greater percentage of them consulted

female physicians. It was however not established whether the nervousness was caused by the physicians. As noted earlier most of these female patients fall within the childbearing age range and as previously explained their main cause of anxiety and nervousness could be traced to the conditions of their children rather than their own conditions. It is also probable that female physicians being mothers themselves may be more sympathetic and this could take the form of positive reinforcement (encouragement and support) or negative reinforcement (rebuke).

Another problem encountered by illiterate mothers is the use of female interpreters in the C.C.P.D. when the physicians do not speak the local vernacular language. There is some evidence that these interpreters are usually less skilled than physicians in getting the message across to patients and rather than facilitate communication they sometimes create barriers to effective communication between the physicians and the patients. This may apply to this study because four of the six consulting physicians depend on such interpreters. The U.C.H. is aware of this problem and has started a training programme for nurse-aids including the interpreters in the hospital.

The youths generally agree that male physicians do not understand the problems of women and that female physicians do not understand the problems of men. The productive adults on the other hand, think otherwise. (Table 3:8). While both the youths

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and productive adults agreed that it is easier for male patients to talk over their problems with female physicians, the youths agreed more strongly. But more productive adults than youths said they were "not sure" about this, implying that the adults were less discriminatory in their choice between physicians of the opposite sex. This could be due in part to the fact that the productive adults have had more medical contact with physicians generally.

A few productive adults claimed that young physicians do not like being consulted by elderly people. It is difficult to see the basis of this claim because the elderly patients said that young physicians like being consulted by them. However the claim of the productive adults could be explained on the influence of cultural norms which require younger persons to show respect for the elderly in society. Respect for age and seniority is shown by the way the younger person greets or addresses elderly or senior people. In traditional Yoruba culture for example, the girl or female would kneel to greet an elderly or senior person and a boy or male would prostrate. The elderly person is never mentioned by his name without prefixing it with his official status. It is possible that some of those productive adults did not see this sign of respect being shown by some young physicians, and therefore assumed that the physicians do not like being consulted by elderly people.

The elderly respondents believe that Generally, old people do not willingly share their problems with younger persons, (Table 3:30). This could be due to the fact that culturally, elderly people are supposed to be knowledgeable about a lot of things, and also full of wisdom. As a result young people may not be consulted on matters even affecting them, and decisions made for them. The oldorly respondents probably still believe in this notion, and this may account for their unwillingness to share their problems with younger people.

There is a belief among some of the youths that young physicians cannot interact very well with the youths, although they (the youths) prefer to share their health problems with younger physicians, (Tables 3:22 and 3:28). On the contrary the productive adults claim that young physicians can interact well with them. This means that young physicians could be treating the patients differentially. This situation could be due to the influence of cultural norms as previously discussed.

All the female patients hold the view that the sex of the consulting physician is not important so long as the patient is being helped, (Table 3:9). This means that the important thing is for them to obtain medical care, and the effectiveness of medical consultations does not depend on the sex of the consulting physicians. Likewise, most of the males agreed with

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them. However a few male patients said they were not sure and the rest disagreed. The male patients who disagreed are probably skeptical about having to disclose certain personal health problems to female physicians or detest the idea of possibly subjecting themselves to physical examinations by female physicians when the need arises. With the male: female physician ratio standing at 10:1 (Nigeria Medical Council 1976), both male and female patients are used to consulting more male physicians than female physicians. Therefore female patients are likely to feel at ease with physicians of either sex. However, some males may not be at ease with female physicians because in the traditional setting it is believed that certain problems are not supposed to be discussed with women. If these male patients who disagreed are holders of such beliefs they are unlikely to communicate very well with female physicians during medical consultations.

Table 3:1:9 shows that male patients who had preferences for female patients and ended up consulting them would like to consult female physicians if they have to return to the hospital in future. On the contrary, those male patients who did not want to consult female physicians but were assigned to them would rather consult male physicians on their next visit. This confirms still further, that patients for various reasons discriminate between the sex of their physicians. It is

significant to mention at this stage that at the C.O.P.D. at U.C.H., all patients are assigned to various physicians on their first registration at the clinic. On subsequent visits they consult the same physicians they consulted on their first visit. If for some reason or other a particular physician is not available for medical consultations on a particular day, patients assigned to that physician are reassigned temporarily to other physicians. Therefore the determinant for preference may not be sex but one of maintaining an established relationship. In other words, it might be a question of "old friends better than new". So it is therefore possible that those who wanted to consult female physicians were those already assigned to female physicians and were therefore used to consulting them. Hence they would feel reluctant to change to another physician, the physician's sex notwithstanding.

