



Provider Perspectives

A qualitative study of caregivers' expectations and communication desires during medical consultation for sick children in Uganda

Sarah Kiguli^{a,*}, David Mafigiri^b, Janet Nakigudde^a, Jan van Dalen^c, Cees van der Vleuten^c

^aSchool of Medicine, Makerere University College of Health Sciences, Kampala, Uganda

^bFaculty of Social Sciences, Makerere University, Kampala, Uganda

^cFaculty of Health, Medicine and Life Sciences, University of Maastricht, The Netherlands

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ABSTRACT

Objective: Little data exist on patients' expectations and communication desires during medical consultation in Non-Western settings. We conducted a qualitative study to compare expectations and communication desires of sick children's caregivers at Mulago Hospital, Uganda, to those of patients in Western countries.

Methods: Three Focus Group Interviews and three Key Informant Interviews were conducted with 24 caregivers of sick children in Mulago Hospital Kampala, Uganda. An interview guide adapted from the Calgary-Cambridge Guide was used to conduct focus group and Key Informant Interviews. Two investigators worked independently to review transcripts and analyse them for content and emerging themes.

Results: Caregivers of sick children in Mulago Hospital expect attending doctors to build a relationship with them, by demonstrating the verbal and nonverbal skills outlined in the CCG including maintaining eye contact, using appropriate gestures and voice during communication, and being nonjudgmental. **Conclusion:** The communication needs and expectations of caregivers of sick children in Mulago Hospital are similar to those of patients and caregivers in Western countries.

Practice implications: The CCG can be used as a training guide to enhance the communication skills of current and future doctors in Mulago Hospital.

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1. Introduction

Communication is essential to all aspects of health care, from history taking to providing information to the patient. Silverman provides a usable summary of the research literature on what makes a difference in doctor–patient communication, and reflects the evidence for communication skills training in medicine [1]. However, previous studies have indicated that there is dissatisfaction about the quality of communication in every phase of the medical encounter [2–4]. Patients often present to health care facilities with expectations from consultation with the doctor, including receiving information about their diagnosis, getting explanation about their illness and getting a prescription for medication and specialized referral [5]. These expectations may be influenced by several factors including the patients' perceived vulnerability to illness and experience with the health care system,

acquired knowledge, social cultural antecedents including illness beliefs and culture, as well as gender, education and ethnicity [4,6,7].

In an earlier study on communication skills, Korsch et al. found that mothers of sick children expected the paediatricians to be friendly, to communicate well, and to provide information about their child's condition and cause [8]. Furthermore, this study indicated that for parents expecting to learn about their child's illness, failure to have this expectation met led to considerable dissatisfaction.

Understanding patients' concerns, expectations and requests is important for clinicians, in order to maintain quality of health care [5]. However, available data on patient/caregiver communication are mainly from studies done in Western countries. According to Hofstede, values in the workplace are influenced by culture. Hofstede indicated a considerable difference in 'Power Distance' between European/American countries and African countries [9]. Gudykunst discusses three prominent cultural concepts that might influence communication in personal relationships across cultures. These include, the extent to which we accept unequal power relations (power distance), whether we focus on the present or future (orientation towards time) and the

* Corresponding author at: Department of Paediatrics, School of Medicine, Makerere University, P.O. Box 7072, Kampala, Uganda. Tel.: +256 414 531 875; fax: +256 414 532 204.

E-mail address: skwalube@yahoo.co.uk (S. Kiguli).

tendency to communicate in an explicit or implicit way (low and high communication styles) [10].

Little is known about the expectations, communication desires and experiences of patients in African countries and therefore they cannot be assumed to be absolutely comparable to those reported in the industrialized, Western world. This study was therefore designed to explore the expectations of Ugandan caregivers regarding the communication skills of the attending doctors. We conducted the study with women, since they can be assumed to be especially vulnerable from greater power distance in line with Korsch's study on communication skills in the Western world [8]. Mothers/caregivers of sick children were enrolled as study subjects. We hypothesized that mothers in Uganda would have different expectations of their doctors compared to mothers in Western countries because of cultural differences affecting interpersonal communication [9,11].

2. Methods

We conducted a qualitative cross-sectional study in October–November 2006 among adult caregivers of sick children regarding communication skills of attending doctors in order to compare them with patients' needs reflected in evidence from Western countries. Three Focus Group Interviews (FGIs) and three Key Informant Interviews (KIIs) were conducted with adult caregivers of sick children who had been admitted within a period of 48 h on two of the three general paediatric wards of Mulago National Referral Hospital in Kampala, Uganda.