Patients virtually insist that notwithstanding what beliefs or preferences they have about the sex of physicians, the most important thing is that they want to get better. A time will come in future when the physician-population ratio would have gone up considerably. But at the moment, the country is so short-staffed that although patients have ideas about what their ideal physicians should be, they appreciate the fact that physicians are busy and also doing their best under the prevailing circumstances.

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4.2 Conclusions

This study has shown that:

a. The effectiveness of any physician-patient interaction during medical consultations does not depend on the sex and age of consulting physicians;

b. The interaction between physicians and patients is better if patients consult the same physicians whenever they return to hospital;

c. Some patients have negative attitudes but these do not influence physician-patient communication during medical consultations because the primary concern of patients whom they come for medical consultations is to obtain medical care and thereby get solutions to their health problems.

It is probable that patients may have some initial anxiety before they consult their physicians but these are not associated with the sex and age of the consulting physicians. Although patients have some attitudes which probably have some socio-cultural foundations, but generally they do not have any negative attitudes towards the sex or age of the consulting physicians. Secondly, they do not allow their own culturally determined general attitudes to influence communication between them and their physicians.

The pattern found in the University College Hospital, Ibadan may not hold for other hospitals for the following reasons. The U.C.H. is a Teaching hospital and therefore the

physician -population ratio is higher than that found in other hospitals. It is also possible that the physicians may be more dedicated. Patients may therefore have more confidence in the physicians and the hospital as a whole.

4.3 Health Education implications.

Attitudes may modify behaviour in some ways. The question being raised is whether the attitudes of patients are likely to affect the physician-patient communication to the extent that patients may fail to comply with regimen. In the model showing the relationships between compliance and its' behavioural antecedents proposed by Green et. al. (1976b), they noted that a good physician-patient relationship is one of the reinforcing factors for patients to comply with regimen. Therefore, if the communication between physicians and patients is influenced by the attitudes of patients, then Compliance with regimen is likely to be affected. As Becker et. al. (1974) also pointed out in their own model (See Figure 1.1), the expected sick role behaviour of any patient is compliance with regimen. They indicated that the readiness of patients to undertake any such sick role behaviour is modified, among other things, by the attitudes of patients towards physicians as well as the quality of the physician-patient communication. It is therefore clear that generally, negative attitudes of patients could ultimately affect compliance with regimen.

One approach which could be used to minimise the effects of attitudes of patients on compliance with regimen is Health Education. Health education is well recognised as a fundamental means by which to improve individual as well as community practices, (Roberts 1970). It is an approach which

helps people to become aware of their health problems; to see the need to deal with their health problems; to assess whether the necessary action fits in with their motives, aspirations and values; to consider possible courses of action for dealing with a problem; to select the course acceptable to them; to commit themselves to this course and to adopt the necessary behaviour and maintain it, (Roberts op. cit.).

Since Health Education deals with the behaviours of people its' activities are primarily directed towards identification and critical examination of those factors (socio-cultural and sensitive ideological matters) which are likely to influence or determine the behaviours of health consumers. Also an individuals' behaviour is determined to a large extent by his knowledge as well as attitudes. It is important to mention at this stage that every experience a patient goes through has educational significance. Hence, there is the need for physicians to take advantage of medical consultations to help in the education of patients on health matters. Physicians should try and explain the nature and causes of the health problems to the patients and how to prevent their re-occurrences. Although it is understandable that there are so many patients to be seen and physicians are few, it is the belief of the author that this will help reduce the workload of physicians in the long run. By engaging in such dialogue with patients, physician might discover certain attitudes of patients and this will help the

physicians to handle similar problems in the future.

4.3.1 Points of intervention.

The attitudes of patients seem to have cultural foundations. Therefore before any attempt is made to change the negative attitudes of patients and reinforce the positive ones, there is the need to know the culture of the local people thoroughly. Cassel (1955) has pointed out that a thorough understanding of local ways and values and the importance of fitting new ideas into the existing cultural framework have been found to be essential if lasting results are to be achieved because taboos, superstitions and the value-systems of a particular culture or subculture will reflect on the way people behave and perceive things.

Health education activities should focus on the following:

a. Physicians;
b. Medical students;
c. Other health workers;
d. The patient as well as the community.

4.3.1.1 Physicians.

Physicians need to be given regular and frequent orientation courses on the health related cultural beliefs of the various people they are likely to come into contact with during medical consultations. This will enable them to improve their relationships with their patients in order to achieve

physicians to handle similar problems in the future.