2.1. Study population

A sample of 24 adult caregivers of sick children who were admitted at the hospital was purposively selected for enrolment into the study. Relying on Patton's framework for identifying participants [12], adult caregivers whose children were not in critical condition were approached to join the study and informed consent sought. Paediatric patients and their caregivers at Mulago Hospital have the opportunity to interact with clinical psychologists when admitted on the wards. Recruitment in this study was undertaken with the assistance of a clinical psychologist who explained the study, determined eligibility and sought informed consent. The clinical psychologist also conducted the FGIs and the KIIs.

To be eligible for inclusion caregivers had to be 18 years of age or older and consent to participating in the interviews. We did not enroll caregivers whose children were critically ill, as it was assumed that this would cause too much anxiety and affect their responses during the interviews. Each FGI had between 5 and 10 caregivers, whose children had shown some improvement in their condition. Together, after taking into consideration theoretical saturation [13,14], 24 caregivers participated in the FGIs, while three caregivers participated in the KIIs.

2.2. Data collection procedures

Two separate interview guides were used to conduct the FGIs and KIIs. The guides were adapted from the Calgary-Cambridge Guide [11] as an accepted clinical skills inventory. The tool was translated and back translated between English and Luganda, the most widely spoken local language during doctor–patient interaction at Mulago Hospital.

Both FGIs and KIIs focused on expectations of caregivers from the medical consultation during the current hospital visit. The interviews collected demographic data, including age, education, and marital status. A hypothetical entry situation was described to the caregivers, and used to extract their expectations. This

situation described a febrile illness, a common childhood problem that most caregivers were likely to have experienced or attended to a child with such a problem. The caregivers were given an opportunity to discuss their expectations. Expectations were to indicate what the caregivers thought would *realistically* happen during consultation with the doctor. Following this discussion, caregivers were interviewed using the CCG in order to elicit their unvoiced desires and to fill in the discussion about their expectations. We used the term “unvoiced desires” to indicate what the caregivers *would like to happen* during the consultation with the doctor.

All Focus Group and Key Informant Interviews/conversations were audio taped. In addition, all the conversations were recorded by taking notes.

2.3. Data analysis

All audio-recorded Focus Group and Key Informant Interviews were transcribed verbatim, first into Luganda, and later translated into English. Two investigators worked independently to review the transcripts and analyse them for content and emerging themes. The results of both investigators were then compared to identify areas of agreement and disagreement [15].

2.4. Ethical considerations

The study protocol was approved by the Mulago Hospital Research Committee and permission to carry out the study was sought from the Hospital Administration. In addition informed consent was sought from all the caretakers before being enrolled into the study. No identifying information was collected on participants and no follow up was conducted. Similarly, names of attending doctors mentioned during interviews were not recorded nor included in the final report.

3. Results

3.1. Characteristics of the study sample

All 24 study participants were female. 20% of the participants had post-primary education, and they all came from Kampala and the surrounding districts. Their mean age was 24 years, with a range of 18–50 years.

Several themes emerged through data analysis as presented below.

3.2. Caregivers expect concern and support during consultation

Caregivers were asked what they thought would happen during consultation. Common expectations mentioned in the FGIs included the need to explain to them what is wrong with the child; show them concern and support; and examine the child as the following quotes illustrate:

I have to explain to the doctor what happened to the child at night. (FGI 1)

The doctor should show concern to me, examine the child, ask me questions such as; how did the child's illness start? What is wrong with the child? How long has the child been ill?(FGI 3)
I would expect to get help, I would want the doctor to examine my child, to ask me questions regarding the problem of the child, and I would then explain the child's problem to the doctor. (FGI 2)

Similarly, data from the KII shows that caregivers expected doctors to ask them about the child's problem and to give them an

Table 1

What caregivers expect (think will happen) during consultation.