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a. Physicians;
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d. The patient as well as the community.

4.3.1.1 Physicians.

Physicians need to be given regular and frequent orientation courses on the health related cultural beliefs of the various people they are likely to come into contact with during medical consultations. This will enable them to improve their relationships with their patients in order to achieve

effective physician-patient interaction during medical consultations. Physicians can then proceed gradually to change the attitudes of patients, (Byrne et. al. 1976). If a physician has reason to believe that a patient is having difficulty in communicating with him, the physician should try and find out the problem in order to enhance the communication process. This will also help the physician to know some of the factors which affect physician-patient communication.

The physicians can also contribute to the satisfaction of patients through helping patients to understand the reasons why they have to wait for some time before they consult the physicians, the procedures of the clinic and what physicians do while the patients are waiting. The reason why this is necessary is that patients could easily be dissatisfied with procedures at the clinic etc. which lead to broken appointments. These broken appointments could lead to increased waiting time when the patients finally report and eventually, further dissatisfaction, (Creen 1976a).

Since the face-to-face approach has been seen to be a very effective method of educating people because of the greater possibility of feedback, physicians will find it a very useful method of getting their messages across. Face-to-face communication enables the participants to work better with each others' feelings about their problems which could otherwise

have been impossible through the use of other impersonal methods. It also minimises the tendency to engage in meaningless communication. Therefore physicians, having been given orientation, would be in better positions to help in the education of people on matters relating to health.

4.3.1.2 Medical Students.

In addition to being given orientation courses like physicians, they should be given adequate preparation in the use of the educational approach to help them identify impediments to the effective use of public health services, (Pino et. al. 1977); (Hutter et. al. 1977), why people behave in certain ways and finally to help them as future physicians appreciate the value of education in solving health problems. In this way, they will become more concerned about the attitudes of the public towards hospitals and clinics or the perceptions of the public about the types of problems for which care is sought.

4.3.1.3 Other health workers.

All health workers are in good positions to assume educational responsibilities (both direct and indirect) and should be given administrative support for assuming those responsibilities. The first and most important thing to remember is that every experience a patient has is educational. A long wait, without any explanation, may teach the patient

that he or she is not important to the health care providers and will therefore be less responsive to treatment. If a health care service puts priority on patients with acute problems, patients will learn to delay seeking treatment until the condition is serious. Also, lack of effective communication between physicians and patients may lead to loss of confidence.

4.3.1.4 The patients and the community.

Some attention must also be focussed on the patients and the community at large. People must be made to realise that the key to better health lies with the people themselves. They must be aware and understand (through health education) how health is vital to individual as well as to national prosperity so that they can participate actively to improve their health status through their own efforts with the assistance of health workers. Since any change required in the peoples' knowledge, attitudes and practices should be consistent with the peoples' framework of cultural beliefs, values and practices, there is the need for all health workers to seek the support of the local leaders and influentials. These leaders can start the change in the knowledge, attitudes and practices of the people by engaging in dialogue with their own people. In engaging in health education activities with the people in mind, the mass media has a big role to play in reshaping peoples' ideas and beliefs. In using them however, their limitations should be borne in mind. Various audio-visuals should

also be used to educate the people of the community, bearing in mind that peoples' understandings, attitudes and behaviour are greatly affected by their daily formal and informal contacts with health workers.

4.4 Recommendations for future research.

In the light of the limitations of the scope of this study as mentioned in sections 2.2 and 2.6, it would be most inappropriate if certain recommendations are not made. Attitudes are generally directed towards objects and situations. The attitudes of patients are therefore mediated by two types of attitudes: attitudes towards the clinic environment and attitudes towards people, which of course includes physicians (Campbell 1963). Attitude formation is a long process and is a result of contacts (both formal and informal) with all categories of people, professional and non-professional. Peer groups, family (immediate and remote), friends as well as social influence contribute immensely towards attitude formation. It is therefore not impossible that attitudes displayed by patients could be a function of a wide range of attitudes held by people. It is therefore recommended that studies should be conducted on the general public to determine their perceptions and attitudes towards physicians as well. Such a study, because it should take place outside any hospital setting would give a more accurate picture of the trends of opinions about physicians and services rendered by

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these. Such a research study should determine who holds any such attitudes; why they hold such attitudes; the effects of these attitudes on compliance with regimen and what the holders of these attitudes think is the best way to get around the problem.