Category	FG1 statements (n)	FG2 statements (n)	FG3 statements (n)	Total statements (n)
Doctor to greet caregiver	1	1	0	2
Caregiver to greet the doctor	1	0	0	1
Caregiver should be able to explain what is wrong with the child	6	1	3	10
Doctor to show concern and support to	2	3	5	10
Doctor to examine the child	4	1	3	8
To be given information (about the child's illness) by the doctor	3	1	1	5
Doctor to provide treatment to the child	3	1	2	6

Most of the caregivers who responded expect to be able to explain the child's problem to the doctor, and the doctor to show them support and concern, and examine the child.

opportunity to explain the child's problem as reflected by the following quotation:

The doctor should ask me, what is it mama (Lady/Mother)? What is the problem with the child? (KII 1)

They also expected the doctor to examine and provide treatment for the child, as reflected below:

I expect the doctor to examine the child, do some blood tests to find out what is wrong with the child, and to give treatment to the child. (KII 2)

3.3. Desired process of consultation

For participants in both FGIs and KIIs, when asked what they would like to happen during the patient–doctor consultation, caregivers mentioned that it would be desirable for the doctors to demonstrate most of the skills outlined in the CCG as shown in Table 1.

The following quotations illustrate some examples of expectations from the patient–doctor consultation:

I would like to first explain the child's problem, after which the doctor should ask me questions. (FGI 3)

To use simple words, by not using medical language. (KII 1)

Even if he/she is writing, the doctor should look at me, because my eyes will be on him/her all the time. (FGI 2)

... by saying 'hmm', by nodding the head. This encourages you, and shows you that the doctor understands what you are telling him, and that he has concern for you. (FGI 2)

.....by responding to me kindly. (FGI 1)

These narratives suggest that the caregivers expect the doctors to use open ended questions, as well as appropriate verbal and nonverbal communication including easily understood language with less medical jargon, while maintaining eye contact during the interaction.

3.4. Caregivers' unvoiced desires are related to the phases of the Calgary-Cambridge Guide

The expectations of the caregivers were grouped into five categories, based on the phases of the CCG. It is worth noting that where as participants' initial responses indicated their perceptions of what the doctors should do during consultation; they did not specifically mention the skills that the doctors had to demonstrate. In addition, the caregivers interviewed in both FGIs and KIIs had "unvoiced desires" and additional communication skills which they would like the doctors to demonstrate during the consultation.

3.5. Initiating and building relationships during medical consultation

Most participants did not expect the doctor to demonstrate skills of establishing rapport such as greeting them, introducing

themselves or their role. In general they did not expect the doctor to demonstrate interest in them. This is reflected in the following statements by the participants:

I greet the doctor, then? [poses question as though to imply no answer is expected]. (FGI 1)

As soon as I enter the consultation room, I have to explain my problem to the doctor, even if he/she has not greeted me. (FGI 3)

However, the participants expected the doctors to identify the reasons for the consultation by asking them open questions.

The unvoiced desires of the study participants included most of the skills outlined in the CCG for initiating the consultation. The caregivers expected the doctors to build a relationship with them by establishing rapport, 'being easy on them', and showing them concern and support as reflected by the following responses:

We would like the doctor to greet us, because sometimes we may be afraid of him/her. If the doctor welcomes you into the room, then you enter with confidence that the doctor is going to help you. (FGI 2)

It is good for the doctor to introduce himself. I like a doctor who introduces himself, (it means) that this doctor is not cruel. (FGI 3)

I would like to agree with the doctor. That is what it means to provide medical care; it results from being in agreement with each other. (FGI 1)

I would like the doctor to show me concern, but sometimes you tell the doctor that your child is very sick, and you are told to go away, and you may not know what to do. (FGI 2)

I would like the doctor to be easy on me before I explain my problems to him/her. (FGI 1)

These statements indicate that the caregivers would like the consultation to be initiated by doctors building rapport through a show of kindness as well as agreeing with them on the agenda for consultation.

Further, as shown in Table 2, most of the caregivers agreed that they would like the doctors to use the skills for building a relationship as outlined in the CCG:

A friendly face... (FGI 3)

It is a good thing for the doctor to maintain eye contact with you; it makes you aware that he/she is talking to you, that he/she is paying attention to you. Even if the doctor is a man, this is a good thing (eye contact), because he is the doctor. (FGI 1)

All of us would like to demonstrate respect for the doctors, and for them to demonstrate respect for us. (FGI 2)

However, it is worth noting that some of the participants felt that they should be the ones to greet the doctors as illustrated in this quote:

It should be me to greet the doctor, because I am the one with the problem. (KII 2)

Table 2
The “unvoiced desires of caregivers.

Category	FG1		FG2		FG3		Total	
	Yes (n)	No (n)	Yes (n)	No (n)	Yes (n)	No (n)	Yes (n)	No (n)
Caregiver would like the doctor to:								
Greet them	6	0	7	0	3	2	16	2
Introduce self and role	3	1	4	1	3	0	11	0
Demonstrate interest and respect, attend to caregiver and child's physical comfort	3	0	7	0	4	0	14	0
Listen attentively, allow caregiver to complete opening statement without interruption or direction	4	0	3	0	8	0	15	0
Negotiate the agenda with them	4	0	3	0	8	0	15	0
Encourage them to tell the story of the child's problems in my own words	7	0	4	0	8	0	19	0
Facilitate their responses verbally and nonverbally	2	0	2	0	3	0	7	0
Use easily understood questions and comments	6	0	2	0	4	0	12	0
When doing physical examination, to explain process, ask permission	1	0	0	2	1	3	2	5
Actively determine caregivers perspective (ideas, concerns, expectations, feelings, effects)	6	0	7	0	8	0	21	0
To pick up verbal and nonverbal cues (body language, affect, facial expression)	6	0	7	0	8	0	21	0
Acknowledges caregiver's view and is not judgmental	2	1	3	1	8	0	13	2
Demonstrate appropriate nonverbal behaviour, e.g. eye contact, facial expression, posture and position, use of voice	6	0	7	0	8	0	21	0
Uses empathy to communicate caregiver's feelings or predicament	6	0	7	0	8	0	21	0
Share thinking with caregiver	6	0	2	0	8	0	16	0
If reads and writes does not interfere with dialogue	6	0	7	0	8	0	21	0
Agree with you on the treatment plan	6	0	7	0	8	0	21	0
Use visual methods of conveying information	6	0	7	0	3	0	16	0
Attends to timing	6	0	4	0	8	0	18	0

Most of the caregivers desired the doctors to demonstrate the skills outlined in the Calgary-Cambridge guide, as shown in this table.

I would like the doctor to demonstrate respect for me, and for me to reciprocate, but I should show more respect (than the doctor), because it is me who will have brought the sick child. (FGI 3)

The above statements may be indicative of the unequal power relationship existing between the doctors and caregivers.

3.6. Gathering patient information

Caregivers expect an opportunity to explain the child's problems to the doctor and in return for the doctor to examine the child:

I enter with the hope that the doctor will examine my child, ask me how the problem(s)/illness started. (FGI 1)
It is good for the doctor to ask you questions. He/she should ask you everything. This helps both doctor and you. He/she starts slowly, then goes deeper. (FGI 2)

Similarly, caregivers expected the doctor to do some investigations. Furthermore, these caregivers had a desire for the doctor to listen to them and facilitate them through verbal and nonverbal behaviour as reflected by the following quotations:

It is good for the doctor to pay attention to you, without being disturbed by or talking to other people at the same time. (FGI 2)
The doctor should... not be just writing. (FGI 3)
The doctor's face will show. (FGI 2)

In addition, the caregivers would like the doctor's questioning techniques to shift from open to closed ended, focused questioning:

I would like to first explain the child's problem to the doctor, after which the doctor should ask me questions. (KII 1)

It was noted that most of the participants were smiling, and nodding their heads when they were being asked about what

verbal and nonverbal communications skills that they would like the doctors to demonstrate.

3.7. Explanation and planning

Caregivers expected doctors to give them information and explanations about the child's problems as illustrated below:

The doctor should explain what is happening to my child and what he/she is going to do for example taking off blood (tests) because she/he will have examined the child and may have found out that the child has fever, and tell me what is required. (FGI 3)

This is what I like most. I like this very much. Most times, the doctor will know what is wrong with your child, and write it down, but you (the mother) will not know. (FGI 1)

The doctor just gives you medicine. It would be good for the doctor to tell that your child has such/this problem (diagnosis), and that this medicine is for treating such a condition. (FGI 2)
If I have not understood, the doctor should write it down for me. (KII 3)

I would also like the doctor to know my concerns, to give me support, so that I am able to look after my sick child with hope. (FGI 3)

It would be good for the doctor to look at me and read my appearance (facial expression); in order to support/comfort me. (FGI 2)

The above two statements indicate that during the process of explanation and planning, the caregivers would like the doctors to support them, by addressing their verbal and nonverbal concerns.

4. Discussion and conclusion

4.1. Discussion

This study was carried out to explore communication skills that patients and their caregivers in an African setting desire during the

consultation process and how these desires relate to those of patients from Europe and North America. The results of this study indicate that caregivers of sick children in Mulago Hospital would like doctors to build a relationship with them, by demonstrating the verbal and nonverbal skills outlined in the CCG such as, maintaining eye contact, using appropriate gestures and voice during communication, and not being judgmental.