Physicians should not be left out because they could be the ones (directly or indirectly) causing the formation of these attitudes. Two areas readily come to mind. The first is what their own views are about some of these attitudes held by patients. Last but not the least, observations of physician-patient interaction (including the actual communication process), should be matched against attitudes of patients to determine how these attitudes come about. The observed patients should be followed up to determine their compliance with regimen. The results of these studies should give some insight to the undercurrents of these attitudes and their effects on compliance with regimen and to help determine future behavioural patterns of patients. Such findings could serve as inputs for orientation courses for physicians, medical students and could be utilised as a framework for educational programmes for the public.

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APPENDIX

INTERVIEW SCHEDULE FOR PATIENTS:

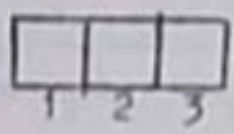
FACTORS AFFECTING COMMUNICATION BETWEEN PHYSICIANS AND THEIR PATIENTS: IMPLICATIONS FOR HEALTH EDUCATION

Please put the corresponding number of the appropriate answer in the corresponding box

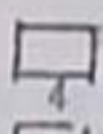
Patients' Number ..... Schedule No .....

Patients' Name .....

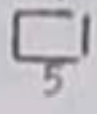
Physicians' Number .....



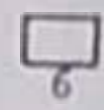
2. Sex — Male 1, Female 2



3. Is this your first visit to U.C.H. — Yes 1, No 2



4. Is this your first time of consulting a physician in the past year? — Yes 1, No 2



5. If No. how many times have you consulted a physician in the past year?

Twice	1
thrice	2
four times	3
five times	4
more than five times	5

6. What were the main reasons for coming to U.C.H. in particular?

cheaper	1
referal	2
nearness to residence	3
best place to solve my problem	4
other (specify)	5

7. Given the choice would you prefer a physician of the

same sex	1
opposite sex	2

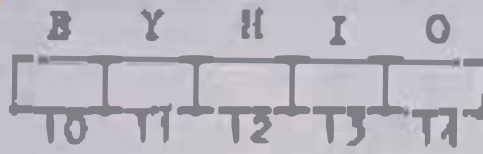
8. Give reasons:

.....

.....

9. Which language/s do you speak? (check as many as possible)

English	1
Yoruba	2
Hausa	3
Ibo	4
Other (specify)	5



10. Given the choice which language would you like to communicate with the physician with (check only one)

English	1
Yoruba	2
Hausa	3
Ibo	4
Other (specify)	5

15

11. Why?

.....

.....

12. Would you be disappointed if the physician decides to use another language?

Yes	1
No	2

16

13. Level of education

Illiterate	1
Some primary education	2
Completed primary education	3
Some post primary education	4
Completed post primary education	5
University education	6
Adult education	7

17

14. What would you like to know or learn from the physician?

nothing	1
what is wrong	2
what to do to get well	3
what to do to prevent falling ill again	4
other (specify)	5

18

15. Normally if a patient and a physician do not speak a common language the services of an interpreter would be required. Would you prefer such an interprete to be

a nurse	1
another hospital official	2

19

16. Why?

.....

.....

17. Would you like the interpreter to sit through the whole consultation?

Yes	1
No	2

20

18. Who would you prefer to consult?

a young physician	1
a middle aged physician	2
an old physician	3

21

19. Give reasons

.....

.....

	Strongly agree	Agree	Don't know	Disagree	Strongly disagree
	5	4	3	2	1
22. It is easier for a male (female) patient to talk to a male (female) physician.					
23. People with little formal education find it difficult to understand physicians.					

14. What would you like to know or learn from the physician?

nothing	1	
what is wrong	2	
what to do to get well	3	18
what to do to prevent falling ill again	4	
other (specify)	5	

15. Normally if a patient and a physician do not speak a common language the services of an interpreter would be required. Would you prefer such an interpreter to be

a nurse	1	
another hospital official	2	19

16. Why?

.....

.....

17. Would you like the interpreter to sit through the whole consultation?

Yes	1	
No	2	20

18. Who would you prefer to consult?

a young physician	1	
a middle aged physician	2	
an old physician	3	21

19. Give reasons

.....

.....

	Strongly agree	Agree	Don't know	Disagree	Strongly disagree
	5	4	3	2	1
22. It is easier for a male (female) patient to talk to a male (female) physician.					
23. People with little formal education find it difficult to understand physicians.					