Caregivers would also like the doctor to explore their beliefs, concerns and expectations about the child's illness, and how the child's illness affected their lives. In addition caregivers wanted to be involved in the management of their children's illness through doctors sharing their thoughts with them and providing information about the child's illness. These desires speak to characteristics of a patient-centered approach [16]. Previous studies have shown that doctors who use a doctor-centered approach may fail to address the patient's perspective [17]. Therefore, the study findings give us an indication about the needs of caregivers of sick children in Mulago Hospital, Uganda, which we need to address in order to improve their satisfaction and concordance with the doctor–patient interaction.

Our study shows that caregivers in Uganda have similar desires to those of their Western counterparts about the verbal and nonverbal communication skills of the doctor during consultation. This is somewhat surprising because previous research in communication was conducted with individuals, including mothers of sick children, in culturally homogeneous areas of the world. Apparently patients' and caregivers' desires are more universal than could be assumed on the basis of Hofstede's work [9].

Caregivers of patients at Mulago Hospital expect to be given an opportunity to explain the child's problem to the doctor. In turn, they expect the doctor to examine and provide treatment to the sick child, and to receive an explanation about the child's illness. These expectations are similar to those of patients in Europe, Canada and the USA [5,7,8], in spite of the different background of the patients in these settings. It should be noted that the CCG, that has been used successfully to train medical and other health professions students in order to meet the communication expectations and desires of patients during the consultation process, was motivated by similar desires shown in our study. This important finding supports the use of the CCG during the training of medical and other health professions students and health workers in non-Western areas such as in Uganda in order to improve their communication skills.

It is worth noting that the caregivers interviewed did not expect the doctor to demonstrate all the skills in the CCG. For instance, they did not expect to be greeted by the doctors during the consultation or the doctors to ask them for permission before examining the child. This finding is different from what is reported in literature, where patients in the western world would expect the doctors to explain the process and ask them for permission before being examined [16]. This difference was not surprising, and could be explained by the unequal power relationship between the doctors and caregivers of sick children in Uganda, or the caregivers' previous experiences where the doctors do not demonstrate these skills. Countries in East Africa have a very high index of power distance [9] which is likely to be reflected in the doctor–caregiver relation in Uganda or other countries. However, whereas the caregivers do not think that the doctor would greet them, most of them would like this to happen.

The caregivers who participated in the FGIs had more expectations regarding the communication skills of doctors than those in the KII, who mainly expressed the expectations of the doctor examining the sick child and providing treatment. This difference may be explained by the fact that the participants in the group interviews are more likely to express themselves and

complement their responses using group dynamics than those interviewed individually, because of the support they get from the other participants. This group interaction and support may have made the FGI participants free to express their feelings and expectations.

Our study may have had some limitations. Firstly, it was conducted in one department of one hospital in Uganda. Its findings may not be generalized to all caregivers of sick children or all patients in Uganda. However, this study was intended to deepen understanding of the expectations of the study participants regarding the communication skills of the attending doctors. There seems to be great agreement about what is expected by these caregivers in line with European and USA communication literature [1,16].

Furthermore, the study was conducted while the children were still admitted. This may have hindered some participants from describing all their expectations. However, we attempted to address potential bias by conducting the interviews away from the wards and not in the presence of health personnel who were looking after the sick children. This was in addition to taking measures to ensure rigor as outlined in the methodology section.

We relied on constructs from the CCG to conduct the interviews, which may have influenced the participants' responses and the themes that emerged from the discussion. However, the study participants did not directly mention these skills and desires when asked what they thought would happen during the consultation. We identified the specific skills outlined in the CCG from the participants' rich descriptions. This would indicate that either the doctors do not routinely practice these skills or that the study participants found it difficult to express their communication needs, which may be explained by the implicit way of communication in the African culture as discussed by Gudykunst [10,11].

4.2. Conclusion

This study has shown that the communication needs and expectations of caregivers of sick children in Mulago Hospital are quite similar to those of patients and caregivers in the Western world. In view of the above findings, we should endeavor to address the expectations of the caregivers, by using both verbal and nonverbal behaviour.

4.3. Practice implications

The CCG can be used as a training guide to enhance the communications skills of current and future doctors in Mulago Hospital. However, further studies should be done to explore the expectations of other patients in Sub-Saharan Africa and to relate these findings to what actually happens between caregivers and their doctors in Uganda.

Conflict of interest

We declare no conflict of interest involved when conducting the study.

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