	Strongly agree 5	Agree 4	Don't know/ not sure 3	Disagree 2	Strongly disagree 1
24. If a physician doesn't speak my language he probably will not be interested in my problem.					
25. Older physicians exhibit better interpersonal relations					
26. It makes a patient uncomfortable if a nurse is listening to his communication with the physician					
27. I usually feel nervous before I see a physician					
28. Male (female) physicians do not really understand womens' (mens') problems.					
29. Interpreters do not always tell the physician everything that is important					
30. Young people feel uncomfortable telling their problems to older people.					
31. The presence of nurses during consultation makes things run more smoothly.					
32. I feel upset when I fall ill and have to go to hospital.					
33. Men (women) should not disclose their personal and health problems to a woman (man).					
34. The more education you have, the easier it is to talk with a physician.					
35. When the physician and the patient speak the same language the patient will get the best of care.					

	Strongly Agree 5	Agree 4	Undecided 3	Disagree 2	Strongly Disagree 1
36. An old person does not like to tell his problems to a young person.					
37. I am happy when I decide to see a physician about my problem.					
38. It does not matter if a patient sees a male or female physician as long as the patient is being helped to overcome his problem.					
39. Physicians are skilled at talking to any patient regardless of the patients educational background.					
40. Hospital interpreters are important for helping provide good service.					
41. Young physicians may not be able to interact well with patients.					
42. It is best to see the same physician when you return to clinic again.					
43. Male doctors are more sympathetic about their patients.					
44. A person should feel free to tell a doctor his problems irrespective of whether the person is educated or not.					
45. Age does not determine whether a physician can interact well with patients.					
46. A patient feels more at ease if another physician has referred him to the clinic.					
47. Physicians are so busy that it is difficult to talk to them.					

Strongly disagree 5	Disagree 4	Don't know 3	Agree 2	Strongly agree 1

48. A young person would rather toll his problems to a young physician.

49. Physicians do not like talking to people who have never been to school.

50. Older physicians should be made avnilable during consultation.

51. Physicians want to take the time to talk to a patient about his problem.

52. Young physicians should work hand in hand with older ones.

53. Young physicians don't like being consulted by old people.

54. Both young and old physicians exhibit similar personal relations with patients.

55. By the way, how old are you?

15-19	1
20-24	2
25-29	3
30-34	4
35-39	5
40-44	6
45-49	7
50-54	8
55-59	9
60-64	10
65-69	11
70-75	12
over 75	13

55 56

56. Are you

Single	1
Married	2
Widowed	3
Divorced	4

57

PART II

57. Which language did the physician use during consultation?

English	1	
Yoruba	2	
Hausa	3	58
Ibo	4	
Other (specify)	5	

58. Did someone have to interpret during the consultation?

Yes	1	
No	2	59

59. Was there a nurse sitting at the consultation table?

Yes	1	
No	2	60

60. The interpreter helped a lot during the consultation.

Yes	1	
No	2	61

61. Were you able to say everything you had to say in connection with your condition/disease?

All	1	
Most	2	
Some	3	62
Nothing	4	

62. Did the physician tell you everything you wanted to know or learn?

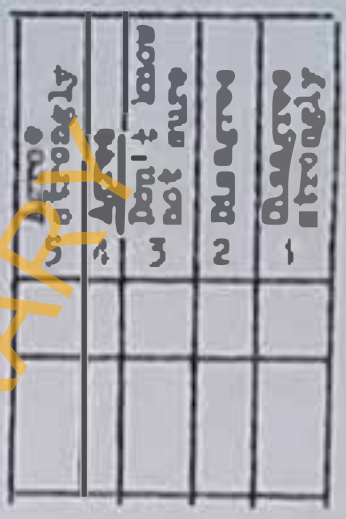
All	1	
Most	2	
Some	3	63
Nothing	4	

63. What did he tell you?

.....

.....

	Strongly Agree 5	Agree 4	Not sure 3	Disagree 2	Strongly disagree 1
64. Young physicians are too busy to listen to peoples problems.					
65. Men should always be treated by male physicians.					
66. Next time I would rather have a male (female) physician.					
67. Older physicians do not understand young peoples problems.					
68. Educated people got better treatment from physicians.					
69. Hospitals should always provide a physician who speaks the same language as the patient.					
70. If a physician cannot understand my language, he will not be able to solve my problem.					
71. It is easier to tell the physician your problems if a nurse is not listening.					
72. The physician made me feel very nervous.					
73. This same physician should see me when I come back to U.C.H.					
74. The physician listened to every word I said.					
75. Physicians prefer to talk to educated people.					



76. I would like to go to a different hospital if I fall ill again.

77. The physician could have paid more attention to what I said.

Thank you very much.
I wish you get well soon.